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MEDICAID 1115 DEMONSTRATIONS

The Impact of Managed Long-Term Services and Supports (MLTSS) Policies on Access to LTSS

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Introduction

Managed long-term services and supports (MLTSS) programs have grown significantly in recent years. The total national enrollment in MLTSS programs increased from an estimated 800,000 in 2012 to nearly 1.7 million in 2017 (Lewis et al. forthcoming). In response to rapidly transforming LTSS systems around the country, the Centers for Medicare & Medicaid Services (CMS) issued guidance on MLTSS in 2013 (CMS 2013), which was integrated into the May 2016 federal Medicaid and CHIP Managed Care Final Rule (hereafter the Final Managed Care Rule) (81 Fed. Reg. 27497 (May 6, 2016)).

The 2013 guidance and 2016 Final Managed Care Rule modernized the framework for federal oversight of MLTSS access, with requirements that address LTSS network adequacy, transitions from fee-for-service LTSS to MLTSS, and inclusion of LTSS in quality assurance and performance improvement programs, among others. However, standardized national measures for LTSS access remain a work in progress. A Medicaid access measurement plan prepared for CMS in 2016 did not include LTSS measures, noting the nascent state of measure development in this area (Kenney et al. 2016). Additionally, the Government Accountability Office recently noted the lack of standardized reporting in this area (GAO 2017).

This brief identifies and compares MLTSS policies that four states (Delaware, Iowa, New Jersey and Tennessee) consider important to ensuring LTSS access: network adequacy standards, transition of care policies, provider reimbursement policies, level of care criteria, participant-directed services policies, and care coordination models. Understanding which MLTSS policies affect access and how they vary across states and over time enables evaluators to control for variations in those policies in their analyses.

MLTSS Policies That Influence Access to LTSS

The states interviewed for this study (Delaware, Iowa, New Jersey and Tennessee) agreed that maintaining access to LTSS is critical to the success of MLTSS, and that certain policies are central to achieving that objective. Four policy areas—network adequacy standards, transition of care, provider reimbursement, and level of care criteria—were cited as key in all four states. Two states noted participant-directed services policy, and one mentioned the care coordination model, as well.

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

For the past two decades, states have increasingly turned to private managed care plans to deliver long-term services and supports (LTSS) to Medicaid beneficiaries with disabilities. Section 1115 is one of several federal authorities that states can use to operate managed long-term services and supports (MLTSS) programs. In contrast to fee-for-service, which pays providers for each service they deliver, states that operate MLTSS programs pay managed care plans a fixed per-member-per-month (PMPM) amount to provide all covered services for enrollees. The capitated PMPM payment arrangement – combined with contract requirements to protect enrollees—can create an incentive for the plans to improve care coordination, reduce unnecessary services, and increase the availability home and community-based alternatives to institutional care.

Network Adequacy Standards

MLTSS programs must ensure access to an adequate network of qualified providers to meet the needs of their enrollees. For LTSS providers, network standards include two elements: (1) time and distance standards when an enrollee is traveling to the provider to receive services (adult day health, for example); and (2) network standards beyond time and distance when the provider travels to the enrollee to deliver services (home care, for example) (42 C.F.R. 438.68(b)(2) (2016)). The Final Managed Care Rule requires states to implement LTSS provider networks standards other than time and distance on or after July 1, 2018 (Lipson et al. 2017). Table 1 summarizes current and anticipated approaches to LTSS network standards in the four states we focused on for this analysis.

The time and distance networks standards for LTSS took the form of mileage requirements when the member traveled to a provider for care in Delaware, Iowa, or Tennessee. States monitor the standard by analyzing provider network files submitted regularly by the MLTSS plans.

New Jersey and Tennessee use the availability of provider choice in assessing LTSS network adequacy. Managed care plans must demonstrate that members have a choice of at least two providers per HCBS provider type per county. Since 2010, Tennessee has also included a standard related to timely initiation and consistent provision of HCBS in accordance with the member's plan of care, and considers this to be the most critical of its network adequacy requirements. Tennessee's approach has been embraced by the MLTSS plan industry, which recently recommended using "time to placement"—the length of time it takes to deliver a service from the time it is authorized—as a key adequacy standard (National MLTSS Health Plan Association 2017).[1] This also emerged as a key theme in interviews with Tennessee and three other states in 2017 (Minnesota, Texas, and Virginia), which were sponsored by Medicaid and CHIP Payment and Access Commission. Those states indicated a preference for adequacy standards that reflect the outcome of timely delivery of services, as opposed to the inputs of how many providers exist and their distance from members (Vardaman 2017).

New Jersey and Tennessee also emphasized the need to incorporate measures of quality into their network adequacy standards. For example, in its 2016 implementation of MLTSS for individuals with intellectual and developmental disabilities (I/DD), Tennessee developed preferred-provider contracting standards that measure the provider's experience and expertise in serving the population and in achieving outcomes aligned with the new program.

Table 1. LTSS network adequacy standards in four MLTSS programs

State MLTSS program and launch date	Time and distance network standards	Beyond time and distance network standards
Delaware Diamond State Health Plan-Plus (2012)	30-mile distance from member's residence for community-based residential alternative setting	Network standards beyond time and distance are under development
Iowa Health Link (2016)	30- or 60-mile distance from member's residence, depending on provider type; exceptions in rural areas based on historical community standards	Network standards beyond time and distance are under development
New Jersey MLTSS (2014)	None for LTSS	• To ensure choice of provider, minimum of two providers per HCBS provider type per county • Additional network standards that incorporate quality and performance measurement of LTSS providers are under development
Tennessee TennCare CHOICES (2010) and ECF CHOICES (2016)[a]	20-, 30-, or 60-mile distance from member's residence, depending on provider type and population density; exceptions in rural areas, based on historical community standards	• To ensure choice of provider, minimum of two providers per HCBS provider type per county • Sufficient number of HCBS providers to initiate and consistently provide LTSS in a timely manner without gaps in care • Contractual incentives for providers with I/DD experience/expertise who deliver better outcomes in the areas of integrated competitive employment and community living (ECF CHOICES)

[a] CHOICES began in 2010 and enrolls elderly persons and persons with physical disabilities. Employment and Community First (ECF) CHOICES, which began in 2016, enrolls persons with intellectual or developmental disabilities.

HCBS = home and community-based services.

I/DD = intellectual and developmental disabilities.

Transition of Care Policy

The Final Managed Care Rule requires states to have a transition of care policy that ensures uninterrupted access when beneficiaries transition from fee-for-service (FFS) to managed care, or from one managed care plan to another (42 C.F.R. 438(62)(b) (2016)).[2] States must ensure that beneficiaries have access to services consistent with their previous service delivery options and can keep their existing providers for a period of time defined by the state and included in the state's contracts with managed care plans. All four states included in this study had transition of care policies in place when they launched MLTSS programs. Table 2 summarizes some key features of those policies.

LTSS transition period at program launch. The transition period at program launch varied across the four states, ranging from as short as 30 days for home and community-based services (HCBS) and nursing facilities in Tennessee to as long as one year for nursing facility services in Iowa. Otherwise, the transition policies are similar across states. All four states require existing LTSS service plans to remain in effect during the transition period, which means that any LTSS authorizations in place immediately prior to MLTSS launch had to be honored by the MLTSS plans. All four states also allowed beneficiaries to keep their preexisting LTSS providers during the transition, whether or not the providers joined the MLTSS plans' networks.

Tennessee's policy is unique among those studied, in that the transition period at program launch varied between 30 and 90 days, depending on how quickly the MLTSS plans conducted an assessment and prepared a new plan of care. The preexisting plan of care had to be honored for a minimum of 30 days. The period then continued to day 90, unless the MLTSS plan conducted an assessment with the enrollee and prepared a new plan of care, in which case the period ended with implementation of the new plan. Tennessee officials explained that the policy was designed to provide an incentive for MLTSS plans to conduct an assessment and engage with beneficiaries as soon as possible, and to ensure that any transitions in services or service providers would not commence without a thoughtful assessment and planning process to guide them.

Iowa had a longer transition period for nursing facilities and other residential settings (one year) than for HCBS because Iowa officials believed that moving a person from a residential placement is more disruptive and takes longer to arrange than changing a person's in-home services. As a practical matter, since all the study states had at least a temporary "any willing provider" (AWP) requirement (discussed further below) for nursing facilities at MLTSS program implementation, there was little reason for individuals to transition between facilities.

LTSS transition period when switching managed care plans. In Delaware and Iowa, the 90-day transition period that applied to HCBS during launch also applied to both HCBS and nursing facilities when beneficiaries switched managed care plans. New Jersey and Tennessee both specified that the transition period when switching managed care plans depends on when the new managed care plan can complete an assessment of the enrollee and develop a new plan of care; Tennessee requires at least a 30-day transition period between plans.

With a few exceptions, all four states reported general satisfaction with the transition period, and none have changed their policies in this area since MLTSS program implementation. Tennessee noted that although its policy did not change, it did identify process improvements related to transferring care plan data to ensure smooth transitions. In Iowa, an issue arose for some I/DD programs around "exceptions to policy." Exceptions to policy are authorizations for service hours beyond what is normally authorized in the state's FFS system. These were to be honored for the duration of the exception, as specified in the FFS service plan. Providers in Iowa reported that MLTSS plans did not always know when an exception was in place for an enrollee, resulting in rejected or delayed claims. More generally, provider organizations in all the study states noted that the switch to MLTSS included

Table 2. LTSS transition of care policies in four MLTSS programs

State MLTSS program and launch date	LTSS transition period at program launch	LTSS transition period when switching managed care plans	Any willing provider policy
Delaware Diamond State Health Plan-Plus (2012)	**HCBS:** 90 days **Nursing facilities:** 90 days	90 days	**HCBS:** none **Nursing facilities:** indefinite
Iowa Health Link (2016)	**HCBS:** 90 days **Nursing facilities:** one year	90 days	**HCBS:** two years **Nursing facilities:** two years
New Jersey MLTSS (2014)	**HCBS:** 180 days **Nursing facilities:** not applicable (those in nursing facilities prior to MLTSS were not enrolled)	Until the new managed care plan conducts an in-person assessment and develops a new plan of care	**HCBS:** two years **Nursing facilities:** two years
Tennessee TennCare CHOICES (2010) and ECF CHOICES (2016)	**HCBS:** at least 30 days, and up to 90 days or until a new plan of care is in place **Nursing facilities:** same as HCBS	At least 30 days and until new managed care plan develops plan of care	**HCBS:** none **Nursing facilities:** indefinite

operational challenges, such as getting contracts in place, learning the credentialing and billing systems of multiple MLTSS plans, and learning how to communicate with the MLTSS plans; the transition period allowed time to work through the challenges without risking access for beneficiaries.

AWP Policy. All four states also have an AWP policy, which requires MLTSS plans to offer contracts to any existing Medicaid providers that want them. The AWP policy extends the ability of pre-MLTSS Medicaid providers to participate in MLTSS beyond the transition period. All four states have an AWP policy for nursing facilities, and two of the four (Iowa and New Jersey) also have an AWP policy for HCBS. In all four states, the AWP policies were initiated by nursing facility lobbies concerned that managed care plans would engage in selective contracting. States emphasized that AWP policies limit the ability of MLTSS plans to promote high-performing providers and prune underperforming providers in their networks. Study states suggested that if AWP policies must continue, they should be transformed into any willing and qualified provider policies (AWQP), in which providers need to meet quality standards of the managed care plans in order to maintain contracts. Under AWQP, managed care plans can set minimum requirements for provider participation in their network. In New Jersey, for example, the state is designing an AWQP program for their nursing facilities and using five metrics from the Minimum Data Set clinical assessment that is required of all nursing homes certified by CMS (State of New Jersey n.d.). These five metrics will serve as a measure of nursing home quality that managed care plans can use in designing AWQP contracting thresholds.

Provider Payment Policy

A common concern of LTSS providers, consumer advocates, and other stakeholders is that MLTSS plans will save money by cutting provider rates, which will result in providers dropping out of networks, and ultimately access will be diminished. Some states have protected existing FFS payment rates in MLTSS, both to address stakeholder concerns and to make clear that they expect managed care plans to earn savings through better coordination of care rather than through provider rate cuts.

The approach to study states' provider reimbursement policy is outlined in Table 3.

All four study states established minimum provider rates for nursing facilities in the transition to MLTSS, and two states (Iowa and Tennessee) established minimum rates for HCBS. In Iowa, the state developed a new methodology to establish HCBS minimum rates. The existing FFS HCBS payment rate methodology was not practicable in a managed care environment because rates were set at the provider and enrollee level (rather than procedure code level), resulting in thousands of payment rates. The state sought to address this by developing weighted-average rate floors for each HCBS provider on the basis of historic payment rates and enrollee case mix. However, because this methodology relied on dated historic payments, provider informants reported that the minimum rates were generally lower than what providers had received before the program was implemented. What each provider ultimately received varied by MLTSS plan. One MLTSS plan offered the minimum rate and did not negotiate; one offered 6 percent above the minimum rate for the first six months to account for increased administrative costs; and the third negotiated with providers above the minimum rate. The third MLTSS plan attracted the most HCBS providers, in part because of its payment policy and in part because of its care coordination model (addressed below). However, this MLTSS plan subsequently announced a change in policy in 2017, whereby all providers will be paid the minimum rate. Since most HCBS providers contracted with this MLTSS plan, the decrease will be felt widely throughout the HCBS provider community.[3] Given stakeholder concerns about the HCBS rates in Iowa, the state is moving toward a tiered system to update the HCBS rate minimums. This change mainly applies to residential services for people with I/DD, which constitute the largest share of HCBS spending; the change is expected to take effect in July 2018.

Tennessee has been engaged in a multiyear effort to revise its LTSS rate-setting methodology to incorporate value-based payment. A bridge payment process to incorporate value-based purchasing strategies has been in place for nursing facilities since 2014, providing a gradual transition to the new

Table 3. Provider reimbursement policies implemented in four MLTSS states

State MLTSS program and launch date	State established minimum provider rates?	Minimum rates based on historical FFS rates?	State established rates for out-of-network providers?
Delaware Diamond State Health Plan-Plus (2012)	**HCBS:** no **Nursing facilities:** yes	**HCBS:** not applicable **Nursing facilities:** yes	Yes, 80% of the minimum in-network rate
Iowa Health Link (2016)	**HCBS:** yes **Nursing facilities:** yes	**HCBS:** partially* **Nursing facilities:** yes	Yes, 90% of the minimum in-network rate
New Jersey MLTSS (2014)	**HCBS:** no **Nursing facilities:** yes	**HCBS:** not applicable **Nursing facilities:** yes	No
Tennessee TennCare CHOICES (2010) and ECF CHOICES (2016)	**HCBS:** yes **Nursing facilities:** yes	**HCBS:** yes **Nursing facility:** yes	Yes, 80% of the minimum in-network rate

*Iowa developed rate floors for each provider based on weighted averages of past FFS experience.

system, which is expected to be fully implemented by July 2018. Development of a value-based methodology for HCBS is underway. Informants noted that the revisions to nursing facility rates also include more accurate risk adjustments, as the CHOICES program serves more people with LTSS needs in the community. Tennessee's transition to value-based payment has allowed it to move gradually from a system of guaranteed minimum payments to one that incorporates quality into the rates.

In New Jersey, which does not require minimum HCBS rates, one MLTSS plan announced a rate cut for personal care providers, effective July 2017. In response, the legislature enacted and the governor approved legislation establishing the Medicaid FFS personal care rate as the minimum in managed care. The law takes effect July 1, 2018 (LegiScan 2016).

Level of Care Criteria

Clinical need for nursing facility services is defined by states in their level of care (LOC) criteria. HCBS waiver programs under section 1915(c) require that a person meet the same LOC criteria as required for a nursing facility or other type of institutional setting. Section 1115 of the Social Security Act allows greater flexibility in the administration of HCBS. Some MLTSS states have used section 1115 to de-link HCBS LOC criteria from nursing facility LOC. States may take this approach if they wish to expand access to HCBS yet maintain access to nursing facilities or make that access more restrictive. Delaware and Tennessee made changes to LOC criteria on or after the launch of their MLTSS programs (Table 4).

Table 4. Level of care criteria changes in four MLTSS programs

State MLTSS program and launch date	Change to LOC criteria on or after launch of MLTSS
Delaware Diamond State Health Plan-Plus (2012)	Yes: LOC changed to make the HCBS requirement less restrictive than the nursing facility requirement
Iowa Health Link (2016)	No change
New Jersey MLTSS (2014)	No change
Tennessee TennCare CHOICES (2010) and ECF CHOICES (2016)	Yes: in 2012, nursing facility LOC criteria became more stringent for new entrants to nursing facilities, and less stringent HCBS LOC criteria were created for individuals at-risk of meeting nursing facility LOC

Delaware officials reported that the LOC criteria were changed to require a need for assistance with one activity of daily living (ADL) for HCBS and two ADLs for the nursing facility LOC. People who were already receiving nursing facility services had need for assistance with more than two ADLs, so they maintained eligibility. LOC changes in Tennessee were more significant, and informants reported changes in access. In 2012, about two years after implementing the TennCare CHOICES program, Tennessee revised the nursing facility LOC criteria, making it more stringent for new entrants to access LTSS in nursing facilities. At the same time, the state created a less stringent LOC for a new category of HCBS targeted to people "at risk" of meeting nursing facility LOC in the future, and created a limited HCBS benefit package for the at-risk group. Initially, the at-risk group had the same financial eligibility criteria as did those at the nursing facility LOC (300 percent of Supplemental Security Income, or SSI), but upon expiration of maintenance of effort provisions of the Affordable Care Act and the authority granted to the state under the terms and conditions of its 1115 demonstration, the state tightened financial eligibility for the at-risk group to 100 percent of SSI, consistent with the original program design. Informants reported that changes to LOC in Tennessee have reduced access to nursing facilities for new applicants and expanded access to HCBS, though the scope of the HCBS expansion was subsequently scaled back by the changes in financial eligibility.

In each case, changes in LOC were policy decisions not directly related to the implementation of MLTSS. Delaware and Tennessee took the opportunity to implement desired changes in LOC policy as part of the 1115 amendments that authorized MLTSS, but they were not related to managed care per se.

Participant-directed Services Policy

Two states (Delaware and Tennessee) reported policy changes that increased access to participant-directed services. Before Delaware's Diamond State Health Plan-Plus (DSHPP) was implemented in 2012, participant-directed services were offered through a state-funded program with a capped budget and a long waiting list. One goal of DSHPP was to expand access to participant-directed services. Delaware added participant-directed services as a Medicaid benefit to DSHPP, with no limit on the number of participants. MLTSS plans are required to offer the participant-directed option at the initial person-centered planning meeting and in regular care plan review meetings held every 90 days. The state reported that the number of participants using the self-directed option doubled in the first year of DSHPP and continues to grow, totaling about 2,300 participants as of June 2017.

Before Tennessee's CHOICES program was implemented in 2010, there were no Medicaid participant-directed services available for older adults and adults with physical disabilities. Adding this option was an important part of the program design, as reflected in the authorizing legislation and approved 1115 waiver. The basic employer authority model has evolved over time to a modified budget authority model, using the services of a single statewide financial management service organization procured by the state Medicaid agency. Using materials developed by the state, managed care plans are required to offer participant

direction to every beneficiary receiving HCBS whose plan of care includes services available through the participant-directed model. Managed care plans are incentivized through MFP (Money Follows the Person) Rebalancing Demonstration benchmark payments to increase the number and percentage of CHOICES members in participant direction, which has grown to nearly 2,000 members electing to receive some or all HCBS through the model.

Care Coordination Model

A variety of care coordination approaches have emerged in MLTSS, including in-house models and shared functions models (Saucier and Burwell 2015). In-house models rely primarily on managed care plan staff to conduct care coordination, whereas shared functions models include community-based agencies conducting certain aspects of care coordination as subcontractors to the managed care plans. While all four states include care coordination as a key service in their programs, differences in how the Iowa managed care plans implemented care coordination had a particular impact on access. Iowa Health Link plans were free to implement the care coordination model of their choice. Two of the managed care plans implemented in-house models, whereas the third implemented a shared functions model with all existing community-based care coordination agencies.

The third managed care plan was the enrollment choice of a majority of HCBS participants when Health Link launched. Both state and provider informants believe this was in part because of its care coordination model, which enabled participants to keep their existing care coordinators in community agencies. The lesson that Iowa observers take from this experience is that maintaining access to specific care coordinators is very important to HCBS participants.

Analysis of MLTSS Policies' Impact on Access to LTSS

In general, state and provider informants in Delaware, Iowa[4], New Jersey, and Tennessee did not observe significant adverse impacts to access when MLTSS was implemented in their states. Tennessee and Delaware observed expanded access to participant-directed LTSS because of specific requirements for MLTSS plans to offer the option as part of the service planning process. Tennessee also observed greater access to HCBS and more targeted access to nursing facilities because of changes in its LOC criteria. The two states with the most recent MLTSS launches (Iowa and New Jersey) were still operating under AWP policies for both HCBS and nursing facility providers at the time of the study, and informants in those states expressed concern that in the absence of an AWP policy, provider networks may be reduced, despite some limited evidence to the contrary (Kasten, Saucier, and Burwell 2013).[5] Observers also noted that MLTSS has not solved persistent access problems dating back to their FFS systems. Notable examples are shortages of provider agencies serving rural areas and shortages of direct service workers, particularly in urban areas.

Traditional network adequacy standards (time and distance), buttressed by transition of care and AWP policies, have preserved the FFS status quo and successfully maintained access to LTSS providers that had been operating in the FFS system. These policies are effective in preventing service interruptions during the transition to managed care, but they also limit the potential to improve the quality of providers over time. Once MLTSS programs are operating smoothly, adding adequacy standards that focus on achieved access, such as the length of time from service authorization to service delivery, can expand the concept of adequacy from one based on quantity of providers to one based on performance. Additionally, states' new requirement to implement electronic visit verification (EVV) systems for Medicaid-covered personal care services or home health services (Congress.gov 2016) effective January 1, 2019 and January 1, 2023 respectively, and the advent of EVV technology, will greatly expand the availability of data for implementing standards based on achieved access.

State provider payment policies may also impact access. States have sought to prevent potential negative impacts by establishing minimum MLTSS provider rates that reflect what LTSS providers were paid in FFS. In Iowa, the policy goal of maintaining rates was complicated by the adoption of a new rate-setting methodology that went from calculating individual rates for persons with I/DD to calculating provider-level rates, which resulted in some providers receiving less revenue. As with transition of care policies, rate minimums may be an effective approach to maintaining access to pre-MLTSS providers. Tennessee began with such a base rate for nursing facilities and has added a value-based component as an incentive to improve quality over time.

Implications for Evaluation Efforts

Three policy areas stand out as particularly important to consider in MLTSS evaluations: network adequacy standards, transition of care and AWP periods, and level of care criteria. When evaluating network adequacy in MLTSS, it is important to understand what existed in the FFS system. Study states Iowa and New Jersey noted that access in rural areas has been a long-standing challenge in those states, and Tennessee noted that preexisting standards must be recognized in certain rural areas where time and distance standards cannot otherwise be met because the provider supply is very limited. States have been implementing new network adequacy standards based on achieved access, which can be supported by data collected in EVV systems. The shift to new network standards in MLTSS complicates evaluation, as it may be difficult or impossible to retrospectively calculate comparable measures for the FFS system.

Transition of care and AWP periods are designed to maintain access to pre-MLTSS providers, and therefore evaluators should not expect to see significant access changes while these policies are in effect. The time period following the expiration of such policies is of great interest to stakeholders and important to understanding the impacts of MLTSS on access.

Finally, LOC criteria determine who is functionally eligible for LTSS and therefore impact access by definition. Some states have decided to change LOC criteria concurrently with implementation of MLTSS, although doing so is not an MLTSS policy. Evaluators should determine whether LOC changes were made with or after MLTSS implementation and control for the effects of such changes.

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ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid Section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program and to inform CMS's decisions regarding future Section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four types of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports. This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. These briefs will inform an interim outcomes evaluation report in 2017 and a final evaluation report in 2019.

METHOD AND DATA SOURCE

From May through August 2017, Truven Health Analytics conducted hour-long semi-structured telephone interviews with state government officials representing MLTSS programs in four states. Additional hour-long semi-structured telephone interviews were held with LTSS provider organizations representing HCBS and institutional providers in each of the states.

The four programs selected represent a range of MLTSS program maturity, with implementation dates from 2010 to 2016. Three MLTSS programs were implemented under Section 1115 authority and one under concurrent Section 1915(b) and 1915(c) authority. States were asked to identify the most prominent provider organizations for both institutional and HCBS services, and interviews were requested of those groups.

Interviews were supplemented with reviews of documents provided by the states and contracts between states and managed care plans. State officials were given an opportunity to review a draft of this brief for accuracy.

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Endnotes

[1] The National MLTSS Health Plan Association has proposed using Time to Placement to measure adequacy of the network for services delivered to the member's location. They define Time to Placement as how long it takes from the time a given service is initially requested by the payer to the time it is initially delivered to the consumer's location.

[2] 42 C.F.R. 438.62(b) states: "The State must have in effect a transition of care policy to ensure continued access to services during a transition from FFS to a [managed care organization] MCO, [Prepaid Inpatient Health Plan] PIHP, [Prepaid Ambulatory Health Plans] PAHP, [Primary Care Case Management] PCCM, or PCCM entity or transition from one MCO, PIHP, PAHP, PCCM or PCCM entity to another when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization."

[3] When we conducted our Iowa interviews in May 2017, this change in payment had been announced by the MLTSS plan but not yet implemented.

[4] AmeriHealth, the largest provider of MLTSS currently serving 70% of the LTSS population, will end its contract to provide MLTSS on November 30, 2017.

[5] A 2013 study of MLTSS provider impacts in three mature MLTSS programs found that most preexisting providers continued to participate in networks long after continuity of care periods and any willing provider policies had ended, and that two of the three programs saw the number of HCBS providers expand.