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The Growth of Managed Long-Term Services and Supports Programs: 2017 Update

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Acknowledgements

The authors appreciate feedback provided by several staff at CMS on the design and presentation of this study. We also would like to thank numerous state officials from across the country who provided comments on the summaries of state programs included in this report.

Executive Summary

State Medicaid Agencies have rapidly increased the use of managed care to provide long-term services and supports (LTSS). Medicaid spending for managed long-term services and supports (MLTSS) more than doubled in three years from fiscal year 2012 to fiscal year 2015, and growth is expected to continue as states implement new programs.[1] As additional states pursue MLTSS, understanding state MLTSS approaches can help identify national trends in practice and help states identify peers that have overcome common challenges in program implementation.

This study reviewed available information about the status of Medicaid MLTSS programs, as an update to an inventory completed for the Centers for Medicare & Medicaid Services (CMS) in 2012.[2] We provide updates on the prevalence of MLTSS programs, total enrollment, and specific program design elements as of August 2017. Findings include:

- Twenty-four states operated MLTSS programs in 2017, a 50 percent increase from the 16 states with these programs in 2012.
- More states offered multiple programs, with 11 states offering more than one MLTSS program; several of these states established separate programs for people dually eligible for Medicare and Medicaid as part of the CMS Financial Alignment Initiative.
- The total number of MLTSS programs more than doubled from 19 programs in 2012 to 41 programs in 2017.

[1] Eiken, S., K. Sredl, B. Burwell and R. Woodward Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015. 2017. Prepared for the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Cambridge, MA: Truven Health Analytics, part of the IBM Watson Health business. Available online at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf

[2] Saucier, P., J. Kasten, B. Burwell and L. Gold. The Growth of Managed Long-Term Services and Supports (MLTSS): A 2012 Update. 2012. Prepared for the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Cambridge, MA: Truven Health Analytics (now IBM Watson Health). Available online at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf

- Total enrollment in MLTSS programs more than doubled, from 800,000 in 2012 to 1.8 million in 2017.
- More states used §1115(a) demonstrations to authorize the managed care portion of MLTSS programs in 2017 (19 programs; 46 percent of programs) than in 2012 (five programs; 26 percent).
- As in 2012, a slight majority of 2017 programs required mandatory enrollment for participants (21), while 20 programs had voluntary enrollment.
- The most common populations served continued to be older adults (33 programs in 2017) and adults with physical disabilities (30 programs in 2017).

In addition, this report provides information on new areas of study—state goals for MLTSS programs, functional assessment processes, and network adequacy standards. State MLTSS program goals are centered around five themes, listed in order of frequency: 1) improved participant outcomes and improved quality of care; 2) increased access to HCBS; 3) improved care coordination; 4) improved efficiency; and 5) increased consumer choice. Most states reported program goals for several of these themes.

Functional assessment processes were diverse across the programs. A variety of entities contributed to completing a functional assessment and collecting information to demonstrate a person's need for LTSS, including managed care plans, State Medicaid Agencies, and

§1915(c) Waiver Operating Agencies. Generally, assessor credentials were related to the LTSS populations being served. Most states used home-grown assessment tools specific to their state or program. Finally, there was much variance in the level of detail describing programs' functional eligibility criteria.

A majority of programs (26) had documented network adequacy standards specific to LTSS in publicly available sources. Common standards, in order of most to least frequent, concerned choice of providers; travel distance; travel time; and service initiation time.

The Growth of Managed Long-Term Services and Supports Programs: 2017 Update

The use of managed care plans to provide Medicaid long-term services and supports (LTSS) is growing rapidly. Medicaid spending for managed long-term services and supports (MLTSS) more than doubled in three years from fiscal year 2012 to fiscal year 2015, and growth is expected to continue as states implement new programs for a variety of reasons such as aligning Medicare and Medicaid incentives, improving care coordination, and increasing the predictability of costs and expenditures.[3]

In MLTSS programs, State Medicaid Agencies provide capitated payments to managed care plans for the provision of LTSS, often in addition to other services. States have implemented a variety of MLTSS models of care, including those that focus primarily on LTSS, comprehensive programs that provide most or all Medicaid services, and fully integrated programs including all Medicare and Medicaid services.[4]

This study updates an inventory of MLTSS programs for the first time since 2012 to examine national trends in MLTSS programs, including program expansion, enrollment, covered populations, benefits, and use of Medicaid authority to support program operations. We also explore how states complete functional assessments to determine whether people need LTSS and the standards states established to ensure an adequate network of providers to meet the needs of program participants.

This study is a point-in-time snapshot of the status of Medicaid MLTSS as of 2017 based on a variety of written sources including §1915(b) and §1915(c) waiver applications, program fact

[3] Eiken, S., K. Sredl, B. Burwell and R. Woodward Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015. 2017. Prepared for the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Cambridge, MA: Truven Health Analytics, part of the IBM Watson Health business. Available online at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf

[4] Saucier, P., J. Kasten, B. Burwell and L. Gold. The Growth of Managed Long-Term Services and Supports (MLTSS): A 2012 Update. 2012. Prepared for the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Cambridge, MA: Truven Health Analytics (now IBM Watson Health). Available online at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf

sheets, §1115(a) demonstration approval packages including standard terms and conditions, managed care contracts, and other information available on federal and state websites.[5]

[5]Enrollment data are based on reports dated in 2016 or 2017, using the most recent data available. For some programs, certain types of data such as enrollment totals and network adequacy standards were not available in the sources reviewed for this study. We sent a one-page summary of each program to states for their review and incorporated state feedback throughout the report. Appendix A contains these summaries, which focus on the data elements discussed in the body of the report, along with additional source information.

We included programs that deliver LTSS to older persons, persons with physical disabilities, and/or persons with intellectual/developmental disabilities. We did not, however, collect comprehensive data for managed care plans providing services to those with severe emotional disturbance, severe mental illness, or substance use disorder, such as the behavioral health carve-out programs that exist in many states, due to resource limitations. We also did not include the Program of All-inclusive Care for the Elderly (PACE). Although PACE sites were among the first to deliver capitated LTSS, we have excluded them from this inventory because the PACE model has been described extensively elsewhere and site locations are published by the National PACE Association.[6]

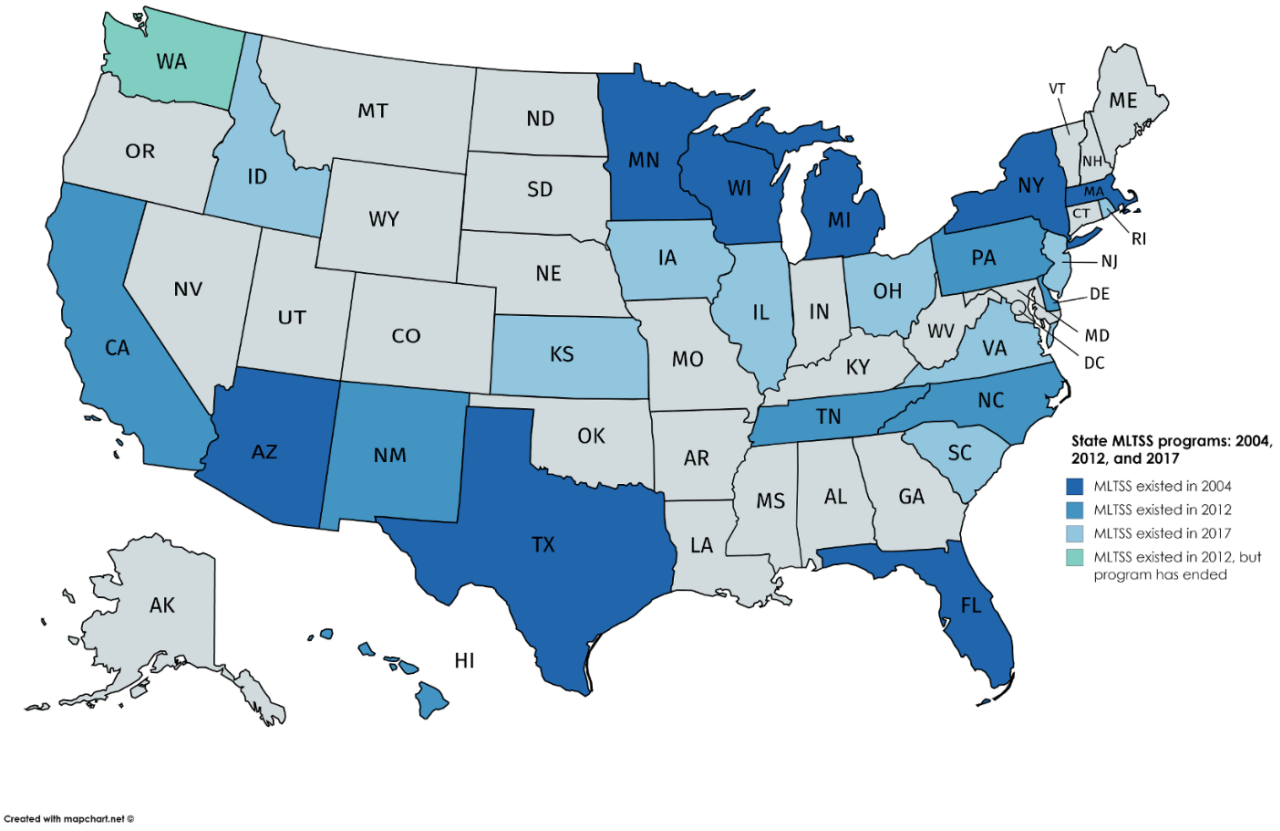
[5] This study relied in part on information compiled for CMS as part of its Medicaid 1115 Demonstration Performance Metrics Database and Analytics project, CMS-2014-141718.

[6] Find a PACE Program in Your Neighborhood" 2012. Prepared by the National PACE Association. Available on-line at http://www.npaonline.org/pace-you/find-pace-program-your-neighborhood

MLTSS Prevalence

The number of states implementing MLTSS and the number of MLTSS programs have grown rapidly in recent years. When first researched in 2004, only eight states had at least one implemented MLTSS program.[7] By 2012, the number of states doubled to 16, with 19 programs.[8] In August 2017, 24 states had implemented 41 MLTSS programs. Since 2012, nine states started providing MLTSS (see Figure 2.1), while only one state stopped providing MLTSS. Washington ended its only MLTSS program, the Washington Medicaid Integration Partnership, a small program that served approximately 5,000 people in 2012.

Figure 2.1: Prevalence of MLTSS in 2004, 2012, and 2017



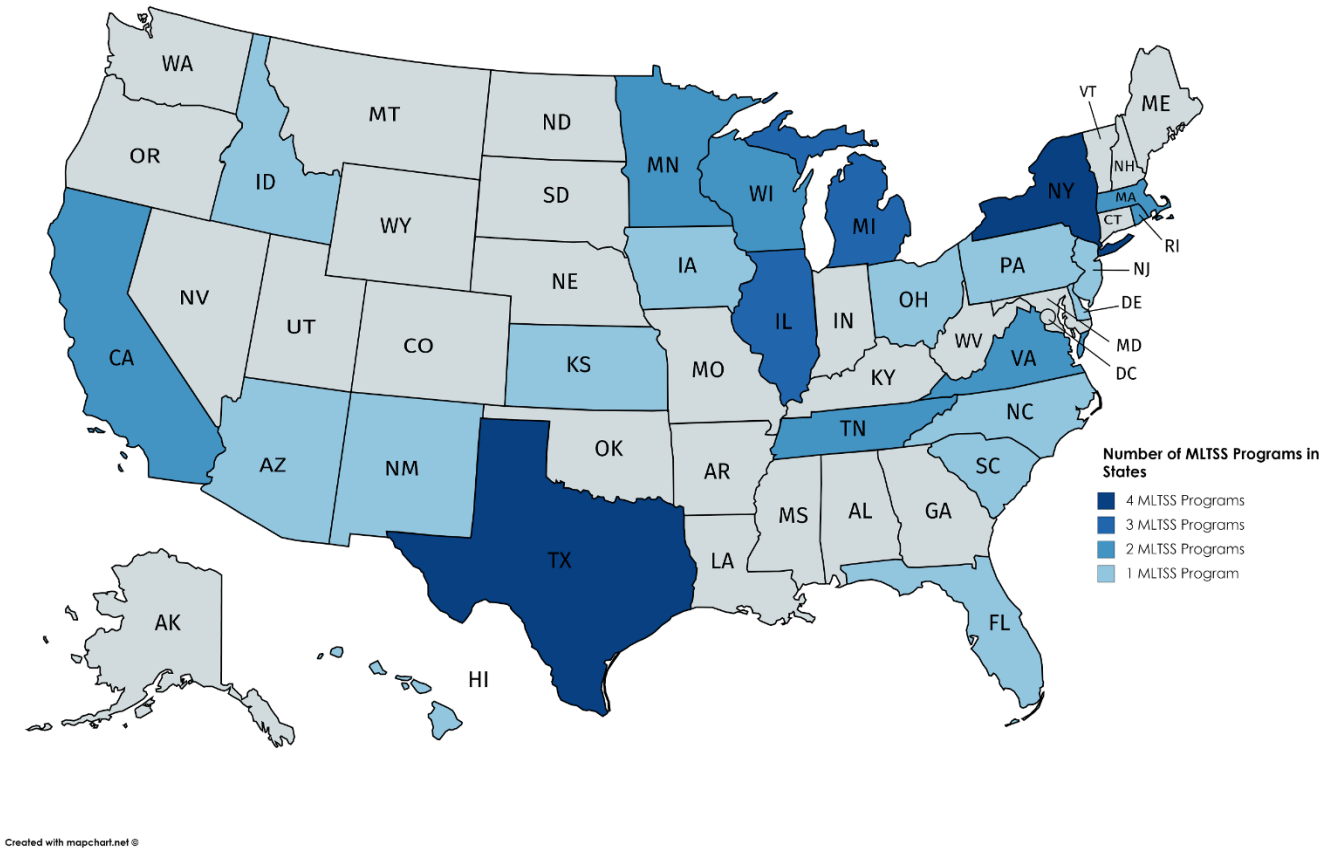
[7] Saucier, P., B. Burwell and K. Gerst. The Past, Present and Future of Managed Long-term Care. 2005. Prepared for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning & Evaluation. Cambridge, MA: Thomson Medstat (now Truven Health Analytics part of IBM Watson Health). Available online at: http://aspe.hhs.gov/daltcp/reports/mltc.htm

[8] Saucier, P., J. Kasten, B. Burwell and L. Gold. The Growth of Managed Long-Term Services and Supports (MLTSS): A 2012 Update. 2012. Prepared for the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Cambridge, MA: Truven Health Analytics (now part of IBM Watson Health). Available online at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf

The number of programs more than doubled from 19 in 2012 to 41 in 2017 as more states chose to implement multiple MLTSS programs. Figure 2.2 shows the number of MLTSS programs in each state, ranging from one to four programs.

The number of programs grew more rapidly than the number of states implementing MLTSS programs. This is due, in part, to states developing separate programs targeting participants dually eligible for Medicare and Medicaid under the authority granted by the CMS Financial Alignment Initiative (FAI). Some states with FAI programs also offered a Medicaid-only MLTSS program, including California, Massachusetts, Rhode Island, Texas, Illinois, and New York. In addition, a few states offered distinct programs targeting different populations. For example, Michigan and Tennessee offered separate programs for people with intellectual disability and other developmental disabilities (I/DD) and for older adults and people with physical disabilities.

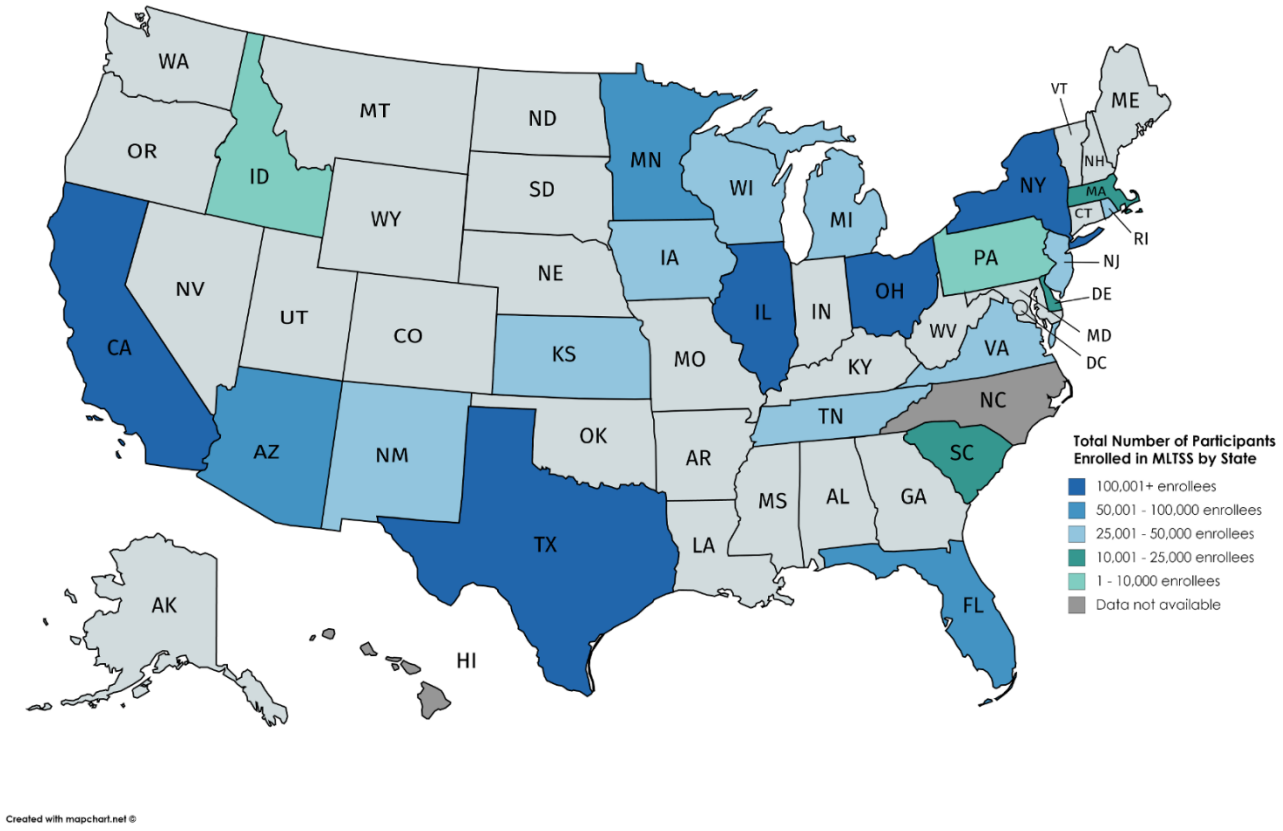
Figure 2.2: Number of MLTSS Programs by State, 2017



Note: One of Virginia's programs, the Coordinated Care Initiative, ended on December 31, 2017.

Total MLTSS program enrollment varied across the states, as shown in Figure 2.3. Five large states each served more than 100,000 individuals: California, Illinois, New York, Ohio, and Texas. The smallest program, in Pennsylvania, served fewer than 500 persons. Enrollment data in Figure 2.3 were combined across all MLTSS programs available in a state. Further, several states' MLTSS programs serve individuals who did not use LTSS but were enrolled in a program for populations at risk of needing LTSS such as older adults and people with disabilities. Additional information about how LTSS enrollment was defined is in Appendix A.

Figure 2.3: Total Number of Participants Enrolled in MLTSS by State, 2017



California, Massachusetts, Michigan, and Texas enrollment data do not include programs for which data were not available in sources reviewed for this study.

Total MLTSS program enrollment using the most recent data available (2016 or 2017) was 1.8 million, more than double the 800,000 identified in the 2012 report (using data from 2011 or 2012). Several states including New York and Texas expanded MLTSS programs statewide during this time, increasing enrollment. Table 2.1 on the following page shows enrollment data by program.

Table 2.1: Total Enrollment in MLTSS Programs, 2016 - 2017			
State	**Program Name**	**Total Enrollment**	**Year**
AZ	AZ Long-Term Care Services	60,044	2017
CA[1]	Cal Medi-Connect	118,096	2017
CA	Managed Medi-Cal Long-Term Services and Supports	data not available	n/a
DE	Diamond State Health Plan Plus	12,666	2016
FL	Statewide Medicaid Managed Long-Term Care Plan	93,843	2017
HI	Quest Integration	data not available	n/a
IA	Health Link	36,825	2016
ID	Medicare Medicaid Coordinated Plan	2,489	2016
IL[1]	Integrated Care Program	114,365	2017
IL[1]	Medicare-Medicaid Alignment Initiative	52,004	2017
IL	Managed Long-Term Services and Supports	28,640	2017
KS	KanCare (MLTSS Component)	33,615	2017
MA	Senior Care Options	data not available	n/a
MA[1]	One Care	17,938	2017
MI	Managed Specialty Services and Supports	data not available	n/a
MI[1]	MI Health Link	39,965	2017
MI	MI Choice	data not available	n/a
MN[1]	Senior Health Options	37,649	2017
MN[1]	Senior Care Plus	16,265	2017
NC	NC Innovations (MH/DD/SA)	data not available	n/a
NJ	NJ FamilyCare (MLTSS Component)	28,731	2016
NM	Centennial Care	34,947	2016
NY	Managed Long-Term Care Partial Cap	186,626	2017
NY	Medicaid Advantage Plus	8,356	2017
NY	Fully Integrated Duals Advantage	4.468	2017
NY	Fully Integrated Duals Advantage – I/DD	701	2017
OH[1]	OH MyCare (Integrated Care Delivery System)	111,994	2017
PA	Adult Community Autism Program	147	2016
RI[1]	Rhody Health Options	15,234	2016
RI[1]	Integrated Care Initiative, Phase 2 (Neighborhood Integrity)	13,725	2017
SC[1]	Healthy Options Prime	11,907	2017
TN	CHOICES	28,941	2017
TN	Employment and Community First CHOICES	1,389	2017
TX[1]	STAR+PLUS	519,105	2017
TX[1]	Duals Program	41,182	2017
TX[1]	STAR Health	30,912	2016
TX	STAR Kids	data not available	n/a
VA[1]	Coordinated Care Initiative	26,063	2017
VA	Commonwealth Coordinated Care Plus	data not available	n/a
WI	Family Care	44,404	2017
WI	Family Care Partnership	3,000	2017
US[1]	Total Reported Enrollment	1,776,236	2016-17

Notes:

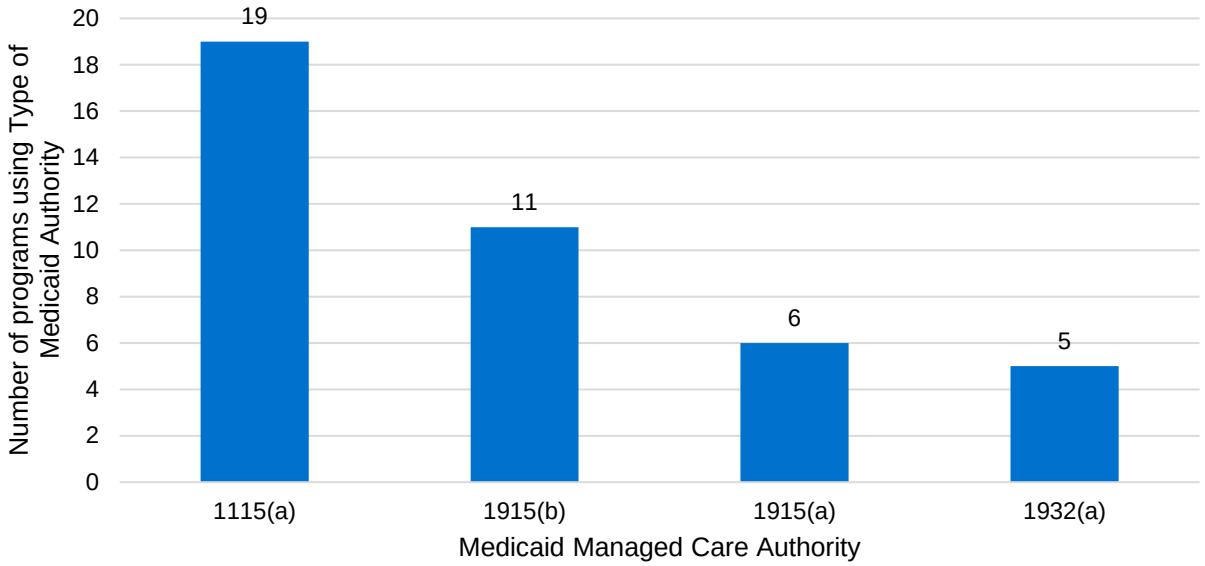
[1] Enrollment data for these programs include individuals who did not use LTSS but are enrolled in a program that targets populations at risk of needing LTSS.

"Data not available" means the data were not within the publicly available sources reviewed for this report. Virginia Commonwealth Coordinated Care Plus started August 1, 2017; no publicly available enrollment data was available yet.

States used a variety of Medicaid program authorities to authorize implementation of managed care for LTSS. As shown in Figure 2.4, 19 programs were authorized through a §1115(a) demonstration (46 percent of programs) and 11 programs were authorized by a §1915(b) waiver (27 percent). The remaining programs were authorized under §1915(a) contracts (six programs; 15 percent) and §1932(a) state plan amendments (five programs; 12 percent).

Figure 2.4 only refers to the authorization of Medicaid managed care; states also must authorize the provision of LTSS benefits such as §1915(c) waiver services and state plan personal care. Some states authorized services similar to §1915(c) waiver services within a §1115(a) demonstration.

Figure 2.4: Number of MLTSS Programs by Medicaid Managed Care Authority, 2017



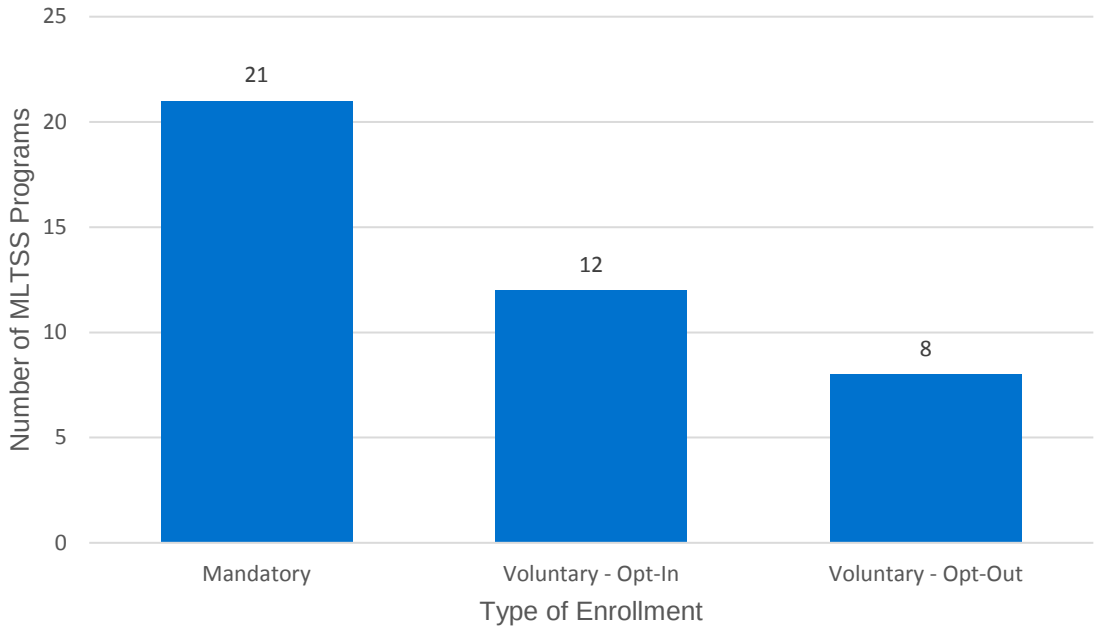
States chose the managed care authority based on their preferred program design. The various authorities provide specific opportunities for program development and implementation. For example, only §1115(a) demonstrations and §1915(b) waivers allow states to require mandatory enrollment in managed care. Each authority incorporates other requirements that states must consider, such as budget neutrality under a §1115(a) demonstration or cost-effectiveness under a §1915(b) waiver.

State use of program authorities changed significantly from 2012 when states were about evenly split in using §1915(a) authority (seven programs, 37 percent); §1915(b) waivers (five programs, 26 percent), and §1115(a) demonstrations (five programs, 26 percent). Only two programs used

§1932(a) authority (11 percent). In 2017, a higher percentage of programs used §1115(a) demonstrations (from 26 to 46 percent) while a lower percentage of programs used §1915(a) contracts (from 37 to 15 percent). More states are using §1115(a) demonstration authority as they seek large-scale reform of Medicaid program elements and test new program designs or other innovations.

Programs also varied in their use of mandatory and voluntary enrollment (see Figure 2.5). In 2017, states required mandatory enrollment in 21 programs,[9] a little more than half of the 41 MLTSS programs. Beneficiaries voluntarily chose to enroll in 12 programs (voluntary opt-in).[10] In the remaining eight programs, states passively enrolled beneficiaries, who had the option to leave the program (voluntary opt-out).

Figure 2.5: Number of Programs Using Types of Enrollment, 2017

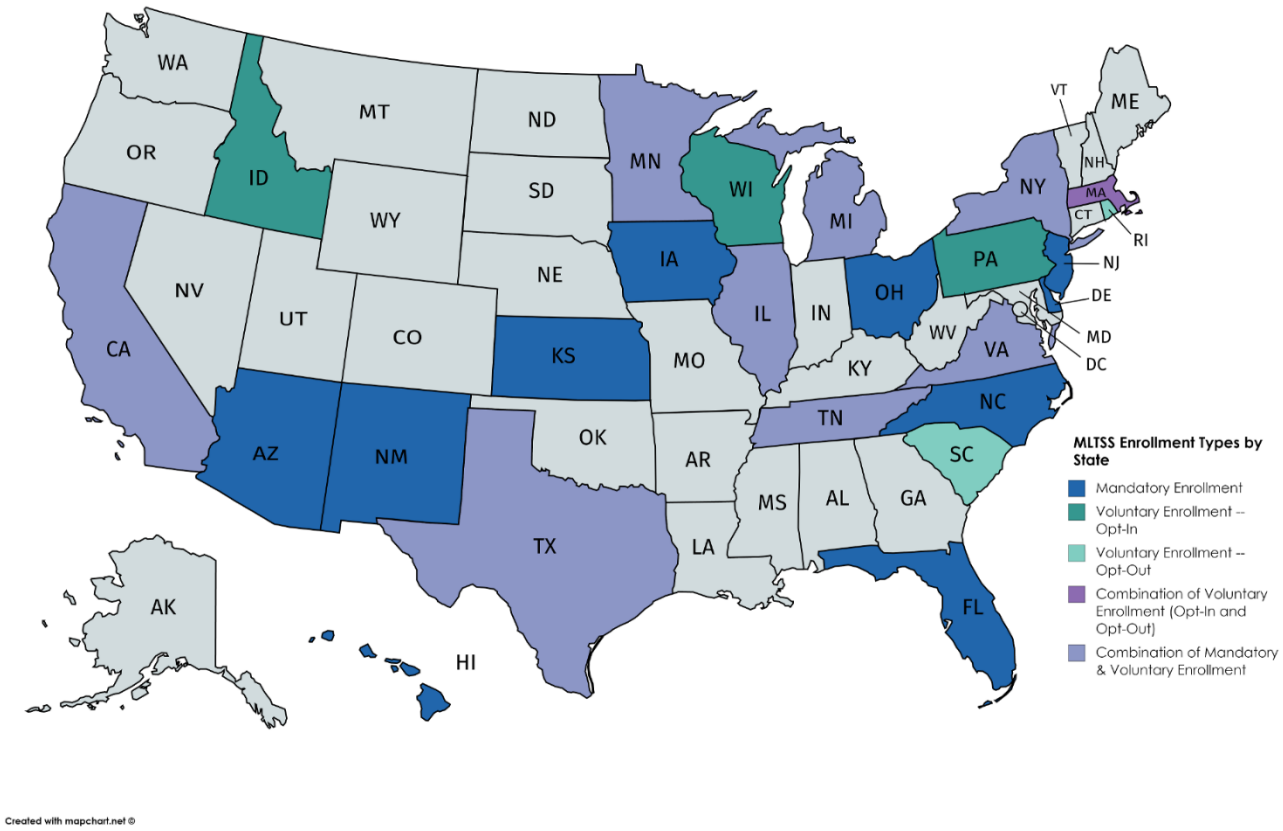


[9] The number of mandatory programs includes Texas STAR+PLUS, which requires enrolment for most of its eligible population (older adults and people with physical disabilities) but does not require enrollment for children with disabilities.

[10] The number of voluntary opt-in programs includes Tennessee's Employment and Community First CHOICES, which offers voluntary opt-in enrollment for most of its eligible population (people in an I/DD waiver), but requires new I/DD waiver participants to enroll.

Similarly, 2012 MLTSS programs were about evenly split between mandatory and voluntary enrollment. Eight states required mandatory enrollment, six states offered voluntary enrollment (opt-in), and one state offered voluntary enrollment (opt-out). A difference between 2017 and 2012 is the growth of states with programs using both types of enrollment from one to eight, as the map in Figure 2.6 shows. In 2012, only Minnesota offered one program with mandatory enrollment and one program with voluntary enrollment (opt-in).

Figure 2.6: MLTSS Enrollment Types by State, 2017



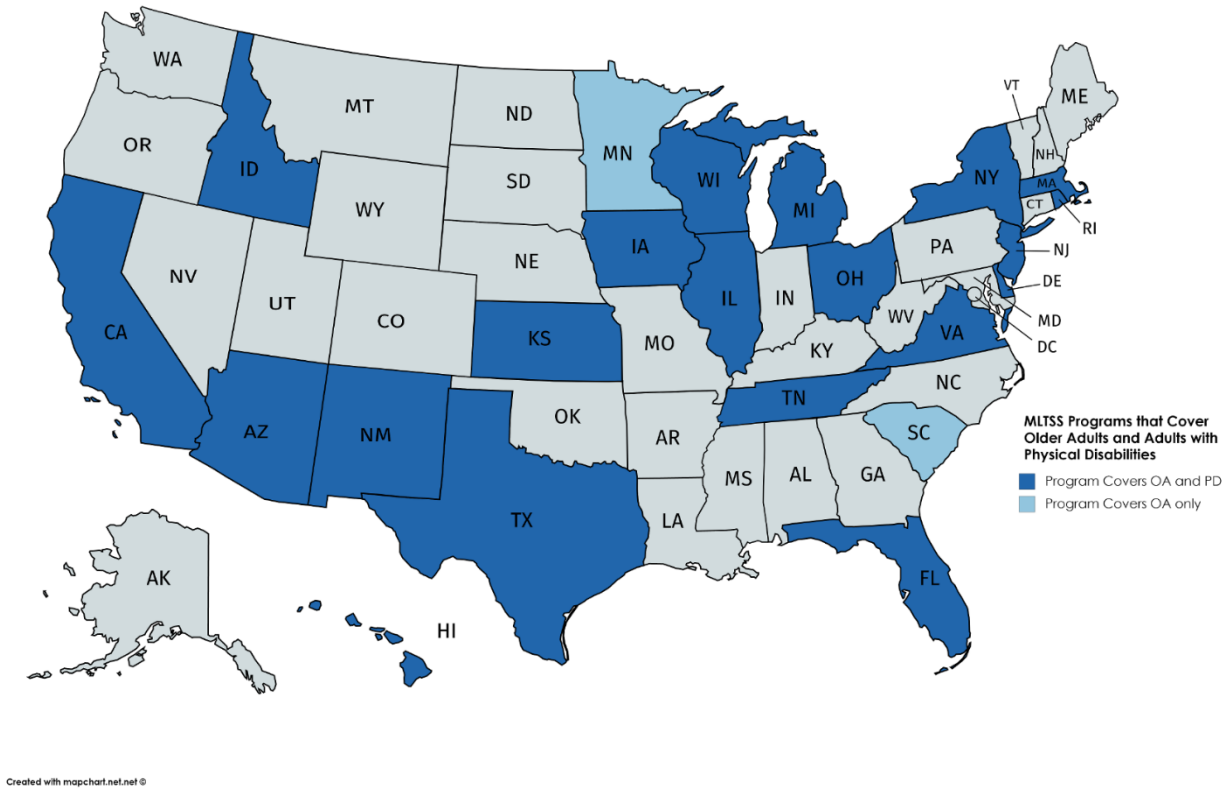
Note:
One of Virginia's programs, the Coordinated Care Initiative, ended on December 31, 2017. The remaining program requires mandatory enrollment.

Populations Served in MLTSS Programs

States most commonly used MLTSS to serve older adults and people with physical disabilities. In 2012, nine states with MLTSS programs targeted both older adults and adults with physical disabilities (12 programs). By 2017, 19 states had programs that covered both older adults and adults with physical disabilities in MLTSS (29 programs). Another state, Massachusetts, offered separate programs for older adults and people under age 65 with physical disabilities, so 20 total states offered MLTSS to both populations (see Figure 3.1). Among the programs were FAI demonstrations in ten states enrolling dually eligible beneficiaries.

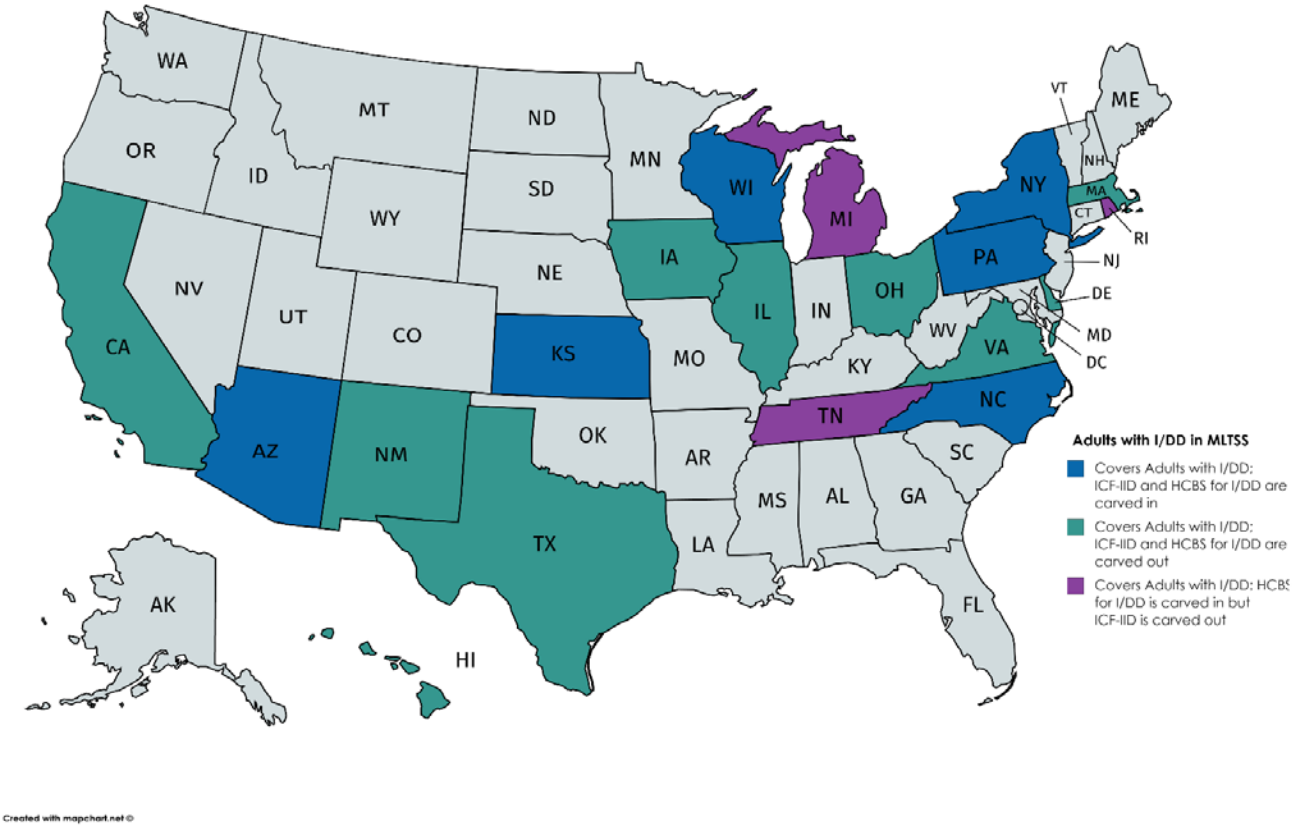
Two additional states, Minnesota and South Carolina, with three programs served only older adults in MLTSS. The number of states serving only older adults through MLTSS decreased from four in 2012. Three of the 2012 states—California, Florida, and Massachusetts—added MLTSS for people with physical disabilities by 2017. Minnesota continued to serve only older adults while South Carolina added an MLTSS program only for this population.

Figure 3.1: MLTSS Programs Serving Older Adults and Adults with Physical Disabilities, 2017



The number of MLTSS programs serving adults with I/DD also grew, from eight states and nine programs in 2012 to 19 states and 24 programs in 2017. As in 2012, most of these states did not include LTSS services targeted people with I/DD: either intermediate care facilities for individuals with intellectual disabilities (ICF/IID) or HCBS for people with I/DD. Nine states covered HCBS targeting this population and six states included ICF/IID services within their MLTSS programs. Michigan, Rhode Island, and Tennessee covered HCBS, but not ICF/IID, in MLTSS, as shown in Figure 3.2.

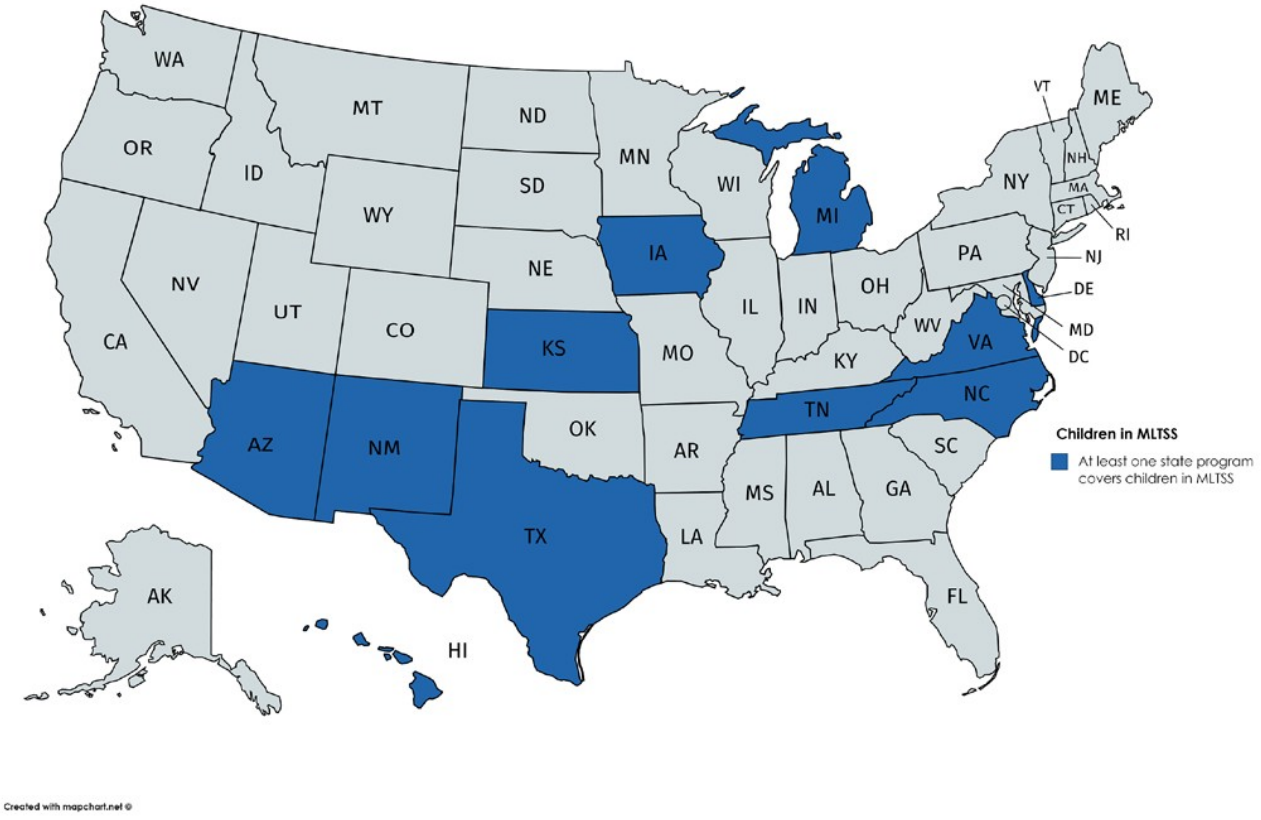
Figure 3.2: MLTSS Programs Serving Adults with I/DD, 2017



Note:
Michigan and Rhode Island both enroll adults with I/DD in two programs: one carves out ICF/IID but carves in HCBS for I/DD; the other carves out both ICF/IID and HCBS for I/DD.

The number of MLTSS programs serving children with disabilities has not grown as rapidly as the number of programs serving other populations. In 2012, eight states served children in a total of eight MLTSS programs. Five years later, 14 programs in 11 states included children, as shown in Figure 3.3. Iowa, Kansas, and Virginia began serving children in MLTSS between 2012 and 2017. Twelve of these programs covered adults as well as children. Only Texas has developed MLTSS programs specifically for children, the STAR Kids program for children with disabilities and the STAR Health program for children and youth currently or formerly in foster care.

Figure 3.3: MLTSS Programs Serving Children with Disabilities, 2017



Note:
North Carolina does not include children ages 0 to 3 years in their MLTSS program.

State Goals for MLTSS Programs

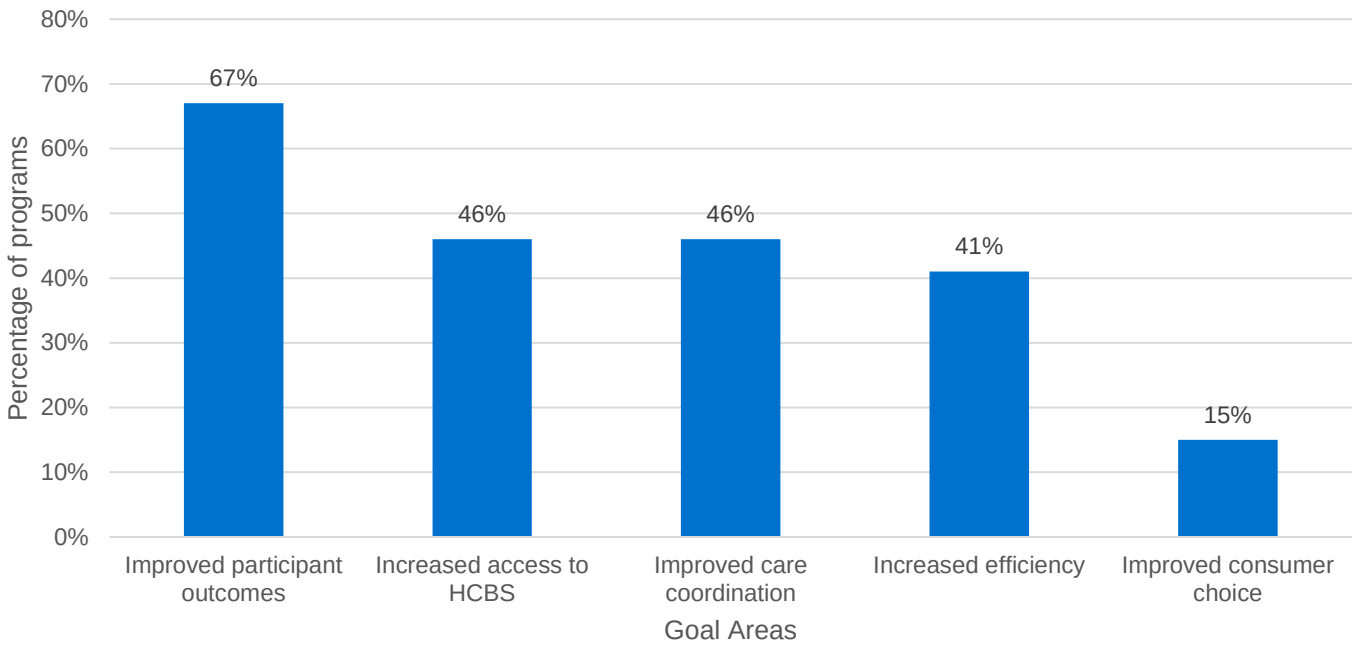
To better understand the reasons for the rapid growth of MLTSS, we reviewed states' program goals, a new focus area for this study. Across the states, five common themes emerged among MLTSS program goals:

1. **Improved participant outcomes and quality of care**: States sought to improve health outcomes and quality of life for participants. Particular goals included increased monitoring of unusual incidents and improved health outcome data and participant satisfaction.
2. **Increased access to HCBS**: States sought to expand the network of providers or otherwise increase the availability of HCBS.
3. **Improved care coordination**: States sought to provide better care coordination across physical health, LTSS, institutional care, and, in some programs, behavioral health services.
4. **Improved efficiency**: States sought to improve the cost-effectiveness of services by making the dollars spent in the program go further.
5. **Increased consumer choice**: States sought to offer a broader choice of available services, providers, and settings.

State goals were identified from a variety of written sources such as §1115(a) approval documents and fact sheets, §1915(c) HCBS waiver applications, managed care contract language, and state websites. The descriptions of each MLTSS program in Appendix A describe goals, and the sources, in more detail. Program goals were not located in the resources reviewed for two programs: South Carolina Healthy Options Prime and Texas STAR+PLUS.

Several states had goals that did not fall into one of these five themes; these goals also are summarized in Appendix A. Almost all states articulated more than one goal for MLTSS; exceptions to this are Michigan (Managed Specialty Services and Supports and MI Health Link) and Minnesota (Senior Health Options), specifying one program goal each. Many programs sought improvements in several of the areas discussed above, as well as other state-specific priority areas. The percentage of MLTSS programs that identified each of the five goal areas is shown in Figure 4.1 on the following page.

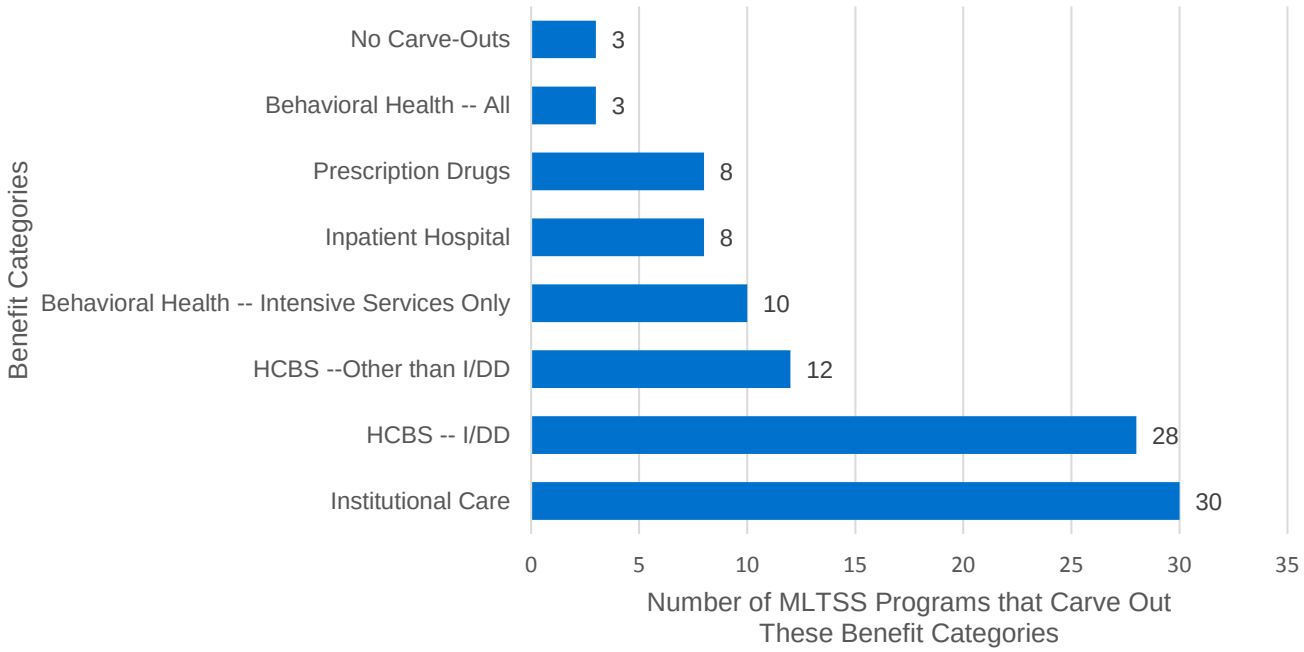
Figure 4.1: Goal Areas Identified for MLTSS Programs, 2017



MLTSS Program Benefits and Exclusions

Only three MLTSS programs covered all Medicaid covered benefits within the managed care capitation rate: Arizona Long-Term Services and Supports, Kansas KanCare, and Wisconsin Family Care Partnership. All other programs carved out one or more benefits from the managed care capitation rate. Most programs excluded LTSS for people with I/DD—institutional care and/or HCBS—from the managed care capitation rate. Other common types of benefits carved out from the MLTSS program include behavioral health services, prescription drugs, and inpatient hospitalization, as presented in Figure 5.1.

Figure 5.1: Benefits Carved Out of Managed Care Capitation Rates, 2017



In 30 programs, some type of institutional care is carved out of the managed care capitation rate. This includes 25 programs in which only care provided in an ICF/IID is excluded, two programs that carved out ICF/IID and nursing facility stays of more than 180 days, and three programs that excluded all ICF/IID and nursing facility care.

Similarly, HCBS provided to participants with I/DD was carved out of the managed care rate in 28 programs. Twelve programs carved out HCBS provided for other target groups such as older adults and people with physical disabilities.

Other categories of service were carved out less often: prescription drugs (eight programs); inpatient hospital (eight programs); all behavioral health services (three programs); and intensive behavioral health services such as day treatment or state plan rehabilitative services (ten programs in addition to the three that excluded all behavioral health services). Six programs reported benefits carved out of the managed care capitation rate that did not fit within the above categories. These benefits are described in the summary of each program in Appendix A.

Functional Assessments in MLTSS

A new area of study in 2017 is how programs completed functional assessments and collected information to demonstrate a participant's need for LTSS, whether for institutional care or for HCBS. This report describes the type of entities and professionals that performed assessments, the assessment instruments used, and functional eligibility criteria for MLTSS. Functional assessment process information is based on §1115(a) approval documents, §1915(c) waiver applications, and managed care contracts. Information was not available in the sources reviewed for this study for some MLTSS programs, as described in Appendix A.

This section of the report focuses on variation across states and programs, but the functional assessment process also can vary within an MLTSS program. Some programs under concurrent authority with a §1915(c) waiver listed different assessment processes for each §1915(c) waiver. For example, Illinois' Integrated Care Program is a single managed care program authorized under §1932(a) state plan authority, but other program requirements and descriptions exist under five §1915(c) waivers. Each waiver authorizes a specific entity to perform or approve the assessment, assessor credentials, and functional eligibility criteria for waiver services.

States and programs varied greatly in the description of the assessment process. Some programs identified specific entities completing the assessment and credentials of the assessors. Four common types of assessment entities were:

- Managed care plans (24 programs);
- The State Medicaid Agency (13 programs), either contributing to the assessment or making the final determination of eligibility based on another entity's assessment;
- The Waiver Operating Agency (seven programs), the agency delegated to oversee the day-to-day operations of a §1915(c) waiver program under the authority of the State Medicaid Agency; and
- Other entities (14 programs), including Area Agencies on Aging, Aging and Disability Resource Centers, other county or local agencies, and contractors specially selected for this task.

States varied in identifying and describing assessor's credentials as well. Some programs included a team approach and listed each required member of the team. Others listed specific individual professional or educational credentials (for example, registered nurse or a bachelor's degree in a human services field). Some states specified training criteria related to the assessment instrument itself that had to be completed and mastered prior to performing assessments.

A common theme among assessor credentials was a specific relationship to the population served by the MLTSS program. For example, assessment by a registered nurse for adults with physical disabilities meeting a nursing facility level of care or assessment by qualified developmental disabilities professionals for participants with I/DD.

Similarly, assessment tools varied significantly but appeared related to the LTSS population targeted for the program. Many assessment tools were used statewide, but some managed care contract language indicated that the contractor would be responsible for developing their own assessment tool. Most assessment tools also appeared to be developed specifically for the state or program that used them. Only a few programs used national assessments, such as Iowa Health Link (InterRAI),[11] and Kansas KanCare (the Child Behavior Checklist, used in assessments of children with autism spectrum disorder).[12]

Consistent with the variation in staff credentials and assessment tools, functional assessment criteria to determine the need for LTSS also varied across states, populations, and programs. Some states had very specific criteria. For example, Michigan MI Choice described seven "doors" of eligibility, each with their own minimum score on the state's assessment a person would need to achieve to be enrolled. Other states offered several levels of eligibility, such as Rhode Island (highest needs group, high needs group, and preventative needs group) and associated criteria for each level. Still others, such as Illinois, required a minimum score on the assessment measure (for example, 29 points) to receive either institutional care or HCBS.

[11] More information about the InterRAI is available at http://www.interrai.org/

[12] More information about the Child Behavior Checklist is available at http://www.aseba.org/

MLTSS Network Adequacy Standards

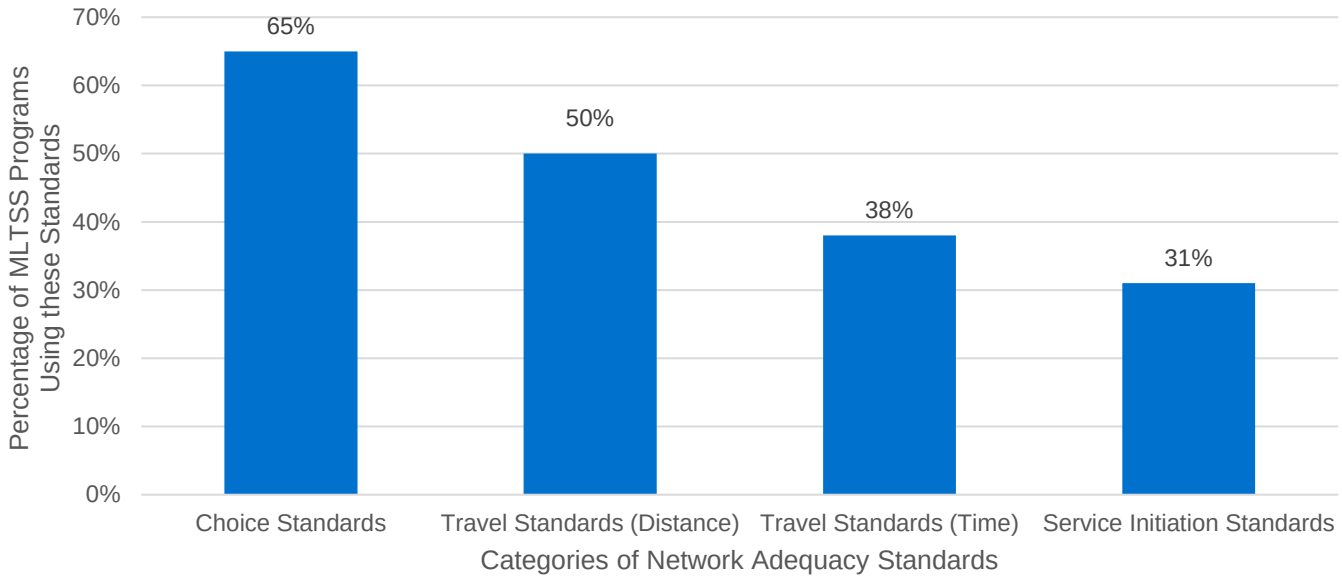
MLTSS programs are required to publish network adequacy standards specific to LTSS in contracts with rating periods beginning on or after July 1, 2018. In anticipation of this deadline, we reviewed network adequacy standards where information was available in sources reviewed for this study. Twenty-six of the MLTSS programs studied had published network adequacy standards specific to LTSS as of 2017. This information was reviewed primarily through §1115(a) approval documents such as standard terms and conditions and managed care contracts that were publicly available. Specific sources are listed in Appendix A.

States tended to use one or more of the following network adequacy definitions:

1. **Choice standards**: A minimum of two of more providers in a service area from which a participant could choose to receive services, unless an exception was made by the state. For example, Virginia requires only one provider to be available in a locality for certain services such as assistive technology, environmental modification, personal emergency response systems, and durable medical equipment and supplies.
2. **Travel standards (distance)**: A measure of travel in miles from the participant's residence to the point of service. Some states defined this differently for HCBS, measuring distance from the provider's home office to the participant's residence. This travel standard was generally defined separately for urban and rural areas.
3. **Travel standards (time)**: A measure of travel in minutes from the participant's residence to the point of service, or, for HCBS, from the provider's home office to the participant's residence. Again, different standards applied to urban and rural areas.
4. **Service initiation standards**: The time between the date a referral for service was made to the date the service was initiated for a participant.

In many cases a state or a program used a combination of network adequacy categories. Figure 7.1 on the following page shows the percentage of programs that used each type of standard, based on the 26 programs reporting specific standards for LTSS.

Figure 7.1: Network Adequacy Standards Identified for MLTSS Programs, 2017



A few states used other standards for network adequacy such as requiring certain cultural or language competencies among providers; the ability to serve a certain percentage of participants with existing providers in the area; or providers that do not have waiting lists. More information is provided in the program description tables in Appendix A.

Conclusion

Medicaid MLTSS grew rapidly in the past five years. The number of states using managed care to deliver LTSS increased by eight to 24, the number of programs increased from 19 to 41, and enrollment in MLTSS programs increased by almost a million beneficiaries.

As was true in previous versions of this report, most MLTSS programs served older adults and adults with physical disabilities. More programs were available in 2017 for adults with I/DD and, to a lesser extent, for children with disabilities, than were available in 2012.

Similar to findings in 2012, MLTSS programs are split between mandatory and voluntary enrollment types, with a little more than half of the programs using mandatory enrollment.

MLTSS programs varied considerably in functional assessment processes and network adequacy standards, although common patterns emerged. Future study in these areas may identify new trends over time. For example, will states begin to shift to nationally standardized assessment instruments? How will states define network adequacy standards for LTSS in future years? Finally, as the CMS HCBS Settings Rule becomes effective in 2022, it is likely that these programs will need to adjust and adapt to the new requirements. A future study may identify patterns across states in these areas.

States continue to pursue MLTSS as they reform their Medicaid programs. For example, CMS recently approved Pennsylvania's Community Health Choices program and phased implementation started January 1, 2018. This program was authorized using §1915(b) and §1915(c) concurrent waiver authorities. Other states developing or considering implementation of MLTSS programs are Arkansas, Alabama, Louisiana, Nebraska, New Hampshire, Nevada, and Oklahoma, suggesting MLTSS growth is likely to continue over the next five years.[13]

[13] Dobson, C., S. Gibbs, A. Mosey, and L. Smith. 2017. Demonstrating the Value of Medicaid MLTSS Programs. Available online at http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12- 17.pdf.

Appendix A: Description of Existing MLTSS Programs as of August 2017

Table of Contents

Abbreviations in MLTSS Program Tables

ADLs: Activities of Daily Living

CMS: Centers for Medicare and Medicaid Services

FAI: Financial Alignment Initiative

FFS: Fee for Service

HCBS: Home and Community-Based Services

IADLs: Instrumental Activities of Daily Living

ICF/IID: Intermediate Care Facility for Individuals with Intellectual Disabilities

I/DD: Intellectual Disability or other Developmental Disabilities

LTSS: Long-Term Services and Supports

MLTSS: Managed Long-Term Services and Supports

NF: Nursing Facility

RFP: Request for Proposal

Data Notes

Total Enrollment: the number of participants enrolled in the MLTSS program. If a program was part of a larger §1115(a) demonstration that covers most of a state's Medicaid population, such as Kansas KanCare, only enrollment for the MLTSS component of the program was reported. For some states, total enrollment includes individuals who did not use LTSS but were enrolled in a managed care program that provides LTSS and targets populations at risk of needing LTSS such as older adults and people with disabilities. If publicly available sources reported different enrollment data, we used the most recent, comprehensive data available. A few states updated enrollment data when they reviewed the one-page program summaries in this Appendix.

LTSS Enrollment: the number of participants currently receiving LTSS, as we could discern from available data. LTSS enrollment data were not publicly available for all programs. LTSS enrollment across all programs with available data was 645,686, an increase of 266,296 participants from 2012 (reported as 389,390). However, the 2012 report included state-reported data and therefore was more complete than this report, which used only publicly available sources. A few states updated LTSS enrollment data when they reviewed the one-page program summaries in this Appendix.

State Program Goals, Process for Functional Assessment Completion, and Network Adequacy Standards: Text in this Appendix reflects language in publicly available documents regarding each state's program, but is not necessarily exact quotations from those documents.

Data not available: indicates data that was not in the sources reviewed for this study or provided by the state during their review.

State responses: have been integrated into the data tables presented in this section.

Arizona – Arizona Long-Term Care System (ALTCS)

Program Characteristics	Program Description Notes
Program Start Date	January 1, 1989
LTSS Population Served	Older adults, adults with physical disabilities, adults with I/DD, children with disabilities
Benefits Carved-Out of Managed Care Capitation	None
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Mandatory
Total Enrollment	60,044 August 2017 Source: State website
LTSS Enrollment	60,044 August 2017 Source: State website
State Program Goals	To test delivery system models that coordinate care for both acute and long-term care needs, and to test the extent to which population health outcomes are improved by expanding coverage to additional groups. Source: 1115(a) demonstration approval document
Process for Functional Assessment Completion	A registered nurse or social worker employed with the managed care plan completes a prescreening assessment to determine if the beneficiary is at risk of institutionalization in a NF or ICF/IID, and if they meet criteria for ALTCS. Source: 1115(a) demonstration approval document
Network Adequacy Standards	Not specific to LTSS: travel standard (distance), service initiation standard, and other standard. Timely, accessible, and geographically convenient; comparable to those in FFS Medicaid. Source: Managed care contract
Managed Care Contract:	Available on State website

California – Cal Medi-Connect

Program Characteristics	Program Description Notes
Program Start Date	April 1, 2014
LTSS Population Served	Older adults, adults with physical disabilities
Benefits Carved Out of Managed Care Capitation	Behavioral health – intensive, institutional – ICF/IID, HCBS – I/DD, HCBS – other
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary (opt-in)
Total Enrollment	118,096 August 1, 2017 Source: ICRC website
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	To improve the continuity of care and use person-centered approaches, to maximize peoples' ability to remain at home and in the community, to increase availability and access to HCBS alternatives, to preserve the ability to self-direct care, and to provide high-quality care, and to optimize use of resources. Source: State website
Process for Functional Assessment Completion	A health risk assessment is completed by managed care plan interdisciplinary team if requested, or by the primary care physician or care coordinator if not. This assessment generates appropriate referrals to LTSS as indicated. Source: Managed care contract
Network Adequacy Standards	Not specific to LTSS: other standard. The contractor must demonstrate an adequate network with regards to physical, communication, and geographic access. Source: Managed care contract
Managed Care Contract:	Available on FAI section of CMS.gov.

California – Managed Medi-Cal Long-Term Services and Supports

Program Characteristics	Program Description Notes
Program Start Date	April 1, 2014
LTSS Population Served	Older adults, adults with physical disabilities, adults with I/DD Excludes adults with I/DD if they are living in a Two Plan/Geographic Managed Care County
Benefits Carved Out of Managed Care Capitation	Behavioral health – intensive, HCBS – other
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	Data not available in sources reviewed for this study
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	Strengthen California's health care safety net; maximize opportunities to reduce the number of uninsured individuals; optimize opportunities to increase federal financial participation and maximize financial resources to address uncompensated care; promote long-term, efficient, and effective use of state and local funds, improve health care quality and outcomes; and promote home and community based care. Source: State website
Process for Functional Assessment Completion	Process completed by a managed care plan employed registered nurse. Source: 1115(a) demonstration approval documents
Network Adequacy Standards	Not specific to LTSS: travel standard (distance), travel standard (time), and other standard. Sufficient number of providers to meet needs without a waitlist, within an hour transportation time, to meet care and communication needs, culturally appropriate. Source: 1115(a) demonstration approval documents
Managed Care Contract:	Not available in sources reviewed for this study

Delaware – Diamond State Health Plan - Plus

Program Characteristics	Program Description Notes
Program Start Date	April 1, 2012
LTSS Population Served	Older adults, adults with physical disabilities, children with disabilities
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID, HCBS – I/DD
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Mandatory
Total Enrollment	12,666 March 31, 2016 Source: 1115(a) demonstration report
LTSS Enrollment	12,666 March 31, 2016 Source: 1115(a) demonstration report
State Program Goals	Improving access to health care for the Medicaid population, including increasing options for those who need LTSS by expanding access to HCBS; rebalancing the state's LTSS system in favor of HCBS, promoting early intervention for individuals with, or at risk for having, LTSS needs; increasing coordination of care and supports; expanding consumer choices; improving the quality of health services; creating a payment structure that provides incentives for resources to shift from institutions to community-based LTSS services where appropriate; improving coordination and integration of Medicare and Medicaid benefits for full benefit dual eligibles; expanding coverage to additional low-income individuals; and improving overall health status and quality of life for individuals enrolled in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program. Source: 1115(a) demonstration approval document
Process for Functional Assessment Completion	A preadmission screening team completes all initial level of care evaluations to determine if a participant meets the nursing facility level of criteria, is at risk of nursing facility level of care, or meets acute hospital criteria. The preadmission screening team does all annual re-evaluations for people in nursing facilities. Managed care organizations do annual re-evaluations for people receiving home and community-based services. Source: 1115(a) demonstration approval document
Network Adequacy Standards	Not specific to LTSS: other standard. The state must ensure the delivery of all covered services and the managed care plan network must be sufficient to provide access to covered services; the network must be culturally appropriate. Source: 1115(a) demonstration approval document
Managed Care Contract	Not available in sources reviewed for this study

Florida – Statewide Medicaid Managed Long-Term Care Plan

Program Characteristics	Program Description Notes
Program Start Date	August 1, 2013
LTSS Population Served	Older adults, adults with physical disabilities
Benefits Carved Out of Managed Care Capitation	Behavioral health – all, prescription drugs, inpatient hospital, institutional – ICF/IID, HCBS – I/DD, HCBS – other, other non-LTSS Medicaid services
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	93,843 December 1, 2017 Source: state comment on draft summary
LTSS Enrollment	93,843 December 1, 2017 Source: state comment on draft summary
State Program Goals	Rebalance LTSS systems by increasing the percentage of enrollees receiving services in the community instead of a nursing facility; reduce potentially preventable emergency department visits, hospitalizations, and re-hospitalizations. Source: state comment on draft summary
Process for Functional Assessment Completion	The Department of Elder Affairs' Comprehensive Assessment and Review (CARES) program determines whether an individual requires nursing facility level of care (or hospital level of care for individuals diagnosed with cystic fibrosis) Source: state comment on draft summary
Network Adequacy Standards	Not specific to LTSS: travel standard (distance), travel standard (time), and choice standard. For therapy, facility-based hospice, and adult day health: 30-minute travel time for urban areas/60-minute travel time for rural areas. The plan must provide a choice of at least two providers per each HCBS service and for facility-based services including NF and assisted living. Source: Managed care contract
Managed Care Contract:	Available on State Website

Hawaii – Quest Integration

Program Characteristics	Program Description Notes
Program Start Date	January 1, 2015
LTSS Population Served	Older adults, adults with physical disabilities, adults with I/DD, children with disabilities
Benefits Carved Out of Managed Care Capitation	Behavior health – intensive, institutional – ICF/IID, HCBS – I/DD
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Mandatory
Total Enrollment	Data not available in sources reviewed for this study
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	Improve the health care status of the member population; minimize administrative burdens, streamline access to care for enrollees, and improve health outcomes through integration of programs and benefits; align the demonstration with the Affordable Care Act; improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers; expand access to HCBS and allow individuals a choice between institutional care or HCBS; maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided whenever possible in the member's community; establish contractual accountability among the contracted health plans and providers; continue the predictable and slower rate of expenditure growth associated with managed care; expand and strengthen a sense of member responsibility; and promote independence and choice that leads to more appropriate utilization of the health care system. Source: 1115(a) demonstration approval document
Process for Functional Assessment Completion	The managed care plan service coordinators complete the functional assessment to assess whether participants meet or are at risk for NF or hospital level of care. The state will make the final determination of eligibility. Source: 1115(a) demonstration approval documents and RFP for managed care contract
Network Adequacy Standards	Specific to LTSS: other standard. The managed care plan must have providers in the network for each covered HCBS service. Source: RFP for managed care contract
Managed Care Contract: [Note: This is the RFP for 2014]	Available on State website

Idaho – Medicare Medicaid Coordinated Plan

Program Characteristics	Program Description Notes
Program Start Date	July 1, 2014
LTSS Population Served	Older adults, adults with physical disabilities
Benefits Carved Out of Managed Care Capitation	HCBS – I/DD; non-emergency medical transportation
Medicaid Managed Care Program Authority	1915(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary – opt-in
Total Enrollment	2,489 October 1, 2016 Source: State Website
LTSS Enrollment	Not available in sources reviewed for this study.
State Program Goals	The goal of the expanded Medicare Medicaid Coordinated Plan is to increase access to comprehensive care within a care management model and improve health outcomes for participants whose benefits historically have not been well coordinated. Source: State Quality Strategy
Process for Functional Assessment Completion	A licensed professional nurse performs the initial evaluation of level of care for waiver applicants using the Uniform Assessment Instrument, a multidimensional questionnaire which assesses a participant's functioning level, social skills, and physical and cognitive abilities. It provides a comprehensive assessment of a participant's actual functioning level including those elements that are necessary for developing an individualized service plan. The assessment was designed to provide a standardized way of conducting a participant interview to ensure that all participants have an objective assessment of their needs and measures deficits in ADLs, IADLs, Behavioral and Cognitive Functioning. A score of 12 points is needed to demonstrate NF LOC. Source: 1915(c) Waiver Application
Network Adequacy Standards	Specific to LTSS: travel standard (distance); travel standard (time); choice standard: The managed care plan will make every effort to contract with every NF and ICF/IID federally certified to provide service to Medicare/Medicaid beneficiaries; for community LTSS, at least 2 providers within 30 minutes or 30 miles within certain counties and 45 minutes or 45 miles within other counties Source: Managed care contract
Managed Care Contract:	Available on State Website

Illinois – Integrated Care Program

Program Characteristics	Program Description Notes
Program Start Date	May 1, 2011
LTSS Population Served	Older adults, adults with physical disabilities, adults with I/DD
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID, HCBS – I/DD
Medicaid Managed Care Program Authority	1932(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	114,365 July 31, 2017 Source: State website
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	To provide a health plan and primary care provider for every client, maintain continuity of care with that primary care provider, create comprehensive networks of care around our clients, and offer care coordination to help clients with complex needs navigate the health care system. Source: State website
Process for Functional Assessment Completion	As provided for in each 1915(c) waiver: a nurse or social worker completes a determination of need assessment; clients must achieve a minimum need score, including a minimum score on a functional impairment scale. Source: 1915(c) application
Network Adequacy Standards	Specific to LTSS: choice standard and other standard. The contractor shall enter into contracts with at least two providers for each service. The contractor must enter into contracts with providers such that 80 percent of the participants in each county who were receiving such services the day before the managed care plan began serving this population would continue service without interruption. Source: Managed care contract
Managed Care Contract: [Note: This is an RFP for 2018 and had not yet received CMS approval as of September 2017.]	Available on State website

Illinois – Medicare-Medicaid Alignment Initiative

Program Characteristics	Program Description Notes
Program Start Date	March 1, 2014
LTSS Population Served	Older adults, adults with physical disabilities
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID, HCBS – I/DD
Medicaid Managed Care Program Authority	1932(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary, opt-in
Total Enrollment	52,004 August 1, 2017 Source: ICRC website
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	To provide a health plan and primary care provider for every client, to maintain continuity of care with that primary care provider, to create comprehensive networks of care around our clients, and to offer care coordination to help clients with complex needs navigate the health care system. Source: State website
Process for Functional Assessment Completion	As provided for in each 1915(c) waiver: a nurse or social worker completes a determination of need assessment; clients must achieve a minimum need score, including a minimum score on a functional impairment scale. Source: 1915(c) application
Network Adequacy Standards	Not specific to LTSS: other standard. The contractor is tasked with establishing and maintaining a network that is sufficient to provide adequate access to all covered services. Source: Managed care contract
Managed Care Contract:	Available on FAI section of CMS.gov.

Illinois – Managed Long-Term Services and Supports

Program Characteristics	Program Description Notes
Program Start Date	July 1, 2016
LTSS Population Served	Older adults, adults with physical disabilities
Benefits Carved Out of Managed Care Capitation	Prescription drugs, inpatient hospital, institutional – ICF/IID, HCBS – I/DD
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	28,640 July 31, 2017 Source: State website
LTSS Enrollment	28,640 July 31, 2017 Source: State website
State Program Goals	To redesign the health care delivery system for dual-eligible beneficiaries with a focus on improving health outcomes, care delivery and utilization of community-based services and rebalancing its use Medicaid LTSS to expand utilization of community-based services. Source: 1915(b) application
Process for Functional Assessment Completion	As provided for in each 1915(c) waiver: a nurse or social worker completes a determination of need assessment; clients must achieve a minimum need score, including a minimum score on a functional impairment scale. Source: 1915(c) application
Network Adequacy Standards	Specific to LTSS: choice standard and other standard. The contractor shall enter into contracts with at least two providers for each service. The contractor must enter into contracts with providers such that 80 percent of the participants in each county who were receiving such services the day before the managed care plan began serving this population would continue service without interruption. Source: Managed care contract
Managed Care Contract: [Note: This is an RFP for 2018 and had not yet received CMS approval as of September 2017.]	Available on State website

Iowa – Iowa Health Link

Program Characteristics	Program Description Notes
Program Start Date	April 1, 2016
LTSS Population Served	Older adults, adults with physical disabilities, adults with I/DD, children with disabilities
Benefits Carved Out of Managed Care Capitation	Other[1]
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	36,825 September 30, 2016 Source: State website
LTSS Enrollment	36,825 September 30, 2016 Source: State website
State Program Goals	Improvement in the quality of care and health outcomes for members; integration of care across the health care delivery system; emphasis of member choice and increased access to care; increased program efficiencies and budget accountability; rebalancing efforts to provide community-based care; and managed care plan accountability for outcomes. Source: 1915(b) application
Process for Functional Assessment Completion	The State Medicaid Agency or the member's managed care organization completes one of several assessment tools based on the age of the client, focusing on strengths and needs. The State Medicaid agency determines the level of care. Source: 1915(c) application and state comment on draft summary
Network Adequacy Standards	Specific to LTSS: travel standard (distance). No more than 60 miles between the community-based residential alternative placement and the member's residence. Source: Managed care contract
Managed Care Contract:	Available on State website

[1] The state indicated certain high-cost pharmaceuticals and Health Insurance Premium Payments (HIPP) are carved out of the managed care capitation rate.

Kansas – KanCare MLTSS Component

Program Characteristics	Program Description Notes
Program Start Date	January 1, 2013
LTSS Population Served	Older adults, adults with physical disabilities, adults with I/DD, children with disabilities
Benefits Carved Out of Managed Care Capitation	None
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	33,615 October 31, 2017 Source: State comment on draft summary
LTSS Enrollment	33,615 October 31, 2017 Source: State comment on draft summary
State Program Goals	Provide integration and coordination of care across the whole spectrum of health; improve the quality of care; control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and establish long-lasting reforms that sustain the improvements in quality of health and wellness. Source: 1115(a) demonstration approval document
Process for Functional Assessment Completion	Nurses or social workers complete the assessment specific to each target population as described in each 1915(c) waiver application; participants must meet minimum functional eligibility criteria for each waiver. Source: 1915(c) application
Network Adequacy Standards	Specific to LTSS: choice standard. The managed care plan should contract with at least two providers serving each county for each covered LTSS service in the benefit package. Source: 1115(a) demonstration approval document
Managed Care Contract:	Not available in sources reviewed for this study

Massachusetts – Senior Care Options

Program Characteristics	Program Description Notes
Program Start Date	March 1, 2004
LTSS Population Served	Older adults
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – I/DD
Medicaid Managed Care Program Authority	1915(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary – opt-in
Total Enrollment	Data not available in sources reviewed for this study
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	Maintaining elders in a home setting; avoiding, delaying or shortening nursing facility stays; meeting the wishes of elders who wish to stay in their homes; and providing cost-effective alternatives to support elders' care needs. Source: 1915(c) application
Process for Functional Assessment Completion	The managed care organization is responsible for conducting the functional evaluation. They can contract with another organization to conduct the assessments. Source: state comment on draft summary
Network Adequacy Standards	Specific to LTSS: choice standard. Enrollees must have access to at least two nursing facilities and two community long-term care service providers. When feasible, enrollees must also have access to at least two hospitals. Source: Managed care contract
Managed Care Contract:	Available on a University of California at San Francisco site

Massachusetts – One Care

Program Characteristics	Program Description Notes
Program Start Date	October 1, 2013
LTSS Population Served	Adults with physical disabilities; adults – I/DD
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – I/DD; HCBS – other
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Voluntary – opt-out
Total Enrollment	17,938 August 1, 2017 Source: ICRC website
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	Enact payment and delivery system reforms that promote integrated, coordinated care and hold providers accountable for the quality and total cost of care; improve integration of physical, behavioral, and long-term services; maintain near-universal coverage; sustainably support safety net providers; and address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services. Source: 1115(a) demonstration approval document
Process for Functional Assessment Completion	A care coordinator and/or LTSS coordinator complete an assessment tool developed by the managed care plan to assess a participant on several functional domains to determine eligibility for this program. Source: Managed care contract
Network Adequacy Standards	Specific to LTSS: travel standard (distance); travel standard (time); and choice standard. Within a 15-mile or 30-minute radius from the enrollee's zip code of residence, the contract must offer two nursing facilities and two community LTSS providers per covered service, unless the State Medicaid Agency offers prior approval. Source: Managed care contract
Managed Care Contract:	Available on State website

Michigan – Managed Specialty Services and Supports

Program Characteristics	Program Description Notes
Program Start Date	January 1, 1998
LTSS Population Served	Adults with I/DD, children with I/DD
Benefits Carved Out of Managed Care Capitation	Prescription drugs; inpatient hospital, institutional – ICF/IID
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	Data not available in sources reviewed for this study
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	To enable people with intellectual disabilities who have significant needs and who meet the eligibility requirements to live and fully participate in their communities. Source: 1915(c) application
Process for Functional Assessment Completion	A qualified developmental disabilities professional employed by the managed care plan completes the assessment as required by the 1915(c) waiver; the participant must meet ICF/IID level of care and require continuous active treatment. The State Medicaid Agency makes the final determination for enrollment onto the waiver. Source: 1915(c) application
Network Adequacy Standards	Specific to LTSS: other standard. The managed care plan agrees to assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility. Source: Managed care contract
Managed Care Contract:	Available on the managed care plan website

Michigan – MI Choice

Program Characteristics	Program Description Notes
Program Start Date	October 1, 2013
LTSS Population Served	Older adults, adults with physical disabilities
Benefits Carved Out of Managed Care Capitation	Behavioral health – intensive; prescription drugs; inpatient hospital; institutional care; HCBS – I/DD
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	Data not available in sources reviewed for this study
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	To provide home and community-based services and supports to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life. Source: 1915(c) application
Process for Functional Assessment Completion	A physician, registered nurse, licensed practical nurse, social worker or physician assistant with the waiver agency completes the Nursing Facility Level of Care Determination Tool to determine eligibility through one of seven categories of needs. The State Medicaid Agency makes the final determination for enrollment onto the waiver. Source: 1915(c) application
Network Adequacy Standards	Not available in sources reviewed for this study
Managed Care Contract:	Not available in sources reviewed for this study

Michigan – MI Health Link

Program Characteristics	Program Description Notes
Program Start Date	April 1, 2015
LTSS Population Served	Older adults, adults with physical disabilities; adults with I/DD
Benefits Carved Out of Managed Care Capitation	Behavior health – intensive, institutional – ICF/IID, HCBS – I/DD
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary – opt-in
Total Enrollment	39,965 August 1, 2017 Source: ICRC website
LTSS Enrollment	2,833 August 1, 2017 Source: State website
State Program Goals	To coordinate care for dual-eligible beneficiaries in four regions of the state. Source: 1915(c) application
Process for Functional Assessment Completion	A physician, registered nurse, licensed practical nurse, social worker or physician assistant with the managed care plan completes the Nursing Facility Level of Care Determination Tool to determine eligibility through one of seven categories of needs. The State Medicaid Agency makes the final determination for enrollment onto the waiver. Source: 1915(c) application
Network Adequacy Standards	Specific to LTSS: travel standard (distance); travel standard (time); and choice standard. The managed care plan must have at least two available providers for each provider type; for services provided in the community, the enrollee should have a choice of providers and should not have to travel more than 30 miles or for more than 30 minutes. Exceptions can be made for rural areas as approved by the State. Source: Managed care contract
Managed Care Contract:	Available on FAI section of CMS.gov

Minnesota – Senior Health Options

Program Characteristics	Program Description Notes
Program Start Date	January 1, 1997
LTSS Population Served	Older Adults
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; institutional – more than 180 days in a NF; HCBS – I/DD; HCBS – Other[1]
Medicaid Managed Care Program Authority	1915(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary – opt-in
Total Enrollment	37,649 August 1, 2017 Source: State website
LTSS Enrollment	26,853 August 1, 2017 Source: State website
State Program Goals	To provide community-based services in the most integrated and least restrictive setting to keep elderly people in their own homes or delay nursing facility admission. Source: 1915(c) application
Process for Functional Assessment Completion	If the participant is enrolled in managed care, the managed care plan completes the level of care evaluation; if the participant is in FFS, then the county agency completes the level of care. A public health nurse, social worker, or similarly credentialed individual completes the Long Term Care Consultation Assessment Form, the Level 1 Pre-admission screening for persons with Mental Illness or Intellectual Disability: Determination for NF Admission, and the Determining the Need for NF Level of Care forms to assess the individual for need of at least one area of assistance such as physical assistance/ongoing supervision of ADLs or IADLs, extended state plan services to delay nursing facility admission, home modification to maximize independence, or caregiver supports to supplement supports provided by informal caregivers. Source: 1915(c) application
Network Adequacy Standards	Not specific to LTSS: other standards. The managed care plan shall provide care to enrollees using an adequate number of hospitals, nursing facilities, and service locations for all covered services; all services including LTSS not specifically listed in the section shall meet the state's generally accepted community standards. Source: Managed care contract
Managed Care Contract:	Available on contractor website

[1] 1915(c) waivers targeting people with physical disabilities and brain injuries are carved out. Only a 1915(c) waiver for older adults is included.

Minnesota – Senior Care Plus

Program Characteristics	Program Description Notes
Program Start Date	January 1, 2005
LTSS Population Served	Older Adults
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; institutional – more than 180 days in a NF; HCBS – I/DD; HCBS – Other[1]
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	16,265 August 1, 2017 Source: State website
LTSS Enrollment	8,657 August 1, 2017 Source: State website
State Program Goals	To enable access to primary and preventive care visits; to improve the management of chronic care conditions and promote best practice for appropriate quality care in delivery systems; to develop and maintain managed care delivery systems that have incentives to provide and manage services cost-effectively; and to improve coordination of benefits, particularly long-term care services. Source: 1915(c) application
Process for Functional Assessment Completion	A public health nurse, social worker, or similarly credentialed individual employed with the managed care plan completes the Long Term Care Consultation Assessment Form, the Level 1 Pre-admission screening for persons with Mental Illness or Intellectual Disability: Determination for NF Admission, and the Determining the Need for NF Level of Care forms to assess the individual for need of at least one area of assistance such as physical assistance/ongoing supervision of ADLs or IADLs, extended state plan services to delay nursing facility admission, home modification to maximize independence or caregiver supports to supplement supports provided by informal caregivers.
Network Adequacy Standards	Not specific to LTSS: other standards. The managed care plan shall provide care to enrollees using an adequate number of hospitals, nursing facilities, and service locations for all covered services; all services including LTSS not specifically listed in the section shall meet the state's generally accepted community standards. Source: Managed care contract
Managed Care Contract:	Available on contractor website

[1] 1915(c) waivers targeting people with physical disabilities and brain injuries are carved out. Only a 1915(c) waiver for older adults is included.

New Jersey – NJ Family Care (MLTSS Component)

Program Characteristics	Program Description Notes
Program Start Date	July 1, 2014
LTSS Population Served	Older adults, adults with physical disabilities
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – IDD
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Mandatory
Total Enrollment	28,731 June 30, 2016 Source: 1115(a) demonstration report
LTSS Enrollment	28,731 June 30, 2016 Source: 1115(a) demonstration report
State Program Goals	Maintain Medicaid and CHIP state plan benefits; expand access to HCBS; streamline eligibility requirements with a projected spenddown for individuals who meet the NF level of care; allow for self-attestation of resources and income for applicants seeking nursing facility services who have income at or below 100 percent of the federal poverty level; cover additional HCBS to beneficiaries with serious emotional disturbance, opioid addiction, pervasive developmental disorder, and I/DD; expand eligibility to a population of individuals between ages 18 and 65 who have household incomes between 25 and 100 percent of federal poverty level; transform the state's behavioral health system for adults by delivering these services through behavioral health administrative service organizations; and furnishing premium assistance options to individuals with access to employer-based coverage. Source: 1115(a) demonstration approval document
Process for Functional Assessment Completion	A social worker, registered nurse, or similarly credentialed individual completes the New Jersey Choice Tool and Home and Community-Based Long-Term Care Assessment Form. A participant may be enrolled if they meet nursing facility level of care; criteria differs based on the age of the individual. Source: 1115(a) demonstration approval document
Network Adequacy Standards	Specific to LTSS: choice standard. The contractor shall contract with at least two providers for each HCBS, other than community-based residential alternatives, to cover each county. Source: Managed care contract
Managed Care Contract:	Available on State website

New Mexico – Centennial Care

Program Characteristics	Program Description Notes
Program Start Date	January 1, 2014
LTSS Population Served	Older adults, adults with physical disabilities, adults with I/DD, children with disabilities
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – IDD
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Mandatory
Total Enrollment	34,947 December 31, 2016 Source: State website
LTSS Enrollment	34,947 December 31, 2016 Source: State website
State Program Goals	To assure that beneficiaries in the program receive the right amount of care at the right time, cost-effectively in the right setting; ensure that the expenditures for care are measured in terms of quality and not solely by quantity; slow the growth rate of costs; and streamline and modernize the Medicaid program. Source: 1115(a) demonstration approval document
Process for Functional Assessment Completion	The contractor will establish qualifications of those who complete level of care assessments, but should encourage the use of community health workers. The assessor will complete an assessment using the state-approved tool, determining the participant meets the NF level of care by evaluating medical risk factors, support and social resources, environmental assessments, nutrition, communication and cognition, health and safety risks, and ability to perform ADLs and IADLs. Source: Managed care contract
Network Adequacy Standards	Network adequacy standards are not listed for LTSS. Source: Managed care contract
Managed Care Contract:	Available on State website

New York – Managed Long-Term Care Partial Cap

Program Characteristics	Program Description Notes
Program Start Date	January 1, 1998
LTSS Population Served	Older adults, adults with physical disabilities
Benefits Carved Out of Managed Care Capitation	Behavioral health – all, prescription drugs, inpatient hospital, institutional – ICF/IID, HCBS – IDD, HCBS – other, other[1]
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Mandatory
Total Enrollment	186,626 August 1, 2017 Source: State website
LTSS Enrollment	186,626 August 1, 2017 Source: State website
State Program Goals	To expand access to managed long-term care for enrollees who need LTSS; to improve patient safety and quality of care for enrollees; to reduce preventable inpatient and nursing home admissions; and to improve satisfaction, safety, and quality of life. Source: 1115(a) demonstration approval document
Process for Functional Assessment Completion	A registered nurse with the managed care plan completes the Semi-Annual Assessment for Members to determine that they need more than 120 days of community-based long-term care services. Source: 1115(a) demonstration approval document
Network Adequacy Standards	Specific to LTSS: travel standard (distance); travel standard (time); and choice standard. The contractor shall have a minimum of two providers for each covered service; travel must not exceed thirty minutes from the enrollee's residence in metropolitan areas or thirty miles from the enrollee's residence in non-metropolitan areas. Source: Managed care contract
Managed Care Contract:	Available on State website

[1] Other services are carved out such as physician services, outpatient clinic services, hospice, laboratory, and radiology.

New York – Medicaid Advantage Plus

Program Characteristics	Program Description Notes
Program Start Date	January 1, 2016
LTSS Population Served	Older adults, adults with physical disabilities
Benefits Carved Out of Managed Care Capitation	Prescription drugs; institutional – ICF/IID; HCBS – I/DD; HCBS – other
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Voluntary – opt-in
Total Enrollment	8,356 August 1, 2017 Source: State website
LTSS Enrollment	8,356 August 1, 2017 Source: State website
State Program Goals	To improve access to health care; to improve the quality of services delivered; and to expand coverage with resources generated through managed care efficiencies. Source: 1115(a) demonstration approval document
Process for Functional Assessment Completion	The managed care plan shall arrange for health care professionals to provide care management to all enrollees. Assessments will be completed using the patient assessment instrument specified by the State Department of Health, to assess their eligibility for nursing facility level of care; their capability of returning or remaining home without jeopardy to their health and safety; and that they are expected to need at least one service plus care management for at least 120 days. Source: Managed care contract
Network Adequacy Standards	Not specific to LTSS: other standard. The managed care plan will establish and implement mechanisms to ensure that participating providers comply with timely access requirements and provide services in a culturally competent manner. Source: Managed care contract
Managed Care Contract:	Available on State website

New York – Fully Integrated Duals Advantage

Program Characteristics	Program Description Notes
Program Start Date	January 1, 2015
LTSS Population Served	Older adults, adults with physical disabilities
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – I/DD
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary – opt-out
Total Enrollment	4,468 November 1, 2017 Source: State Website
LTSS Enrollment	4,468 November 1, 2017 Source: State Website
State Program Goals	To improve access to health care; to improve the quality of services delivered; and to expand coverage with resources generated through managed care efficiencies. Source: 1115(a) demonstration approval document
Process for Functional Assessment Completion	A registered nurse with the managed care plan completes the uniform assessment system to determine a participant's eligibility. A participant meets the level of care if he/she has a stable medical condition; is self-directing or has a designated representative; needs some or total assistance with one or more personal care services, home health aide services or skilled nursing tasks; is able and willing to fulfill the responsibilities of making informed choices; and participates as needed in the assessment. A participant cannot meet the level of care criteria if they have voluntary assistance available from informal caregivers or adaptive or specialized equipment or supplies. Source: Managed care contract
Network Adequacy Standards	Specific to LTSS: travel standard (distance); travel standard (time); service initiation standard; and choice standard. Community-based LTSS must be available to start within 30 calendar days of enrollment; participants must have a choice of at least two providers within a 15-mile radius or 30 minutes from the participant's zip code. Each plan must also contract with eight nursing facilities per county. Source: Managed care contract
Managed Care Contract:	Available on FAI section of CMS.gov

New York – Fully Integrated Duals Advantage – I/DD

Program Characteristics	Program Description Notes
Program Start Date	January 1, 2015
LTSS Population Served	People with developmental disabilities
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – I/DD
Medicaid Managed Care Program Authority	1915(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary – opt-in
Total Enrollment	701 November 1, 2017 Source: State Website
LTSS Enrollment	701 November 1, 2017 Source: State Website
State Program Goals	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. Source: FAI MOU on CMS.gov
Process for Functional Assessment Completion	The FIDA-I/DD case manager completes an Office of Persons with Developmental Disabilities approved assessment and a comprehensive service planning assessment to determine: 1. Evidence of a developmental disability; 2. Disability manifested before age 22; 3. Evidence of a severe behavior problem (not required); 4. Health care need (not required); and 5. Adaptive behavior deficit in one or more of the following areas: communication, learning, mobility, independent living or self- direction. The applicant must have functional limitations that demonstrate a substantial handicap. For most applicants over the age of eight, the substantial handicap must be determined using a nationally normed and validated, comprehensive measure of adaptive behavior, administered by a qualified professional. For applicants over the age of eight who have an IQ of 60 or lower, the presence of a substantial handicap may be assessed and confirmed through clinical observation or interview rather than standardized testing. Source: Managed care contract
Network Adequacy Standards	Specific to LTSS: travel standard (distance); travel standard (time); service initiation standard; and choice standard. For new-to-service participants, community-based LTSS service delivery must begin within 30 calendar days of enrollment. For participants that are not new to service but transitioning from Medicare and/or Medicaid FFS, the plan must provide continuity of community-based LTSS immediately upon enrollment. The plan must contract with an adequate number of community-based LTSS providers to allow participants a choice of at least two providers of each covered community-based LTSS service within a 15-mile radius or 30 minutes from the Participant's zip code of residence. Plans must include eight nursing facilities per county in their network for participants that are new to service. Source: Managed care contract
Managed Care Contract:	Available on FAI section of CMS.gov

North Carolina – NC Innovations

Program Characteristics	Program Description Notes
Program Start Date	January 1, 2005
LTSS Population Served	Adults with I/DD, children with I/DD[1]
Benefits Carved Out of Managed Care Capitation	Other[2]
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	Data not available in sources reviewed for this study
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	To tailor services to the local consumer by adopting a consumer-directed care model and focusing on community-based rather than facility-based care; to enhance consumer involvement in planning and providing services; and to demonstrate that care can be provided more efficiently with increased local control. Source: 1915(b) and 1915(c) applications
Process for Functional Assessment Completion	Based on the disability of the participant, a psychologist or physician will complete the NC Innovations Level of Care Assessment Tool. The Prepaid Inpatient Health Plan (PIHP) makes a determination if the participant meets the level of care of ICF/IID which requires active treatment and a diagnosis of intellectual disability or a condition that is closely related. Source: 1915(c) application
Network Adequacy Standards	Data not available in sources reviewed for this study
Managed Care Contract:	Not available in sources reviewed for this study

[1] Children ages 0 to 3 years are covered under the fee-for-service delivery system.
[2] State plan services other than mental health, intellectual/developmental disabilities, or substance use disorder services are carved out. This includes physical health and dental services.

Ohio – Ohio My Care (Integrated Care Delivery System)

Program Characteristics	Program Description Notes
Program Start Date	May 1, 2014
LTSS Population Served	Older adults, adults with physical disabilities; adults with I/DD
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – I/DD
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	111,994 December 1, 2017 Source: State website
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	Keep people living in the community; increase individuals' independence; improve the delivery of quality care; reduce health disparities across all populations; improve health and functional outcomes; reduce costs for individuals by reducing or avoiding preventable hospital stays, nursing facility admissions, and emergency room utilization; and improve transitions across care settings. Source: 1915(b) application
Process for Functional Assessment Completion	Registered nurses or social workers with the PASSPORT Administrative Agencies will complete the appropriate assessments: the Adult or Child Level of Care Questionnaire and the Adult or Child Comprehensive Assessment Tool. Applicants must meet either the intermediate level of care or skilled level of care to enter onto the waiver. Source: 1915(c) application
Network Adequacy Standards	Specific to LTSS: travel standard (distance) and other standard. The contractor must contract with at least the minimum number of LTSS providers; for adult day health/assisted living, there must be at least one adult day health and one assisted living provider within 30 miles of each zip code within the region. Source: Managed care contract
Managed Care Contract:	Available on FAI section of CMS.gov

Pennsylvania – Adult Community Autism Program

Program Characteristics	Program Description Notes
Program Start Date	January 1, 2009
LTSS Population Served	Adults age 21+ with Autism Spectrum Disorder
Benefits Carved Out of Managed Care Capitation	Prescription drugs; inpatient hospital; HCBS – other
Medicaid Managed Care Program Authority	1915(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Voluntary – opt-in
Total Enrollment	147 June 30, 2016 Source: State website
LTSS Enrollment	147 June 30, 2016 Source: State website
State Program Goals	Increase a person's ability to care for themselves; decrease family/caregiver stress; increase quality of life for both the person and the family; provide specialized supports to adults with autism spectrum disorder; help adults with autism spectrum disorder reach their employment goals; support more involvement in community activities; decrease crisis episodes; and support development of peer/social networks. Source: State website
Process for Functional Assessment Completion	Adults age 21 years and older with a diagnosis of autism spectrum disorder and certified as meeting clinical eligibility for an "intermediate care facilities for persons with other related conditions", a term in Pennsylvania regulations for ICF/IID level of care for people with conditions other than intellectual disability. Source: State Quality Strategy
Network Adequacy Standards	Not specific to LTSS: choice standard and service initiation standard. Participant should have the choice between at least two primary care physicians; all services are available and can be accessed in a timely manner. Source: State Quality Strategy
Managed Care Contract:	Not available in sources available for this study

Rhode Island – Rhody Health Options

Program Characteristics	Program Description Notes
Program Start Date	November 1, 2013
LTSS Population Served	Older adults, adults with physical disabilities; adults with I/DD
Benefits Carved Out in Managed Care Capitation	Behavioral health – intensive; institutional – ICF/IID; HCBS – I/DD
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Voluntary – opt-out
Total Enrollment	15,234 December 31, 2016 Source: State website
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	A more fully integrated system of care to provide improved outcomes and greater cost-effectiveness and balance of LTSS expenditures. Source: State Proposal on FAI section of CMS.gov
Process for Functional Assessment Completion	A nurse consultant or care manager completes a Comprehensive Functional Needs Assessment to determine if the participant meets the criteria for the Highest Needs Group, the High Needs Group or the Preventative Care Needs group. Source: Managed care contract
Network Adequacy Standards	Specific to LTSS: travel standards (distance); travel standards (time); and service initiation standard. The services must be in place within five days of a member's need determination; nursing homes shall be within 10 miles of the member's primary caregiver's residence; assisted living, adult day care services, and other community-based LTSS must be within 20 minutes of the primary caregiver's residence. Source: Managed care contract
Managed Care Contract:	Available on Leading Age RI website

Rhode Island – Integrated Care Initiative, Phase 2 (Neighborhood Integrity)

Program Characteristics	Program Description Notes
Program Start Date	December 1, 2015
LTSS Population Served	Older adults, adults with physical disabilities; adults with I/DD
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Voluntary – opt-out
Total Enrollment	13,725 August 1, 2017 Source: ICRC website
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	To improve the health, well-being, and health care of Medicare-Medicaid beneficiaries and to reduce overall health care costs by redesigning the delivery system. Source: Managed care contract
Process for Functional Assessment Completion	Nurse consultant or care manager will complete a Comprehensive Functional Needs Assessment (CFNA). All enrollees who are identified as high-risk or whose CFNA indicate a need for LTSS will be referred to the State Medicaid Agency for a Medicaid LTSS eligibility assessment and level of care determination. Source: Managed care contract
Network Adequacy Standards	Specific to LTSS: travel standard (time) and service initiation standard. Required community-based LTSS must be in place within five days of the enrollee's needs determination; assisted living facilities, adult day centers, and other community-based LTSS must be within 20 minutes of the enrollee's residence. Source: Managed care contract
Managed Care Contract:	Available on FAI section of CMS.gov

South Carolina – Healthy Options Prime

Program Characteristics	Program Description Notes
Program Start Date	February 1, 2015
LTSS Population Served	Older adults
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – I/DD
Medicaid Managed Care Program Authority	1932(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary – opt-out
Total Enrollment	11,907 August 1, 2017 Source: ICRC website
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	Data not available in sources reviewed for this study
Process for Functional Assessment Completion	A registered nurse or licensed practical nurse completes the assessment to determine if the participant meets nursing facility level of care. Source: 1915(c) application
Network Adequacy Standards	Specific to LTSS: other standards. For the first year of the demonstration, facility-based LTSS must meet Medicare network standards for skilled nursing facilities. Afterward, the managed care plan must extend contracts to every willing HCBS provider that currently provides services to the targeted population. Source: Managed care contract
Managed Care Contract:	Available on FAI section of CMS.gov

Tennessee – CHOICES

Program Characteristics	Program Description Notes
Program Start Date	March 1, 2010
LTSS Population Served	Older adults, adults with physical disabilities, children with disabilities (in nursing facilities only)
Benefits Carved Out Managed Care Capitation	Prescription drugs[1]; institutional – ICF/IID[2]; HCBS – I/DD
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Mandatory
Total Enrollment	28,941 June 30, 2017 Source: State comment on draft summary
LTSS Enrollment	28,941 June 30, 2017 Source: State comment on draft summary
State Program Goals	Improve coordination and quality of care/quality of life; expand access to HCBS; rebalance LTSS expenditures. Source: State comment on draft summary
Process for Functional Assessment Completion	The managed care plan care coordinator or (in the case of non-Medicaid eligible applicants) Area Agency on Aging and Disability completes a functional assessment; level of care determinations made by RNs in the Medicaid agency based on assessment and supporting medical documentation; enrollees must require a nursing facility level of care for CHOICES 1 or 2 or be at risk of nursing facility level of care for CHOICES 3. Source: State comment on draft summary
Network Adequacy Standards	Specific to LTSS: travel standard (distance); service initiation standard; and choice standard. For adult day and residential services, 20-, 30- or 60-mile distance from member's residence, depending on provider type and population density; community standards may apply in rural areas. The contractor must contract with any willing NF provider and a sufficient number of HCBS providers to initiate services within the timeframes specified and consistently provide services without gaps in care; the contractor must contract with at least two providers for each HCBS service to cover each county. Source: State comment on draft summary
Managed Care Contract:	Available on State website

[1] Applicable to non-dual eligible beneficiaries only.
[2] Institutional ICF/IID services and HCBS – I/DD services are carved into the managed care capitation rate for the Employment and Community First CHOICES program.

Tennessee – Employment and Community First CHOICES

Program Characteristics	Program Description Notes
Program Start Date	July 1, 2016
LTSS Population Served	Adults with I/DD, children with I/DD
Benefits Carved Out of Managed Care Capitation	Prescription drugs[1]; institutional – NF[2] and ICF/IID; HCBS -- other
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Mandatory for all new HCBS applicants; Voluntary – opt-in for persons with I/DD enrolled in longstanding 1915(c) waivers
Total Enrollment	1,389 December 31, 2017 Source: State comment on draft summary
LTSS Enrollment	1,389 December 31, 2017 Source: State comment on draft summary
State Program Goals	Provide HCBS more cost-effectively; serve more people, including people on the waiting list and people with developmental disabilities other than intellectual disability; improve coordination and quality outcomes; and align incentives toward integrated employment and community living. Source: State comment on draft summary
Process for Functional Assessment Completion	The managed care plan support coordinator or, in the case of non-Medicaid eligible applicants, the Department of Intellectual and Developmental Disabilities completes a functional assessment. Level of care determinations are made by registered nurses in the Medicaid agency based on assessment and supporting medical documentation; enrollees must have I/DD and medical or functional needs according to criteria published by the state. Source: State comment on draft summary
Network Adequacy Standards	Specific to LTSS: travel standard (distance); service initiation standard; and choice standard. For adult day and residential services, 20-, 30- or 60-mile distance from member's residence, depending on provider type and population density; community standards may apply in rural areas. The contractor must contract with any willing NF provider and a sufficient number of HCBS providers to initiate services within the timeframes specified and consistently provide services without gaps in care; the contractor must contract with at least two providers for each HCBS service to cover each county. There also are preferred contracting standards based on experience/expertise serving people with I/DD and achieving integrated competitive employment and community living outcomes. Source: State comment on draft summary
Managed Care Contract:	Available on State website

[1] Applicable to non-dual eligible beneficiaries only.
[2] Institutional NF services are carved into the managed care capitation rate for the CHOICES program; persons with I/DD who choose and are determined eligible and appropriate for NF placement (including federal PASRR requirements) are enrolled in CHOICES.

Texas – STAR+PLUS

Program Characteristics	Program Description Notes
Program Start Date	January 1, 1998
LTSS Population Served	Older adults; adults with physical disabilities; adults with I/DD[1]; children with disabilities
Benefits Carved Out of Managed Care Capitation	Other[2]
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Mandatory for adults; voluntary for children
Total Enrollment	519,105 January 1, 2017 Source: CMS Performance Metrics Database and Analytics Program database designed by Customer Value Partners (CVP) and used with CMS permission
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	Data not available in sources reviewed for this study
Process for Functional Assessment Completion	The plan must have and use functional assessment instruments to identify members with significant health problems, members requiring immediate attention, and members who need or are at risk of needing Long-term Services and Supports. The plan, a subcontractor, a local I/DD authority, or a provider may complete assessment instruments, but the plan remains responsible for the data recorded. A service coordinator completes Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, including any applicable addendums, to assess or reassess need for or a change in state plan personal attendant services, state plan day activity and health services, or HCBS STAR+PLUS waiver services. Enrollees must meet nursing facility level of care and must need a minimum of one waiver service. Source: State comment on draft summary
Network Adequacy Standards	Specific to LTSS: service initiation standard and other standards. The managed care plan must have a sufficient number of providers of HCBS that all members will have access to covered services. Through its provider network composition and management, the plan must ensure that the following standards for appointment accessibility are met. The standards are measured from the date of presentation or request, whichever occurs first. Community LTSS must be initiated within seven days from the start date on the Individual Service Plan or the eligibility effective date for non-waiver LTSS. Source: Managed care contract and state comment on draft summary
Managed Care Contract:	Available on State website

[1] Adults with I/DD are covered for acute care only if the individual does not have Medicare coverage; adults receiving services on an I/DD waiver who have Medicare are currently exempt from STAR+PLUS.
[2] Other services are carved out including hospice services, PASRR services, and most acute care services for dually eligible members not enrolled in a STAR+PLUS Medicare-Medicaid Plan.

Texas – Texas Dual Eligibles Integrated Care Demonstration Project

Program Characteristics	Program Description Notes
Program Start Date	March 1, 2015
LTSS Population Served	Older adults, adults with physical Disabilities; adults with I/DD
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – I/DD
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c) Authority	No
Type of Medicaid Enrollment	Voluntary – opt-out
Total Enrollment	41,182 August 1, 2017 Source: ICRC website
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	A fully integrated program in which all Medicare and Medicaid services, including prescription drugs, are provided through a single managed care plan. The plan will retain responsibility for service coordination. Source: State proposal on FAI section of CMS.gov
Process for Functional Assessment Completion	A registered nurse, nurse practitioner, licensed vocational nurse, or physician's assistant employed with the managed care plan completes the assessment. The enrollee must have an unmet need for at least one waiver service and the cost of waiver services must be less than 202 percent of the cost of providing services to the enrollee in a nursing facility. Source: Managed care contract
Network Adequacy Standards	Specific to LTSS: travel standard (distance); service initiation standard; and other standards. Each managed care plan must contract with enough providers to provide access to at least 90 percent of enrollees in each service area; each enrollee should have convenient and timely access to care; and there must be at least one LTSS provider of each service type within 75 miles of the enrollee's residence. Source: Managed care contract
Managed Care Contract:	Available on FAI section of CMS.gov

Texas – STAR Health

Program Characteristics	Program Description Notes
Program Start Date	September 1, 2015 (It began in 2008 but did not include LTSS until 2015)
LTSS Population Served	Children with disabilities[1]
Benefits Carved Out of Managed Care Capitation	Behavioral Health – intensive, HCBS – I/DD, HCBS – Other[2], Other[3]
Medicaid Managed Care Program Authority	1915(a)
Concurrent 1915(c)	Yes
Type of Medicaid Enrollment	Voluntary – opt-out
Total Enrollment	30,912 March 1, 2016 Source: State Website
LTSS Enrollment	Not available in sources reviewed for this study.
State Program Goals	The goal of STAR Health is to give children and young adults who are, or were formerly, in the state's foster care system healthcare services that are coordinated, comprehensive, easy to find, and uninterrupted when the child moves from placement to placement. Source: Managed Care Contract
Process for Functional Assessment Completion	A registered nurse or advance practice registered nurse completes the Screening and Assessment Instrument, including and the Medically Dependent Children Program Module, the Personal Care Assessment Module, and/or the Nursing Care Assessment Module, depending on the child's LTSS needs. Applicants must meet the LOC and medical necessity criteria specified in state regulations. The applicant must also require medical or nursing services that are ordered by a physician; are dependent upon the applicant's documented medical conditions; require the skills of a registered or licensed vocational nurse; are provided either by or under the supervision of a licensed nurse in an institutional setting; and are required on a regular basis. Factors assessed include diagnoses; medications and dosage; physician's evaluation; rehabilitative services; ADL; sensory/perception status; behavioral status; and therapeutic interventions. LOC is determined by combining an ADL score with assessments of medical condition, rehabilitation, nursing care, and confusion or behavioral problems. Source: Managed care contract
Network Adequacy Standards	Specific to LTSS: choice standard and other standard. Except for the Medically Dependent Children Program, the plan must ensure all members have access to at least two providers of each category of HCBS. If a plan cannot ensure access to two providers, it must receive an exception. The plan must have enough Medically Dependent Children Program providers so all members have access to necessary covered services. Source: Managed care contract
Managed Care Contract:	Available on State Website

[1] The STAR Health program specifically covers children in foster care.
[2] Only one 1915(c) waiver is included in the capitation rate, the Medically Dependent Children Program.
[3] Several benefits are carved out including school-based services, medical transportation, hospice, tuberculosis services, environmental lead investigation, early childhood intervention case management and specialized skills training, case management for children and pregnant women, and, for dual eligibles, mental health targeted case management and rehabilitative services.

Texas – STAR Kids

Program Characteristics	Program Description Notes
Program Start Date	November 1, 2016
LTSS Population Served	Children with disabilities
Benefits Carved Out of Managed Care Capitation	Institutional – NF and ICF/IID, HCBS – I/DD, HCBS – Other[1]
Medicaid Managed Care Program Authority	1115(a)
Concurrent 1915(c)	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	Not available in sources reviewed for this study.
LTSS Enrollment	Not available in sources reviewed for this study.
State Program Goals	The goal for STAR Kids is to customize and coordinate acute, behavioral, and LTSS through an individualized planning and service design process. Source: Managed Care Contract
Process for Functional Assessment Completion	A registered nurse or advance practice registered nurse completes the Screening and Assessment Instrument, including and the Medically Dependent Children Program Module, the Personal Care Assessment Module, and/or the Nursing Care Assessment Module, depending on the child's LTSS needs. Applicants must meet the LOC and medical necessity criteria specified in state regulations. The applicant must also require medical or nursing services that are ordered by a physician; are dependent upon the applicant's documented medical conditions; require the skills of a registered or licensed vocational nurse; are provided either by or under the supervision of a licensed nurse in an institutional setting; and are required on a regular basis. Factors assessed include diagnoses; medications and dosage; physician's evaluation; rehabilitative services; ADL; sensory/perception status; behavioral status; and therapeutic interventions. LOC is determined by combining an ADL score with assessments of medical condition, rehabilitation, nursing care, and confusion or behavioral problems. Source: STAR Kids Handbook
Network Adequacy Standards	Specific to LTSS: service initiation, choice standard, and other standard. HCBS must be initiated within seven days from the start date on the individual service plan or the eligibility effective date for non-waiver LTSS unless the referring provider, member or STAR Kids Handbook states otherwise. Except for the Medically Dependent Children Program, the plan must ensure all members have access to at least two providers of each category of HCBS. If a plan is unable to ensure access to two providers, it must submit and receive an exception. The plan must have a sufficient number of Medically Dependent Children Program providers so all members have access to medically necessary and functionally necessary covered services. Source: Managed care contract
Managed Care Contract:	Available on State Website

[1] Only one 1915(c) waiver is included in the capitation rate, the Medically Dependent Children Program.

Virginia – Coordinated Care Initiative

Program Characteristics	Program Description Notes
Program Start Date	April 1, 2014 This program ended on December 31, 2017 and members were transitioned to Commonwealth Coordinated Care Plus
LTSS Population Served	Older adults, adults with physical disabilities; adults with I/DD
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – I/DD
Medicaid Managed Care Program Authority	1932(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary – opt-out
Total Enrollment	26,063 August 1, 2017 Source: ICRC website
LTSS Enrollment	Data not available in sources reviewed for this study
State Program Goals	To incorporate the principles of self-determination and supplement community supports while fostering dignity, quality of life, and security in the lives of older adults and adults with disabilities while maintaining them in the community. Source: State website
Process for Functional Assessment Completion	A registered nurse, social worker, or physician completes the Uniform Assessment Instrument. Enrollees must be dependent in at least two ADLs plus a specific combination of additional semi-dependencies or dependencies in the areas of behavior and orientation, joint motion, mobility, and medication administration. Source: State website
Network Adequacy Standards	Specific to LTSS: travel standards (time) and choice standard. Each enrollee shall have a choice of at least two providers of each service type located no more than 30 minutes travel time in urban areas, and no more than 60 minutes in rural areas. Source: Managed care contract
Managed Care Contract:	Available on FAI Section of CMS.gov

Virginia – Commonwealth Coordinated Care Plus

Program Characteristics	Program Description Notes
Program Start Date	August 1, 2017
LTSS Population Served	Older adults, adults with physical disabilities, adults with I/DD, children with disabilities
Benefits Carved Out of Managed Care Capitation	Institutional – ICF/IID; HCBS – I/DD
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Mandatory
Total Enrollment	Program began on August 1, 2017; no enrollment data publicly available.
LTSS Enrollment	Program began on August 1, 2017; no enrollment data publicly available.
State Program Goals	To incorporate the principles of self-determination and supplement community supports while fostering dignity, quality of life, and security in the lives of older adults and adults with disabilities while maintaining them in the community. Source: 1915(c) application
Process for Functional Assessment Completion	A registered nurse, social worker, or physician completes the Uniform Assessment Instrument or Objective Scoring Tool. Enrollees must meet criteria in one of four need categories to be admitted to the waiver. Source: 1915(c) application
Network Adequacy Standards	Specific to LTSS: travel standards (distance), travel standards (time), and choice standard. For services where the member travels to the provider, there must be at least two providers per locality; additionally, in urban areas, member must travel no more than 30 miles or 45 minutes and in rural areas, member must travel no more than 60 miles or 75 minutes. For services where the provider travels to the member, there must be at least two providers per locality, or one provider per locality for assistive technology, personal emergency response systems, environmental modification, and durable medical equipment and supplies. Source: Managed care contract
Managed Care Contract:	Available on State website

Wisconsin – Family Care

Program Characteristics	Program Description Notes
Program Start Date	January 1, 1999
LTSS Population Served	Older adults, adults with physical disabilities; adults with I/DD
Benefits Carved Out of Managed Care Capitation	Behavioral health – all, prescription drugs, inpatient hospital, other non-LTSS Medicaid services
Medicaid Managed Care Program Authority	1915(b)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary – opt-in
Total Enrollment	44,404 January 1, 2017 Source: State website
LTSS Enrollment	44,404 January 1, 2017 Source: State website
State Program Goals	To provide better choices about services and supports available; to improve access to services; to improve overall quality of the LTSS system by focusing on achieving people's health and social outcomes; and to create a cost-effective LTSS system. Source: 1915(c) application
Process for Functional Assessment Completion	A registered nurse, social worker, or similarly credentialed individual completes a Long-Term Care Functional Screen; enrollees must meet the level of care of nursing facility or ICF/IID. Initial evaluations are completed by Aging and Disability Resource Centers; re-evaluations are completed by the managed care plans. Source: 1915(c) application
Network Adequacy Standards	Not specific to LTSS: service initiation standard and other standards. The managed care plan must require its providers to meet timely access to care standards and to offer hours of operation that are not less than the hours of operation offered to commercial members or comparable Medicaid FFS members. The managed care plan should develop standards for geographic and service initiation access. Source: Managed care contract
Managed Care Contract:	Available on State website

Wisconsin – Family Care Partnership

Program Characteristics	Program Description Notes
Program Start Date	January 1, 1996
LTSS Population Served	Older adults, adults with physical disabilities; adults with I/DD
Benefits Carved Out of Managed Care Capitation	None
Medicaid Managed Care Program Authority	1932(a)
Concurrent 1915(c) Authority	Yes
Type of Medicaid Enrollment	Voluntary – opt-in
Total Enrollment	3,000 January 1, 2017 Source: State website
LTSS Enrollment	3,000 January 1, 2017 Source: State website
State Program Goals	To improve the quality of care while containing costs; to reduce fragmentation and inefficiency in the existing system; and to increase the ability of people to live in the community and participate in decisions about their care. Source: State website
Process for Functional Assessment Completion	A registered nurse, social worker, or similarly credentialed individual completes a Long-Term Care Functional Screen; enrollees must meet the level of care for nursing facility or ICF/IID. Initial evaluations are completed by Aging and Disability Resource Centers; re-evaluations are completed by the managed care plans. Source: 1915(c) application
Network Adequacy Standards	Not specific to LTSS: service initiation standard and other standards. The managed care plan must require its providers to meet timely access to care standards and to offer hours of operation that are not less than the hours of operation offered to commercial members or comparable Medicaid FFS members. The plan should develop standards for geographic and service initiation access. Source: Managed care contract
Managed Care Contract:	Available on State website