Hand in Hand: Enhancing the Synergy between Money Follows the Person and Managed Long-Term Services and Supports

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EXECUTIVE SUMMARY

The Money Follows the Person (MFP) Demonstration and Managed Long Term Services and Supports (MLTSS) both aim to increase the opportunities for Medicaid enrollees needing long-term services and supports (LTSS) to live in the community rather than in an institution. However, these two programs can enroll different populations, cover different services, and operate under different financial incentives and management structures. As an increasing number of states operate both programs, it is important to understand how states are integrating the features of MFP and MLTSS to maximize the ability of people with disabilities to live in the community.

In this report, we describe the interaction between MFP and MLTSS in seven states: Hawaii, Massachusetts, Minnesota, New Jersey, Tennessee, Texas, and Wisconsin. The report updates information on enrolled populations, covered services, and transition coordination featured in a 2013 report (Lipson and Valenzano 2013). It also provides new details on the payment strategies and performance and quality measures used to align incentives for achieving common goals of MFP and MLTSS, and identifies opportunities for further alignment.

The experiences of these seven states offer several lessons that can help other states interested in developing MLTSS so that it provides strong incentives for transitioning people from institutional care and serving them in community-based settings:

- States that link MFP and MLTSS can facilitate transitions to the community among more populations and offer more supportive services than would be available under either program alone. For example, MLTSS can support transitions for individuals who have been in an institution for less than 90 days, which is not allowed under MFP. MFP can provide relocation support, set-up of the home, and supportive employment services in states that elect to cover them; these services generally are not covered by MLTSS.
- MLTSS may allow states to sustain gains made possible through MFP after the demonstration period. All seven study states cover a wide range of transition services in MLTSS, so individuals who wish to transition to the community can have strong supports in place after the MFP demonstration ends.
- States must also build strong financial incentives into MLTSS and communicate the benefits of MFP to MLTSS staff to ensure achievement of each program's goals. When managed care organizations (MCOs) can provide more cost-effective care in the community as opposed to an institution, they will work hard to divert or transition institutional residents to the community. However, promoting awareness of MFP among MLTSS care planners, transition staff, and providers is also critical.

About the Money Follows the Person Demonstration

The MFP Demonstration, first authorized by Congress as part of the Deficit Reduction Act of 2005 and then extended by the Patient Protection and Affordable Care Act of 2010, is designed to rebalance state Medicaid long-term care spending from institutional care to home and community-based services. Congress authorized up to $4 billion in federal funds to support a twofold effort by state Medicaid programs to (1) transition people living in long-term care institutions to homes, apartments, or group homes of four or fewer residents; and (2) change state policies so that Medicaid funds for long-term care services and supports can "follow the person" to the setting of his or her choice. MFP is administered by the Centers for Medicare & Medicaid Services (CMS), which initially awarded MFP grants to 30 states and the District of Columbia in 2007, another 13 states in February 2011, and 3 more in 2012. CMS contracted with Mathematica Policy Research to conduct a comprehensive evaluation of the MFP Demonstration and report the outcomes to Congress.

INTRODUCTION

Two programs—the Money Follows the Person (MFP) Demonstration and Managed Long Term Services and Supports (MLTSS)—share a common goal: providing people with more choices about where they receive long-term services and supports (LTSS). These two programs, however, are distinct in many ways: they operate under separate federal authorities and rules, provide different sets of services, may enroll different types of Medicaid beneficiaries, and are often administered by separate agencies and personnel. By integrating the rules, incentives, and operations across MFP and MLTSS, states can align and strengthen the incentives of both programs to maximize the ability of people with disabilities to live in the community.

The MFP Demonstration, authorized by federal law in 2005, provides grants to state Medicaid agencies to help Medicaid-eligible individuals who reside in institutions move to home and community-based settings, if that is where they wish to live and receive care. State MFP Demonstrations typically employ or contract with transition coordinators, housing specialists, and other professionals to arrange LTSS, housing, and other services that individuals need to make successful transitions and become integrated into the community (Denny-Brown 2015; Lipson and Valenzano 2013). In comparison, under MLTSS, state Medicaid agencies contract with managed care organizations (MCOs) to work with individuals in a person-centered manner to offer an array of LTSS, and sometimes acute and primary care, in exchange for a set per-member, per-month capitation payment.

In recent years, the number of states operating both MLTSS and MFP has grown. As of May 2015, 22 states operated MLTSS programs, up 46 percent since January 2012 (Saucier et al. 2012). Another 4 states have begun discussions with stakeholders or the Centers for Medicare & Medicaid Services (CMS) to develop such programs.[1] Currently, 43 states and the District of

[1] These states are Louisiana, Nebraska, Virginia, and Washington. Mathematica obtained this information from states and CMS in support of the national evaluation of Section 1115 demonstrations (CMS contract number HHSM-500-2010-00026I).

Columbia participate in MFP, an increase from 30 in 2010 (Centers for Medicare & Medicaid Services 2015).

In this report, we describe how MFP and MLTSS interact in seven states, explain the payment strategies and performance and quality measures used to align incentives for achieving the programs' common goals, and identify opportunities for further alignment. The report updates information on programs in five states—Hawaii, Massachusetts, Tennessee, Texas, and Wisconsin—featured in Lipson and Valenzano (2013). It also includes information on two states that have begun programs since 2013—one that launched MFP (Minnesota) and one that started MLTSS (New Jersey).[2]

We first discuss the extent to which the populations and services covered by MLTSS and MFP intersect, and then describe planned changes in Tennessee, Texas, and Wisconsin that increase the overlap. Second, we describe the roles and responsibilities of MCOs and MFP staff in planning and executing transitions to the community, highlighting the different models of coordination between MFP and MLTSS in Minnesota and New Jersey. Third, we describe state approaches to setting capitation payment rates that incentivize home and community-based services (HCBS) within MLTSS programs that include MFP services, and summarize quality and performance measures used to monitor progress toward MFP transition goals included in MLTSS. The report concludes with a summary of state successes to date in integrating MFP and MLTSS and a discussion of further opportunities to strengthen the links.

The findings in this report are based on two primary data sources. The first is a review of state documents, such as MLTSS contracts, MFP operational protocols, and written materials developed to explain program changes to stakeholders. The second is a series of eight telephone discussions with MFP and MLTSS officials in each state conducted between April 27 and May 14, 2015. We also used fee-for-service (FFS) and encounter claims data that MFP grantees submit on a quarterly basis to identify the types of HCBS the Tennessee program provides to MFP participants. This part of the analysis includes Tennessee only because, as of the date of this report, the other states in this study had not submitted sufficient encounter claims records for the HCBS provided to MFP participants. A detailed methods section is found in Appendix A.

POPULATIONS AND SERVICES COVERED IN MFP AND MLTSS PROGRAMS

Overlap in target populations. As reported elsewhere, most state MFP programs serve several population groups, including older adults, adults under age 65 with physical disabilities, those with intellectual or developmental disabilities, and individuals with serious mental illness (Irvin et al. 2015). They may also serve other populations, such as children with disabilities and individuals with traumatic brain injury. MLTSS typically serves adults over age 65 and younger adults with physical disabilities; less frequently, it serves people with intellectual disabilities and those with serious mental illness (Saucier et al. 2012).

[2] Three of the seven states—Massachusetts, Minnesota, and Texas—are also participating in CMS's Financial Alignment Initiative. Because the MFP population in these states interacts with this initiative in a way similar to MLTSS, it will not be discussed here.

Within states that operate both MFP and MLTSS, the populations covered often overlap, but there can be differences. As shown in Table 1, five of the seven study states serve older adults age 65 and older and people younger than age 65 with physical disabilities in both MFP and MLTSS. Children and people with intellectual disabilities are frequently excluded from one or both programs.

Table 1. Populations covered in MFP and MLTSS

State and MLTSS program	Populations served by both MFP and MLTSS	Populations served by MFP only	Populations served by MLTSS only
Hawaii QUEST Integration (QI)[a]	Age 65+, PD	IDD[b]	-
Massachusetts Senior Care Options (SCO)[c]	Age 65+	PD, IDD, SMI, people w/acquired brain injury	-
Minnesota Senior Health Options (MSHO)/Senior Care Plus (MSC+), Special Needs Basic Care (SNBC)	Age 65+ (MSHO/MSC+) PD (SNBC)	Children	-
New Jersey Managed Long Term Services and Supports (MLTSS)	Age 65+, PD, IDD	IDD[b]	-
TennCare CHOICES	Age 65+, PD	IDD[d]	-
Texas STAR+PLUS	Age 65+, PD	IDD[e]	Children with disabilities[f]
Wisconsin Family Care	Age 65+, PD, IDD	Children[g]	-

Sources: Lipson and Valenzano (2013), state MLTSS contracts, and MFP operational protocols.

Note: IDD = Adults who have intellectual or developmental disabilities; PD = Adults who have physical disabilities; SMI = People with serious mental illness without co-occurring conditions

[a] In 2014, Hawaii changed the name of its MLTSS program from QUEST Expanded Access (QExA) to QUEST Integration (QI).

[b] Hawaii and New Jersey provide acute and behavioral health care to individuals with intellectual and developmental disabilities through managed care, but LTSS are provided via FFS.

[c] Massachusetts also operates OneCare, a Financial Alignment demonstration that enrolls Medicare-Medicaid eligibles under age 65.

[d] Tennessee currently provides physical and behavioral health services to individuals with intellectual disabilities, but not LTSS. The state is reforming its 1915(c) waivers and has submitted an 1115 waiver amendment to CMS requesting approval to cover some LTSS services for this population under managed care.

[e] Texas provides acute care services to individuals with intellectual and developmental disabilities through STAR+PLUS, but LTSS are provided via FFS. The state will be developing capitated LTSS pilots to serve the population with intellectual and developmental disabilities.

[f] Texas allows children with physical or intellectual disabilities to opt in to STAR+PLUS; however, most children are currently covered via FFS.

[g] Children in Wisconsin are also served by three FFS 1915(c) waivers.

Overlap in covered services. Lipson and Valenzano (2013) described the significant overlap in services provided by MFP programs and covered by the states' MLTSS systems. All seven study states currently require MCOs to assess individuals in nursing homes for their interest in and ability to transition to the community,[3] develop care plans, and arrange for services. However, in Massachusetts and Texas, MFP provides additional transition services not covered by MCOs, either through state MFP staff or contracts between the MFP program and agencies. These services include relocation support and set-up of the home. Minnesota also uses MFP rebalancing funds to provide additional services to MFP participants, such as teaching community integration skills and providing supportive employment for people under the age of 60. MCOs cover home and community-based services for people age 65 and older who are enrolled in the state's 1915(b)/(c) managed care programs, and also allow their enrollees to access MFP demonstration services. Many of these services are also covered by MCOs, but the counties or tribes that operate 1915(c) waivers ask MFP to provide them because it can provide additional flexibility in their delivery. Minnesota, for example, covers independent living skills in the home setting in its 1915(c) waivers but uses MFP to provide "comprehensive community support services," which allow providers to support individuals outside of the home (for example, in recreation centers).

In the past two years, Texas has begun to provide LTSS to additional populations and geographic areas; Tennessee is planning an expansion to include some HCBS for individuals with intellectual and developmental disabilities, thus increasing the overlap between MFP and MLTSS and providing opportunities for greater alignment. In September 2014, Texas expanded the number of counties served by STAR+PLUS, making it available statewide. In March 2015, Texas added nursing facility services for STAR+PLUS members, which previously had been available only through FFS. The state is now exploring models to deliver LTSS to people with intellectual and developmental disabilities through managed care. Tennessee is expanding MLTSS, known as CHOICES, to include competitive, integrated employment and independent living for individuals with intellectual and developmental disabilities. Wisconsin has taken a slightly different approach and expanded its Family Care program to additional counties in the

[3] The seven study states require that MCOs assess individuals' functional status and ability to live in the community within 30 days of initial enrollment, and reassess their status every 3, 6, or 12 months thereafter, or when there is a significant change in the person's health status and/or level of caregiver support (the time period for reassessment varies by state).

state.[4] Because MFP services and requirements are built into Family Care, the expansion increases the number of users who can receive these services through an MLTSS model. The details of the changes in Texas and Tennessee are discussed below.

TEXAS: EXPANDING AN EXISTING MLTSS PROGRAM TO INCLUDE MORE SERVICES AND MORE POPULATIONS

Texas has operated STAR+PLUS MLTSS since 1998. STAR+PLUS initially covered HCBS in limited regions of the state but gradually expanded the number of regions in which the program operated. In September 2014, Texas expanded it statewide and required Medicaid-eligible individuals with intellectual and developmental disabilities to enroll in managed care to receive acute care medical services. In March 2015, Texas continued expanding STAR+PLUS by adding nursing facility services to the MCO benefit package for adults and enrolling current nursing home residents in managed care plans.[5] By including nursing facility services for adults, state officials report that they are better able to align the goals of both MFP and MLTSS in "providing services in the most appropriate setting."

MCOs participating in STAR+PLUS are now responsible for the delivery of all MFP services with the exception of relocation support, which is provided through a network of relocation contractors managed by the state. MCOs must assess the conditions and ability of nursing facility residents to live in the community within 30 days of admission, and reassess residents every 90 days thereafter. Each MCO must designate a service coordinator for each nursing facility; this individual must visit residents face to face at least quarterly. MFP relocation contractors, with whom the state (not the MCO) contracts, work with individuals wishing to transition to the community by identifying appropriate housing, assisting in relocation, and following up with individuals for 90 days after their move. The MCO service coordinator must follow up with each individual within 14 days of the transition to evaluate whether the person needs additional supports. Service coordinators from the MCO coordinate with the relocation contractor to ensure that arrangements are in place before an individual is discharged from the nursing facility.

> Since March 2015, MCOs participating in Texas's STAR+PLUS program are responsible for the delivery of all MFP services with the exception of relocation support.

The legislation that authorized the STAR+PLUS expansion also directs the state to develop and implement pilot programs to deliver LTSS to individuals with intellectual and developmental disabilities through a managed care model. Texas currently is soliciting input from stakeholders on the design of the pilots and is developing next steps around stakeholder feedback.

[4] In April 2014, Wisconsin's governor announced the expansion of Family Care to 7 additional counties in northeast Wisconsin, bringing the total number of participating counties from 57 to 64 (out of 72 counties statewide). The new territory would add 2,434 people who use county-based LTSS to the Family Care rolls, as well as 977 people on waiting lists for county services and any other eligible residents (Richmond 2014).

[5] Texas Senate Bill 7, 83rd Legislature, Regular Session, 2013.

TENNESSEE: EXPANDING SERVICES FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AND EXPLORING THEIR COVERAGE IN CHOICES

TennCare CHOICES, MLTSS in Tennessee, has operated since 2010 and serves Medicaid-eligible adults age 21 or over with physical disabilities and those age 65 or older who require nursing facility care or are at risk of placement in a nursing facility. Though individuals with intellectual disabilities are enrolled in TennCare managed care plans for medical and behavioral health services, HCBS is provided on an FFS basis for this population through one of three 1915(c) waivers. The state and its stakeholders identified several issues regarding these waivers. Two of them—the Comprehensive Aggregate Cap and Statewide HCBS waivers—reported costs two to four times the national average for comparable 1915(c) waiver programs. There were long waiting lists to get on the waivers and, according to the state, there were almost as many people waiting to receive services as there were people enrolled in these programs. Moreover, the waivers served only people with intellectual disabilities; people with developmental disabilities could not access HCBS. When these waivers were set to expire at the end of 2014, the state approached its stakeholders to explore ways to expand access to HCBS for people with intellectual and developmental disabilities in a cost-effective manner.

With stakeholder input, Tennessee has proposed a phased approach to expanding HCBS for individuals with intellectual and developmental disabilities. First, to help control costs in its existing waivers, the state has revised its largest 1915(c) waiver by using an individual cost cap in lieu of an aggregate cost cap.[6] The state is also making other adjustments, which it hopes will provide more flexibility for community living: (1) modifying service definitions to clarify expectations around person-centered service delivery and integrated community-based service settings, and (2) offering more choice and autonomy in living arrangements, sharing of certain services, and flexibility in the hours that employment and day services are provided. In addition, Tennessee worked with stakeholders to develop a new program, Employment and Community First CHOICES, which will align incentives to promote integrated competitive employment and integrated community living as the first and preferred option for individuals with intellectual and developmental disabilities. Tennessee will implement Community First CHOICES upon approval from CMS. The cost of the existing waivers, concerns regarding the waiting list, and the state's current success with managed care have prompted broad stakeholder support for this change.

> Tennessee is planning to offer some HCBS to individuals with intellectual and developmental disabilities through its CHOICES program.

[6] Under an aggregate cost cap, the cost of all covered services for those eligible for waivers must be no more than the cost to provide institutional and other Medicaid services to the eligible population. Under an individual cost cap, the cost of services used by each waiver enrollee must be at or below the level specified by the state in the approved waiver (in Tennessee's case, the comparable average cost of services in a private intermediate care facility for individuals with intellectual disabilities). Tennessee reports that moving from an aggregate cap in the state's largest waiver to an individual cap will help ensure cost control and serve more people.

COORDINATION BETWEEN MFP TRANSITION COORDINATORS AND MLTSS CARE MANAGERS

MFP transition coordinators and MLTSS care managers play important roles in planning and arranging for a wide range of services available to support individuals who move from an institution to the community. Appendix B demonstrates the wide array of MLTSS services that MFP participants in Tennessee use, for which transition coordinators must work with care managers to arrange and coordinate. Compared to MFP users nationwide, individuals in Tennessee use more personal care (89 percent compared to 49 percent); home-delivered meals (33 percent compared to 11 percent); equipment, technology, and modifications (67 compared to 57 percent); and caregiver support (34 percent compared to 5 percent). This increased usage occurs because the overwhelming majority of participants in Tennessee's MFP program enrolled in CHOICES have transitioned into their own homes or the home of a family member, rather than a residential setting that provides around-the-clock assistance and tends to be more expensive.

Given the breadth of services that can be covered under MLTSS systems such as those in Tennessee, it is important for states to define clearly the roles and responsibilities of transition coordinators and care managers. As described in Lipson and Valenzano (2013), Hawaii, Tennessee, and Wisconsin rely on MCO care managers to handle the entire transition planning process, establish the care plan, arrange for all HCBS, and continue monitoring participants' care after their move to the community. Texas assigns MCO service coordinators specific responsibilities related to discharge and transitioning to the community, and requires that service coordinators work closely with relocation contractors. Massachusetts requires MFP to be responsible for transition planning, whereas MCOs are responsible for post-transition HCBS. The entities responsible for providing transition services and care management in MLTSS programs in each state are shown in Table 2.

New Jersey, which operated MFP and other transition programs long before the launch of MLTSS, also has MFP transition coordinators working alongside MCO care managers. Though the state eventually will require MCOs to be responsible for all transition services, MFP staff currently provide some transition support for MFP eligibles who qualify for its MLTSS and want to return to the community. For nursing facility residents in FFS, MFP staff identify residents who want to transition and coordinate their enrollment into the MCO. For residents already enrolled in an MCO, the MFP staff obtain consent to transition and administer the MFP quality-of-life survey. Following enrollment in an MCO, state MFP staff continue to participate in the MCO-led interdisciplinary team meeting that plans each transition. In this role, MFP staff advocate for the individual and ensure the MCO is planning appropriately for the transition. New Jersey reports that this additional support during the pre-transition planning period is important because "this is the first time the MCOs are providing MLTSS services, and state staff are teaching the MCO care managers how to help individuals transition to the community." Once an individual has made this transition, the MCO is responsible for monitoring the quality and appropriateness of the placement and addressing any

New Jersey requires that MFP coordinators work alongside MLTSS staff to plan transitions, whereas Minnesota assigns either the MCO, county, or tribe to lead transition planning.

ongoing needs. Each MCO has a dedicated MFP liaison to monitor quality issues for MFP participants; the liaison coordinates with the state MFP program as needed.

Table 2. Entities responsible for transition services and care management in MLTSS

State and MLTSS program	Transition services	Care management
Hawaii QI	MCO	MCO
Massachusetts SCO	Varies by population[a]	MCO
Minnesota MSHO/MSC+, or SNBC	Lead agency[b]	Lead agency[b]
New Jersey MLTSS	Varies by population[c]	MCO
TennCare CHOICES	MCO	MCO
Texas STAR+PLUS	MFP[d]	MCO
Wisconsin Family Care	MCO[e]	MCO

Sources: Lipson and Valenzano (2013), state MLTSS contracts, and MFP operational protocols.

[a] Transition assistance is provided by Aging Services Access Points (ASAPs) for people in nursing homes, the Department of Mental Health for people living in psychiatric facilities, the Department of Developmental Services for people in intermediate care facilities, and the University of Massachusetts Medical School for people with acquired brain injury.

[b] MCOs serve as the lead agencies for MSHO or MSC+ enrollees; counties or tribes serve as the lead agencies for SNBC enrollees.

[c] For nursing facility residents served in FFS, the state will identify potential transitions and coordinate enrollment into the MCO, which is responsible for the procurement and cost of all assessed transitional needs. For residents enrolled in an MCO, the MCO identifies, coordinates, and plans transition services.

[d] A network of contractors employed by the state provides relocation support.

[e] In counties that do not offer Family Care, transition assistance is the responsibility of the FFS HCBS waiver program.

Unlike other states that assign roles to either the MCO or MFP staff, Minnesota uses a model that assigns a "lead agency" to be responsible for assessment, planning, and monitoring of transition services based on the program in which an individual is enrolled. MCOs participating in Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+), which are responsible for 180 days of nursing facility care as well as HCBS, serve as the lead agencies for their members. Counties or tribes serve as the lead agencies for individuals enrolled in Special Needs Basic Care (SNBC) because MCOs administering the program are not responsible for waiver services. All lead agencies rely on case managers, employed by the MCO, county, or tribe, to provide transition coordination services, though MCOs often contract with county-based case managers for this type of service.

PAYMENT INCENTIVES TO ENCOURAGE HCBS AND TRANSITIONS TO THE COMMUNITY

APPROACHES TO CAPITATION

As described in the previous report, states can structure their capitation payments to MCOs (that is, a fixed, per-member per-month amount paid to cover LTSS services for members) in a way that provides them with incentives to increase the use of HCBS and reduce nursing facility care (Gore and Klebonis 2012). The states profiled in this report use one of three approaches to set capitation rates for MLTSS: (1) paying separate amounts, referred to as "rate cells," for individuals served in institutions or the community; (2) paying a "blended rate" that covers average expected costs for both HCBS and institutional services; and (3) paying separate amounts based on location of care, as in the first approach, but adjusting the timing of payments to create incentives similar to those present in a blended model. A summary of rate-setting approaches used in the seven study states is included in Appendix C.

1. **Rate cells:** New Jersey and Texas structure their rates using rate categories or "cells" based on characteristics that distinguish different populations served. For example, states might create rate cells based on age, gender, region (urban versus rural), diagnosis, degree of frailty, setting of care (institutionalized or community), waiver enrollment, and/or eligibility for Medicare. Managed care plans receive different per-member per-month payment amounts based on the number of enrollees in each cell. When an individual's need changes (for example, when the person moves to a new care setting), he or she "moves" to a new cell, and the amount paid for that individual changes. The MLTSS capitation rates paid in New Jersey are provided in Table 3. Because New Jersey is new to MLTSS, it will be important to assess whether the amounts paid offer sufficient incentives going forward.

Table 3. MLTSS capitation rates in New Jersey, state fiscal year 2015

Population	HCBS settings (includes ALF)	Custodial NFs	SCNFs[a] (vents and pediatrics)	Other SCNFs[a]
Medicare-Medicaid enrollees	$2,708	$6,436	$17,163	$13,440
Medicaid-only enrollees	$7,667	$9,060	$25,548	$17,928

Source: New Jersey Department of Human Services.

[a] Special care nursing facilities (SCNF) or units provide special long-term care services, such as behavior management and ventilator care.

ALF = assisted living facility; HCBS = home and community-based services; NF = nursing facility; SCNF = special care nursing facility

2. **Blended rate:** Hawaii, Tennessee, and Wisconsin encourage community-based placement for all beneficiaries who meet these states' nursing home level of care requirements by paying the same rate regardless of care setting. To calculate this rate, a state and its actuaries add together the expected LTSS costs for individuals in both institutional and home and community-based waiver services, multiplied by the targeted percentage of

individuals residing in each of those settings. The result is a single rate that covers both HCBS and institutional costs; because serving individuals in the community typically costs less than an institution, MCOs have an incentive to keep individuals out of institutions and return them to the community as quickly as possible when necessary admissions occur (Dominiak et al. no date).

3. **Modified blended rates:** Massachusetts and Minnesota use an approach that combines multiple rate cells reflecting variation in frailty or care setting, but manages the timing of an individual's placement in a different rate cell to provide an incentive for HCBS over institutionalization. States that use this approach often pay lower HCBS rates for a period of time following admission to a nursing facility setting to incentivize diversions. Conversely, the state pays higher nursing facility rates for a period of time following discharge to an HCBS setting to incentivize transitions. For example, Massachusetts pays MCOs participating in Senior Care Options a community capitation rate for the first 90 days of an institutional stay, after which the state pays MCOs a higher institutional rate to match expected cost of care more closely. MCOs also receive the higher nursing facility capitation rate for the first three months after a member returns to the community. Additional details on Massachusetts's payment strategy are provided by Lipson and Valenzano (2013).

   Minnesota's per-member per-month rate structure consists of a base rate that covers all state plan long-term care services, plus two add-on payments to cover either nursing facility care or services for the state's 1915(c) Elderly Waiver (depending on the individual's eligibility). MCOs receive both the base rate and one or both add-on payments. When a member moves from the community to a nursing home, MCOs immediately lose the nursing facility add-on payment for that individual; they only receive the Elderly Waiver add-on payment for the first 30 days of a nursing home stay. After the add-on payments cease, however, MCOs continue to remain liable for the cost of nursing home care for 180 days for MSHO/MSC+ participants and 100 days for SNBC participants. Once stays exceed the maximum, the state assumes the cost of the stay and reimburses the provider on an FFS basis.

Additional incentives to encourage transitions from institutions to the community

In addition to the incentives built into the capitation payment rate, two states offer MCOs an incentive payment outside of the capitation rate when a plan identifies and transitions institutional residents who can be served safely in the community. As described in Lipson and Valenzano (2013), Tennessee offers incentive payments to MCOs, financed by MFP rebalancing funds, to encourage them to make transitions and sustained community living a priority.

In 2013, Wisconsin introduced a per-member "incentive" payment for each individual who transitioned from a nursing home to the community.

Recently, Wisconsin has also developed a similar "transition incentive payment" to help defray the administrative costs associated with carrying out MFP transitions. Wisconsin pays Family Care MCOs $1,000, awarded on a calendar basis, for each MFP-eligible individual transitioned from a nursing home to the community. The state representatives interviewed for this study reported that it is not clear whether the incentive has increased the volume of transitions among Family Care members, but it has provided incentives for MCOs to report MFP-eligible transitions. Respondents indicated that other program features, including capitated payments and contractual requirements for person-centered planning and placement in the least

restrictive setting, have been the major drivers of increases in transitions and rebalancing in Wisconsin. Minnesota reported an interest in developing similar incentive payments for the future, but does not currently offer them in MLTSS. New Jersey officials are also interested in transition incentive payments but do not believe they are politically feasible at this time.

One state (Tennessee) also uses financial disincentives in its managed care program to encourage MCOs to help individuals who have transitioned from certain settings to the community stay there, although this is not part of MFP or MLTSS in Tennessee. TennCare MCOs are fined $1,500 each quarter if more than 10 percent of members discharged from a psychiatric inpatient or residential treatment facility are readmitted within 7 days and/or more than 15 percent are readmitted within 30 days.[7] Few states share Tennessee's approach. Hawaii, which does not use penalties or sanctions, asserts that its strongest incentive is public reporting of quality measures, because plans cite these measures in competing with each other for members. Measures are currently shared among plans on a monthly basis, and the state is working to make a summary version of its "performance dashboard" public and available to Medicaid beneficiaries through its website. Wisconsin, which also does not apply penalties or sanctions based on the rate of transitions, asserted that its focus "is not on what could be an arbitrary goal for transitions, but on assuring that the care plan is reflective of Family Care members' long-term care needs and preferences because the fundamental principle of Family care is that members should live in the community."

QUALITY AND PERFORMANCE MEASUREMENT

Quality and performance measures, which summarize elements of an individual's experience of care, are important tools that states and stakeholders can use to monitor the performance of MLTSS. Although measures for LTSS are not as well developed as those used to assess care provided in clinical settings, states are increasingly including a variety of LTSS-related measures in their MLTSS contracts (Reaves and Musumeci 2015). Several of the measures that plans must report for MLTSS also gauge progress toward MFP goals. Table 4 summarizes MLTSS measures related to MFP goals; a more detailed comparison of measures is available in Appendix D.

[7] This penalty is one of many that MCOs in Tennessee face if they do not comply with contract requirements or benchmarks, but not all penalties are related to MFP or MLTSS. When taken together, the state reports that these fines provide a significant incentive for compliance.

Table 4. Number of states reporting MLTSS quality measures related to MFP goals

Measurement domain	Number of study states using a measure (out of 7)
Transitions from institutions to the community	6
Re-institutionalization	6
Person-centered planning process	6
Quality of life	5
Critical incidents	5
Timeliness of home-based care and meals	1
Housing	1

Source: Mathematica review of state MCO contracts and personal communication with Hawaii state personnel. Links to publicly available contracts for all states except Hawaii can be found in the References section of this report.

Across the study states, most require their MCOs to report measures related to the number of transitions, re-institutionalizations, and person-centered planning; however, other measurement domains vary across states. Five have the MCOs report information from the MFP quality-of-life survey that all MFP grantees must administer to participants, and one (Tennessee) collects information on housing.[8] The Financial Alignment Initiative, in which Massachusetts, Texas, and Minnesota participate, requires a separate set of measures largely aimed at assessing the quality and coordination of Medicare and Medicaid services for dually eligible individuals. Several of the measures, however, address transitions from institutions to the community and person-centered planning. Although these measures are not required of other MLTSS programs that operate outside of the initiative, states may look to them as a way to assess MFP goals under MLTSS.

Several states are interested in developing measures to assess care transitions and housing availability.

States report several challenges in collecting and using MLTSS performance measures. First, apart from certain nursing facility measures that rely on Minimum Data Set information, few standardized, nationally recognized performance measures exist related to LTSS. In comparison, there are multiple measure sets available for acute care, such as the Healthcare Effectiveness Data and Information Set (HEDIS) and the Agency for Healthcare Research and Quality's (AHRQ) Prevention Quality Indicators and Pediatric Quality Indicators. Second, in states new to MLTSS or expanding existing MLTSS to new regions and populations, MCOs may find it difficult to report quality and performance measures in a way that is (1) consistent with

[8] To participate in the MFP national demonstration, states must administer an MFP quality-of-life survey shortly before the transition, one year after the transition, and again two years afterward. The quality-of-life survey data are part of the national evaluation of the MFP demonstration, but state grantees may also use the data to assess or monitor their participants.

other plans and (2) in line with the state's expectations. For example, in Texas, differences in how individual MCOs collect, aggregate, and report MLTSS measures make it difficult to track trends statewide.

States may also have challenges in developing incentives or penalties related to quality and performance measures. The legislation that expanded STAR+PLUS to nursing facilities directs Texas to develop payment incentives that "encourage provider reform and more efficient delivery and provider practices."[9] Before the state can develop such incentives, it must establish an accurate baseline for its state-developed nursing facility performance measures—namely, the rate of admissions to nursing facilities from community settings and the number of individuals who transition from the community to a hospital setting and then move to a nursing facility and remain in nursing facility care. Texas will also survey its nursing facilities residents on their experience of care. These data, in combination with the state-developed nursing facility measures, will be used to develop a future financial incentive program for nursing facility services (expected by 2017).

[9] Texas Senate Bill 7 of 2013, Section 5.10.

Independent assessments in person-centered planning

In January 2014, CMS issued new rules designed to enhance the quality of HCBS and provide additional protections to the individuals who use such services. The rules describe specific requirements for the person-centered planning process, including that service plans must be performed by an agent that does not "hold financial interest in an entity providing care for the individual" and is not "a provider of State plan HCBS for the individual, except when the State demonstrates that the only willing and qualified agent to develop person-centered service plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of agent and provider functions within provider entities."[10] In essence, the rules require firewalls in the process of care planning and service delivery so that conflicts of interest do not prevent an individual from receiving the full set of services he or she requires or create financial incentives to provide unnecessary care.

In MLTSS models, CMS allows MCOs to perform functional assessments and provide case management as long as the MCOs do not also provide direct services. In most managed care delivery models, MCO staff do not provide direct services; instead, they contract with providers to deliver services in the care plan. However, if MCOs provide any direct services, they must use separate personnel for them, and every beneficiary must have the right to appeal the denial or reduction of services. Furthermore, if an MCO performs direct assessments that result in scores determining the level of care, the state must validate the assessments using representative sampling methods.[11]

Though each of the seven study states complies with these expectations, they differ in how they structure functional assessments and case management responsibilities. Minnesota, Tennessee, and Wisconsin use state or county entities to conduct or verify the initial functional assessments that LTSS need. In Minnesota, these county or tribal-based assessment staff are often under contract with MCOs. In contrast, Hawaii, Massachusetts, New Jersey, and Texas allow the MCOs to conduct initial assessments, and most use state staff or contract with an external organization to validate the MCOs' findings and monitor care planning and delivery. Massachusetts' SCO program requires Geriatric Support Services Coordinators (GSSC) employed by Aging Services Access Points (ASAPs) to assess the individual for LTSS needs and develop care plans for community-based service packages in collaboration with SCO plans. Contract management teams from the state and CMS also oversee contract compliance, and an independent evaluator conducts annual assessments and site visits. State staff in Texas monitor provider performance and conduct utilization reviews. MCOs in all states are responsible for conducting ongoing functional assessments for enrolled members, creating care plans, and contracting with providers to deliver services according to the care plan.

[10] 42 CFR 441.730.

[11] CMS, Mission Analytics Group, and New Editions Consulting. Balancing Incentive Program National Call, January 21, 2015.

CONCLUSION

States increasingly recognize that MLTSS and MFP demonstrations have very similar goals; as a result, they have tried to leverage MLTSS to support MFP transitions or use MFP resources to enhance the ability of MLTSS to rebalance the LTSS system toward home and community-based care. However, both programs have their limitations; coordinating them allows states to take advantage of each one's strengths. For example, to be eligible for MFP participation, an individual must be in an institution for at least 90 days; however, states that wish to encourage transitions after shorter stays or avoid unnecessary institutional admissions can use MLTSS to facilitate community living. States that operate MLTSS using 1915(c) waivers and managed care authorities may also find that MFP allows them to supplement the HCBS that cannot be offered through fee-for-service 1915(c) waivers alone.

Both MFP and MLTSS use a variety of strategies to encourage transitions to the community, such as offering incentive payments for successful transitions, enforcing contract requirements regarding person-centered planning, and public reporting on the balance of institutional to home and community-based services for participating MCOs. However, most states report that building strong financial incentives to promote the use of HCBS into the capitation rates paid to MCOs is the most effective lever a state can use. Quality measures may also help states monitor MCO performance in relation to MFP goals.

States that integrate MFP and MLTSS also report that they face fewer challenges in sustaining the progress they have made with their MFP programs when the national MFP demonstration ends. Although CMS will not be able to award any additional demonstration programs after federal fiscal year (FFY) 2016, states with MFP demonstrations in place may continue MFP transitions through the end of FFY 2018 and will have until the end of FFY 2020 to spend all remaining grant funds. Because MFP is time limited, states such as Massachusetts and Minnesota, which provide some or most MFP services on an FFS basis, report that they will use another funding stream and the state's Aging and Disability Resource Center (ADRC) network to support additional transition services and training when the demonstration ends. This issue suggests that states operating or developing MLTSS should consider the most effective ways of designing them to ensure that the systems and benefits developed through MFP to promote successful transitions are well integrated into MLTSS benefit packages.

Although aligning program features and incentives is important, respondents from all seven study states suggest that increasing awareness of MFP—and the factors that characterize successful transition processes—among state MLTSS managers and MCO administrators, care planners, transition staff, and providers is key to making community living possible for everyone who wants it. MFP has demonstrated that person-centered transition planning requires creativity and investment. Home modifications and ramps may cost more in the short run but can pay off in the long term by reducing the rate of falls, hospital visits, and readmission to nursing homes. Some states, like New Jersey, provide training on transitions directly to MCOs and care management staff. Other states, like Wisconsin, communicate their expectations to MCO leadership and provide capacity-building grants to MCOs to support staff training on facilitating transitions. Texas facilitates this awareness by embedding MFP staff in the MLTSS transition planning process, which helps to communicate the opportunities available through MFP to MLTSS plans serving these new populations and their diverse providers.

Among the biggest challenges to states operating both programs is the need to expand the availability of affordable, accessible housing to Medicaid beneficiaries. MFP programs have consistently cited the lack of affordable and accessible housing as the biggest barrier to helping more people transition to the community (Irvin et al. 2015). To understand the magnitude of the problem for its beneficiaries, Tennessee has begun collecting data on housing (see Appendix D). However, the strategies that state MFP programs have used to address this problem—developing inventories of affordable and accessible housing, offering temporary or permanent rental subsidies, and assigning housing specialists to work with MFP transition coordinators—must be embraced by MCOs operating MLTSS if they are to succeed in making community living a genuinely viable option.

Through increased awareness and sharing of lessons and resources across MFP and MLTSS, states can help facilitate their common aim: to maximize the ability of people with disabilities to live in the community.

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APPENDIX A – METHODS AND DATA

In this study, we examined policies and practices related to MFP and MLTSS in seven states: Hawaii, Massachusetts, Minnesota, New Jersey, Tennessee, Texas, and Wisconsin. Five of these states were profiled in a similar report by Lipson and Valenzano (2013); the remaining two states (Minnesota and New Jersey) have launched MFP and MLTSS programs since 2013. We reviewed a variety documents to gather information on the way in which MFP and MLTSS interact, including each state's most recent MLTSS contract; the MFP operational protocol, which outlines details of the program; and publications and state presentations on major changes to MLTSS.

We also conducted semi-structured telephone discussions with MFP and MLTSS officials in each state in April and May 2015. For Minnesota and New Jersey, our discussions covered seven major topics: (1) MFP and MLTSS goals; (2) eligibility requirements for MFP and MLTSS; (3) payment; (4) coordination of transition planning between programs; (5) performance measures for MFP transitions; (6) HCBS independent assessment requirements; and (7) lessons learned by states. For the five states profiled by Lipson and Valenzano (2013), our discussions focused on major changes to MFP or MLTSS that have occurred since 2013, as well as incentives and quality measures in place to encourage transitions to the community.

To summarize the types of HCBS used by MFP participants (Appendix B), we adapted the HCBS taxonomy that Truven Health Analytics and Mathematica developed and tested for CMS (Eiken 2014; Peebles and Bohl 2014; Wenzlow et al. 2011). As with the HCBS taxonomy, MFP-paid services are organized into 16 mutually exclusive service categories; we added a 17th category to capture services we could not classify because of inadequate information on the claims record (for example, vague procedure code descriptions). Within each of the 16 categories that represent categorized services, we created 39 mutually exclusive subcategories of services—a much lower number than the 66 used in the original HCBS taxonomy. We used a smaller number of subcategories because the volume of claims did not always support the level of detail the HCBS taxonomy was designed to capture. When summarizing expenditures and service use by subcategory, we indicate when we adapted the HCBS taxonomy to better meet the needs of this study.

For this analysis, we applied the MFP taxonomy to services provided to MFP participants in Tennessee. The analysis included encounter claims for 923 Tennesseans transitioning through the MFP program by the end of 2014. All MFP participants in Tennessee were enrolled in managed care with the exception of 50 individuals in FFS. We included claims for services provided through the end of 2014, meaning that individuals who had transitioned more recently have a shorter claims run-out period, and we may not have captured all of their MFP expenditures. When applying the taxonomy, Tennesseans used services falling into 10 service categories and 20 subcategories. When calculating expenditures for each category, we used the Medicaid amount paid for FFS claims and the charge amount for encounter claims.

APPENDIX B – HCBS USE IN TENNESSEE

Table B.1. Categories and subcategories of HCBS provided to MFP participants in Tennessee

Category and subcategory of service	Use of services, by type		
	Number of unique users in Tennessee[a]	Percentage of all participants using service in Tennessee[a]	Percentage of all participants using service nationwide (FFS only)[a]
Overall	**990**	**100**	**100**
Home-Based	**895**	**90**	**56**
Companion	24	2	3
Homemaker	52	5	9
Personal care	881	89	49
Round-the-Clock	**63**	**6**	**21**
Group living (assisted living)	3	0	4
Residential, unspecified	61	6	13
Coordination and Management	**207**	**21**	**73**
Housing supports	93	9	5
Transition	100	10	50
Case management	51	5	52
Day Services	**66**	**7**	**12**
Adult day health	20	2	6
Day habilitation	46	5	7
Nursing	**5**	**1**	**20**
Meals	**326**	**33**	**12**
Home delivered	326	33	11
Caregiver Support	**333**	**34**	**5**
Equipment, Technology, and Modifications	**667**	**67**	**57**
Equipment/supplies	273	28	41
Modifications	265	27	13
Personal systems	463	47	24
Mental and Behavioral	**21**	**2**	**12**
Behavioral health	21	2	12
Other Health and Therapeutic	**46**	**5**	**17**
Dental services	28	3	1
Nutrition	26	3	1
Occupational/physical/speech therapy	34	3	6
Other	**42**	**4**	**17**

Sources: Mathematica analysis of MFP services files and program participation data files for Tennessee for 990 of the 1,080 individuals who transitioned by the end of 2014. We excluded 90 individuals who recently transitioned for whom claims are not yet available. Includes both FFS and capitated services use and expenditures. For the national data, Mathematica included MFP services files and program participation data files submitted by 30 grantee states for 19,877 MFP participants transitioning by the end of 2012. Expenditures include qualified, demonstration, and supplemental services, but exclude all managed care expenditures. Texas was excluded because a high proportion of MFP participants were believed to receive HCBS through managed care. Thus, their claims information is not equivalent to that for participants in FFS systems. Idaho, Massachusetts, Maine, Nevada, Rhode Island, South Carolina, Tennessee, Vermont, and Wisconsin were excluded from the 2012 nationwide analysis because they lacked the data needed for analysis.

[a] Service subcategories are not mutually exclusive. Categories of services reported at the national level also include subcategories of services not used in Tennessee. For these reasons, the number and percentage of users in each subcategory may not equal the total for the category overall.

FFS = fee for service; HCBS = home and community-based services.

APPENDIX C – SUMMARY OF RATE-SETTING APPROACHES USED IN THE SEVEN STUDY STATES

State and program	Summary of MLTSS capitation payment method[a]	Transition incentive payments	Penalties or sanctions for re-institutionalization
Blended HCBS and NF rates			
Hawaii QUEST Integration (QI)	Blended rate paid to each plan, comprising the weighted average of medical and LTSS costs based on the island of residence, gender, and age.	None	None
Tennessee TennCare CHOICES	Blended rate comprising the weighted average of medical and LTSS costs, adjusted by target change in ratio of HCBS to institutional care use.	$1,000 for each transition up to the annual MFP goal; $2,000 for each transition over the goal; $5,000 each time a member is transitioned and remains in the community for 365 days.	$1,500 each quarter if > 10% of members discharged from a psychiatric inpatient or residential facility are readmitted within 7 days and/or > 15% are readmitted within 30 days.
Wisconsin Family Care	For members at NF LOC, regression model adjusts for functional status and service need for three target groups.	$1,000 for each transition; payment defers administrative costs for MFP enrollees.	None
Modified blended HCBS and NF rates			
Massachusetts Senior Care Options (SCO)	Weighted average of medical and LTSS costs; separate rate cells for enrollees in NF and community settings. Plans paid at lower community rate for first three months of an NF admission.	Plans paid at higher nursing home rate for first three months in the community when members with a nursing home admission of at least three months return to the community.	None
Minnesota Senior Health Options (MSHO)/Senior Care Plus (MSC+), Special Needs Basic Care (SNBC)	Separate rate cells for enrollees in NF, community settings, and (if applicable) the HCBS Elderly waiver. Add-on payments are made to MCOs while members are in the community but cease when they enter an NF and stay for 30+ days. MCOs remain responsible for 180 days of NF care in MSHO/MSC+ and 100 days of NF care in SNBC.	If enrollee is in FFS at the time of transition, the provider is eligible for flat fees for developing a transition plan and completing the transition. No additional incentive paid to MCOs.	None
Separate rate cells for NF and HCBS users			
New Jersey Managed Long Term Services and Supports (MLTSS)	Separate rate cells for enrollees in NF, special care NF (vents and pediatrics), and community settings for duals and non-duals.	None	None
Texas STAR+PLUS	Separate rate cells for enrollees in NFs and community settings.	None; incentive payments under consideration for 2017.[b]	None; penalties under consideration for 2017.[b]

Sources: Information for Hawaii, Massachusetts, Tennessee, and Wisconsin is from Lipson and Valenzano (2013); interviews with state personnel provided the information for Minnesota, New Jersey, and Texas.

[a] Texas Senate Bill 7 of 2013, Section 5.10 enables the state to "pursue and, if appropriate, implement premium rate-setting strategies that encourage provider payment reform and more efficient service delivery and provider practices."

HCBS = home and community-based services; LOC = level of care; LTSS = long-term supports and services; MCO = managed care organization; and NF = nursing facility.

APPENDIX D – MLTSS QUALITY AND PERFORMANCE MEASURES RELATED TO MFP GOALS

Domain\Measure topic	Hawaii QUEST Integration (QI)	Massachusetts Senior Care Options (SCO)	Minnesota Senior Health Options (MSHO)/ Senior Care Plus (MSC+), Special Needs Basic Care (SNBC)	New Jersey Managed Long Term Services and Supports (MLTSS)	Tennessee TennCare CHOICES	Texas STAR+PLUS	Wisconsin Family Care	Financial Alignment Demonstration Core Measure
Transitions between institutions and the community								
Transitions from a qualified institution to the community, by residence type and target population[a]	✓	✓ (by NF LOC)	✓	✓	✓	✓		
Transitions from the community to an institution for a short-term stay (number of days)		✓ (< 30, 30–90 days)	✓	✓ (≤ 180 days)	✓ (90 days)			
Potential candidates for transitions from a nursing facility			✓		✓			
Care transition record transmitted to health care professional			✓					✓
Care transitions are managed, problems identified, and unplanned transitions prevented, when possible			✓					✓
Quality of preparation for care transitions (self-report)			✓					✓ (U of CO, CTM-3)
Re-institutionalizations								
Transitions from an institution to the community that result in a return to the institution (within a specific number of days)[a]	✓ (30 days)	✓ (60 days)	✓	✓ (90 days)	✓ (90 days)	✓		
Person-centered planning and care								
Receipt of options counseling			✓	✓			✓	
Offer of choice between institutional and HCBS	✓		✓	✓	✓		✓	
Development of care plan	✓		✓	✓	✓		✓	✓
Review of care plans, annually	✓		✓	✓	✓		✓	
Alignment of services and supports with assessed need	✓		✓	✓	✓		✓	✓ (receipt of functional assessment)
Face-to-face service coordination encounters or visits	✓		✓		✓	✓	✓	
Quality of life	✓ (CAHPS and MFP QoL)		✓ (CAHPS and HOS)	✓ (CAHPS nursing home long-stay resident survey)		✓ (CAHPS nursing home long-stay resident survey)	✓	✓ (CAHPS, ECHO, and supplemental questions)

Domain\Measure topic	Hawaii QUEST Integration (QI)	Massachusetts Senior Care Options (SCO)	Minnesota Senior Health Options (MSHO)/ Senior Care Plus (MSC+), Special Needs Basic Care (SNBC)	New Jersey Managed Long Term Services and Supports (MLTSS)	Tennessee TennCare CHOICES	Texas STAR+PLUS	Wisconsin Family Care	Financial Alignment Demonstration Core Measure
Critical incidents and receipt of care								
Timely reporting of critical incidents	✓			✓ (in writing w/in 48 hrs)	✓		✓	
Critical incidents, by incident type, setting, and/or provider[a]	✓	✓ (death only)		✓	✓		✓	
Timeliness of personal care, attendant care, and home-delivered meals, and reasons for late visits					✓		✓	
Housing								
Wait time to transition to housing					✓			
Barriers to obtaining housing					✓			
Monthly income devoted to housing					✓			
Housing options chosen upon transitioning from an institution					✓			

Source: Mathematica review of state MCO contracts. Links to publicly available contracts for all states except Hawaii can be found in the References section of this report.

Notes: CAHPS = Consumer Assessment of Healthcare Providers and Systems; ECHO = Experience of Care and Health Outcomes for Behavioral Health; HOS = Medicare Health Outcome Survey; NF LOS = nursing facility level of care; QoL = quality of life survey.

[a] MFP-required measure.