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Initial Stakeholder Feedback on Implementation of the Managed Care Expansion in Long-Term Services and Supports

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Executive Summary

Background

In July 2014, New Jersey brought four §1915(c) home and community based services (HCBS) waivers into managed care with its new comprehensive §1115 waiver. About half the states in the US are bringing long-term services and supports (LTSS) into managed care, mostly in the past few years. New Jersey's Medicaid managed long-term services and supports (MLTSS) program is open to people who have nursing facility level of care needs (needing assistance with at least three activities of daily living, or ADLs) and qualify financially for Medicaid. The Community Care Waiver, a §1915(c) waiver for people with developmental disabilities, remains outside MLTSS in New Jersey. Spend-down for MLTSS is allowed through a qualified income trust system¹ for people who are technically above the Medicaid income limit but whose expenditures for LTSS bring their income below the limit. All HCBS services, new nursing facility entrants or those who are changing to a level of nursing facility care are included in MLTSS. Nursing facility residents in place prior to July, 2014 remain in a fee-for-service arrangement indefinitely; those in special care nursing facilities remain fee-for-service until July of 2016. Nursing facilities have an any willing provider arrangement until July of 2016 (i.e., MCOs must accept all nursing facilities who want to participate in their networks). All other providers are subject to MCO approval, though a network adequacy requirement of at least two providers per county is mandated by the state.

As of March, 2015, the state reported that nearly 33 percent of the Medicaid long-term care population was in HCBS, up from about 29 percent in July of 2014. The nursing facility population decreased by over 1,500 individuals between June 2014 and March of 2015.²

Study and Methods

Rutgers Center for State Health Policy is evaluating New Jersey's comprehensive §1115 waiver. This report discusses initial stakeholder feedback on implementation of the managed care expansion into LTSS. We held 16 telephone interviews with 34 key informants between February

and June of 2015. Interviewees included state staff involved in MLTSS implementation, managed care organizations (MCOs) participating in MLTSS, as well as LTSS providers and provider associations, advocacy groups for consumers enrolled in MLTSS programs, and other organizations that work with MLTSS enrollees (e.g., county welfare agencies, who assess and recalculate financial eligibility). Some but not all interviewees were members of the MLTSS Steering Committee, which informed the development of MLTSS. Interviews frequently included multiple staff members from organizations involved with MLTSS, as well as individual providers together with provider associations. The authors have also attended numerous meetings with state staff and other stakeholders which provided useful background information for this report.

Findings

Our analysis of interview discussions revealed a number of general themes that were discussed in multiple interviews and generally by more than one type of stakeholder. We also include some more limited findings that weren't as widely expressed but still seemed important in terms of their impact on consumers or the system of care delivery.

Theme 1: The state has a continuous improvement philosophy, including a multifaceted stakeholder communication process. Most stakeholders felt the state had listened to them, though not all were satisfied with the way the state incorporated their feedback. Disparities among stakeholders combined with resource constraints for the state make it challenging to design processes in which all voices can be heard, as some stakeholders are greater in number or have more resources than others.

Theme 2: Many stakeholders felt that the staged rollout of MLTSS was a best practice. (Staged refers to the transfer of the state plan services of adult day and personal care assistant (PCA) services to managed care in 2011, case management for most new waiver clients handled by the MCOs beginning in February 2014, the grandfathering of fee-for-service nursing home residents, and the initial any willing provider arrangement for nursing facilities.)

Theme 3: MLTSS represents a shift in philosophy of services, toward a model that is both more integrated across different types of care and more rationalized with respect to allocating services and controlling costs. Due to such shifts, organizations have taken on new roles, which creates learning demands for their staff and new processes that require evaluation and possible adjustment. Consumers, while in some cases benefiting from more integrated services, have to adjust to new care team members and may experience a decrease in services in some cases.

Theme 4: Despite strong continuity of care provisions, consumers and providers faced uncertainty and anxiety with implementation. MCOs were required to continue the services

previously in place until the care manager created a new plan of care with which consumers agreed or appealed. However, some consumers faced uncertainty with the wait for the initial MCO care manager to visit and a smaller number faced anxiety waiting for a follow up assessment by the state Office of Community Choice Options if it looked as though they were not clinically eligible for MLTSS. Providers in some cases experienced payment delays.

Theme 5: It is too early to gauge the effects of MLTSS on the health of consumers or the provider community. Quality metrics are taking more time to release than anticipated, and the time from initial Medicaid application to services received appears not to be measured.

Theme 6: There have been anecdotal reports of reductions in hours of service and eligibility, but there do not appear to be sufficient data to determine whether this is a general trend.

Theme 7: The MLTSS population has very vulnerable members who may be very isolated socially and have difficulty communicating problems with their care.

Theme 8: There has been a large increase in self-directed services contemporaneous with the transition to MLTSS.

Theme 9: Providers have experienced an increase in administrative burden to become credentialed and contracted, obtain authorization for services, file claims, and in the amount of time to receive payment under MLTSS.

Theme 10: Providers feel uncertain about what their future looks like with MLTSS.

Theme 11: Some stakeholders see potential for increased coordination of services from integration of acute, long-term and behavioral services under MLTSS.

Theme 12: Some stakeholders see potential for managed care to bring increased quality oversight to MLTSS.

Theme 13: Stakeholders expressed concern over the state's capacity to oversee and monitor MLTSS.

Specific Findings:

1. County welfare agency staff in one county described a loss of communication with consumers' case managers with the move to MLTSS. Previously they had worked through

case managers to communicate with clients who had residence changes to ensure continued eligibility.

2. Referral options are needed for consumers who must establish a qualified income trust in order to access services. Consumers who are close to the income limits may not have the resources to hire a lawyer to draft the trust or a person to administer the trust.
3. Some see a need to develop options for companionship for consumers. Staff at one of the managed care organizations reported investigating how to get volunteers to provide companionship for members for things like just talking, playing cards together, etc., to enhance their benefit package. Prior to the rationalization of services that has occurred under MLTSS, some consumers may have received some time like this from a home care aide.

Conclusions and Next Steps

Though early indications in terms of numbers served in HCBS since MLTSS began seem promising, most stakeholders thought it was too soon to know the impact of MLTSS on consumers or even on providers. There have been definite short term adjustments for all stakeholders. There are anecdotal reports of service reductions due to the rationalization of processes with MLTSS, but it is not clear how widespread these are. Quality measures are still mostly forthcoming due to a need to wait for claims periods to expire and to ensure harmonization of data across MCOs. Some items appear not to be measured or planned, such as the time from application to services received (or reimbursed, if institutions take consumers who are in the application process), and any reductions in services with MLTSS.

The state has a philosophy of continuous improvement and a multifaceted stakeholder communication process, but it is challenging to design processes that take into account the disparities among stakeholders (e.g., the preponderance of older adults on MLTSS and the greater resources of some provider organizations). Many felt that the fact that some providers were allowed additional time to adjust to MLTSS (e.g., the grandfathering of existing fee-for-service nursing facility residents and the initial any willing provider arrangement for nursing facilities) was a best practice, and one MCO stakeholder commented that, though the MCOs were initially unhappy about the loss of members with the fee-for-service carve-out, it was probably better for all involved to have a gradual adjustment. Consumers and providers who were not allowed the opportunity to remain in a fee-for-service arrangement generally wish they had been allowed the opportunity. All providers feel uncertain about what the future will bring for their ability to provide care.

Many stakeholders feel that there is a potential for managed care to provide better integration of acute, behavioral and long-term services and supports and also a potential for improved

quality oversight of these services. However, there is also concern, as there is nationally, about the capacity of state government to oversee MLTSS. New Jersey has faced challenging budget conditions and a hiring freeze, which meant that new employees needed to manage the oversight process had to be hired on a temporary basis. The state has a strong communications infrastructure with organized stakeholders and by all accounts is responsive to issues raised by providers and consumer advocates. However, given the vulnerability of many consumers on MLTSS, there is concern about consumers who may be disconnected from resources and unable to communicate problems with their care. There are also stakeholders desiring opportunities for more in-depth discussions about systemic issues with the state and other stakeholders.

Our final stakeholder report is due to the state on June 1, 2017. Between now and then, we will be taking feedback on this initial report, continuing our meetings with state staff and other observations of MLTSS processes, and having additional conversations with stakeholders, with a mix of both people we have spoken with previously and new contacts. If you would like to provide input for our final report, please contact the primary author at jfarnham@ifh.rutgers.edu or 848-932-4675.

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Introduction

Background

In July 2014, New Jersey brought four §1915(c) home and community based services (HCBS) waivers into managed care with its comprehensive §1115 waiver. Many states are bringing long-term services and supports (LTSS) into the range of services managed by managed care organizations (MCOs). Services organized in this way are often referred to as managed long-term services and supports, or MLTSS. MLTSS involves capitated payments (i.e., a standardized payment per enrollee) to the MCO for long-term services and supports. Enrollees may be separated into different categories based on clinical need (often called acuity), with different payment amounts for different categories. Long-term services and supports (LTSS) refers to assistance with activities of daily living (ADLs), such as bathing, eating, dressing, and using the toilet and instrumental activities of daily living (IADLs), such as shopping, preparing meals and managing medications. Collectively, ADLs and IADLs represent those activities that are generally necessary for independent living. LTSS may be delivered in an institutional setting, such as a nursing facility, or in a community setting, such as a private home. MCOs are required to offer a standard package of services to enrollees and meet other requirements, such as having an adequate network of providers, but each MCO may contract with a different group of providers, so the LTSS experience of enrollees may differ across MCOs.

Purpose of this Report

This report will discuss the initial stakeholder feedback on the implementation of the managed care expansion into LTSS. Some discussion of operational details and programmatic changes that have occurred is included to give context to the findings, along with material on the national picture in MLTSS. The goal of the report is to show readers what the implementation has looked like from different stakeholder perspectives, discussing where perspectives are similar and where they may diverge. To the extent that judgments are made about competing perspectives, our highest priority interest is the health and quality of life of consumers enrolled in MLTSS, and the

population health among people in New Jersey who are or may become eligible for MLTSS, whether enrolled or not.

Target readers include stakeholders in New Jersey, CMS staff, and stakeholders in other states who are implementing, managing, or considering MLTSS programs.

It was apparent to us in attending meetings and conducting interviews that all of the stakeholders we encountered were very committed to fostering positive relationships with other stakeholders and working constructively together to implement and to improve MLTSS as it moves forward. It is our hope that this report will fit into this framework of constructive relationships.

New Jersey and the National Picture

As of late 2014, about 24 states are implementing MLTSS in some way.³ Most Medicaid MLTSS waivers have been approved in the past few years. Though the first waiver including MLTSS was approved in 1989, the next did not appear until 1998. Eleven MLTSS waiver approvals occurred in or after 2012. Nearly all the waivers include older adults and younger people with physical disabilities (as New Jersey's program does), but only five include people with intellectual or developmental disabilities. New Jersey's waiver designed for people with intellectual and developmental disabilities⁴ remains outside MLTSS. Most waivers are statewide and require enrollment in managed care, as New Jersey's program does. All waivers include home and community based services (HCBS). A small number of states do not include behavioral health or acute/primary care. New Jersey's waiver includes these services. Four states do not have full inclusion of institutional care benefits. New Jersey includes institutional care benefits for new enrollees or those who have changed levels of care, but New Jersey consumers who were in a nursing facility at the time of MLTSS implementation remain fee-for-service unless they change facility or level of care.

National research has raised concerns about the limited experience of MCOs in managing LTSS, the administrative capacity of LTSS providers to operate within a managed care system, and state capacity in terms of the number and expertise of personnel to oversee MLTSS.⁵ The Kaiser Commission on Medicaid and the Uninsured, Department of Health and Human Services Office of Disability, Aging and Long-Term Care Policy and CMS have issued suggestions and resource information regarding design, implementation and quality measurement of MLTSS programs.⁶

MLTSS in New Jersey

MLTSS in New Jersey is provided through a comprehensive §1115 waiver that combined several §1915(c) waivers serving people who have care needs at an institutional level along with new entrants to nursing facilities. Residents of nursing facilities at the time of MLTSS implementation

remain in a fee-for-service arrangement unless they have a change in the status of their level of care. The largest historical §1915(c) waiver, Global Options (GO), had served older adults and transitioned 10,949 consumers into MLTSS. Three smaller waivers included or targeted younger individuals. The Traumatic Brain Injury (TBI) waiver included people diagnosed with acquired brain injury after age 21 but before age 65, and transitioned 309 consumers into MLTSS. Community Resources for People with Disabilities (CRPD) served individuals of any age, including children, and transitioned 292 consumers into MLTSS. The AIDS Community Care Alternatives Program (ACCAP) waiver served individuals of any age with AIDS and children under the age of 13 who were HIV positive, and transitioned 154 consumers into MLTSS.

Table 1: Former Waiver Members Transitioned to MLTSS

Former Waiver	Number Transitioned to MLTSS	Percent
GO (older adults)	10,949	93.5%
TBI	309	2.6%
CRPD	292	2.5%
ACCAP	154	1.3%
<i>Total</i>	11,704	100%

Source: NJ Department of Human Services, Quality Committee, March 2015

As of March, 2015, the state reported that nearly 33 percent of the Medicaid long-term care population was in HCBS, up from about 29 percent in July of 2014. The nursing facility population decreased by over 1,500 individuals between June 2014 and March of 2015.⁷

Caveats with Our Analysis

1. Area Agency on Aging (AAA) viewpoint not adequately represented in this initial report. Due to the retirement of the Steering Committee AAA representative, we had a delay in contacting the AAAs to solicit their response and were not able to have a full interview with anyone in time for this report. AAAs are a key stakeholder with MLTSS and we plan to hold direct interviews with them for the final report. We know that they have provided important feedback to the state and that the state meets with them regularly.
2. Respondents may have characterized some effects as due to MLTSS that may not be affecting MLTSS enrollees directly. We realized in conducting our analysis that home care agencies or adult day providers aren't necessarily distinguishing between MLTSS clients receiving their services and state plan clients. For instance, it may be that some of the wait times experienced for MCO assessment were for clients coming on to state plan services, because MCO nurses were busy doing MLTSS reassessments.

Methods

The primary method of collecting information regarding stakeholder feedback was through key informant interviews. However, the evaluation team also meets regularly with state staff implementing MLTSS, attends a variety of meetings with stakeholders to gather background information, and monitors news and social media for relevant items.

Interview Subject Recruitment

The research protocol was approved by the Institutional Review Board at Rutgers. Sixteen telephone interviews with 34 key informants were conducted from February 2015 through June 2015. Interviewees included state staff involved in MLTSS implementation, managed care organizations participating in MLTSS, as well as a variety of stakeholders. Stakeholders included advocacy groups for older adults and younger people with physical disabilities, providers of LTSS and their provider associations, agencies or associations of agencies that work with MLTSS enrollees in a variety of contexts (e.g., county welfare agencies). Some interviewees are members of the MLTSS Steering Committee and should therefore be knowledgeable about the intent of the program (i.e., what is supposed to be happening) in addition to on-the-ground program details (i.e., what is happening). However, we also included informants not represented on the Steering Committee. In many cases interviews included multiple staff members from organizations affected by MLTSS, providers along with provider associations, and so on. To protect the confidentiality of our interviewees, we are not listing the names or specific organizations of those with whom we spoke.

Question Development

Questions were developed to address the research questions detailed in the Waiver Special Terms and Conditions⁸ regarding the impact of MLTSS on access to care and the quality of care received, the impact of procedural changes in the eligibility process and the perceptions of stakeholders regarding the program. Informing the questions was knowledge gained by CSHP researchers through observation and/or participation in various meetings, conference calls, and review of various reports and news articles regarding MLTSS. In addition, the research team consulted with two national experts with knowledge of New Jersey's LTSS system regarding the kinds of informants and questions that should be pursued. As the interviews progressed, information from earlier interviews was used to create new questions or follow-up prompts for later interviews.

Questioning Strategy

All interviews were conducted by a senior research analyst with a background in long-term services and supports research and evaluation. The interviewer used a semi-structured list of

basic questions with detailed potential follow-up questions noted in advance and also created new follow-up questions at the time of the interview if appropriate (See Appendix A for the list of questions). Interviewees were given a handout containing the basic questions prior to the interview.

Documentation and Analysis

Interviews were audio-recorded if all participants were willing to allow recording. Where recording was not desired, notes were taken by more than one researcher. The interviewer created detailed summaries of the findings from each interview for other evaluation team members to review. The interviewer took the lead at identifying themes from the interviews, using an inductive process⁹ and coding interview notes to document the themes. The interviewer also documented and included in the report key findings that weren't necessarily common themes.

Findings

General Themes

General themes are common ideas expressed in more than one interview and by more than one type of stakeholder. We also include some more limited findings in the next section that weren't as widely expressed but still seemed important in terms of their impact on consumers or the system of care delivery.

Theme 1: The state has a continuous improvement philosophy, including a multifaceted stakeholder communication process. Most stakeholders felt the state had listened to them, though not all were satisfied with the way the state incorporated their feedback. Disparities among stakeholders combined with resource constraints for the state make it challenging to design processes in which all voices can be heard, as some stakeholders are greater in number or have more resources than others.¹⁰

Appreciation and compliments. Most stakeholders appreciated the extensive efforts the state has made in outreach and communication to affected stakeholders. We heard from people in a position to have witnessed MLTSS implementation in other states who were particularly complimentary of New Jersey's work in this area. The MCO staff with whom we spoke felt that the frequent conference calls they have with state staff are very helpful to them in serving their MLTSS members and providers.

Additional requests for communication, interaction and transparency. However, some advocates and providers felt there should be more ongoing in-person dialogue to work out lingering issues

or to discuss systemic issues and visions for future system improvements. We heard comments that while state staff are very responsive to calls and emails, there is a value to getting stakeholders together for in-person discussions. We also heard comments that Steering Committee meetings are more of a one-way exchange of information and updating from the state to stakeholders and not a forum for discussion, and that it does not contain many consumers or consumer advocates. Our observations as attendees of these meetings are that the state allows time for discussion at the end of each meeting and has an external facilitator to run the discussion, but attendees must bring up items.

In addition, a few providers and consumer advocates felt that hotline phone numbers, email addresses and forum advertisements were not well publicized enough, and that there were potential systemic barriers for consumers in accessing fair hearing appeals because of a fear that they may have to pay back program funds spent for their care if they lose the appeal or because they are afraid that the appeals process will be too taxing for them because they are too frail to appear in person. One advocate mentioned having seen administrative law judges travel to facilities to accommodate consumers who could not travel, but was not sure if they would be willing to go to a private home.

Finally, some stakeholders felt that the state should be more transparent in proactively sharing information relevant to MLTSS. One example mentioned was the MCO contract — consumer advocates recalled not getting a copy of the contract until November of 2014 and having some process concerns that were addressed by the state, but that could have been addressed earlier if the contract had been shared earlier. Another example mentioned was the PCA tool, which was piloted during the Fall of 2014 and implemented in January of 2015. It does not appear that copies of the tool are available on the internet, and advocates are concerned that consumers and advocates have no way of verifying whether hours of service are being calculated correctly. A final example mentioned was cost reconciliation information--advocates recall that under the previous waivers, consumers were provided a sheet that reconciled the costs of their services relative to cost guidelines. Now, there are apparently not such reconciliations, which makes it difficult for consumers and advocates to know whether MCOs are calculating items correctly.

Stakeholder diversity and disparities. It was apparent in our conversations with stakeholders that 1) some have more resources than others in terms of funding, staff and time to organize; 2) there are several waiver populations brought together in the comprehensive waiver, but one group dominates in terms of numbers; and 3) there are some areas of disagreement among stakeholders that can make it challenging for the state or others to gather information about programs or potential policy impacts.

As Table 1 shows, about 94 percent of people who transitioned were older adults using the GO waiver. Stakeholders working with people from the other waiver groups felt that these other populations, who tend to be younger with very high care needs, were sometimes getting lost in the shuffle.

After feedback in stakeholder forums about billing problems in Assisted Living, the state designed a survey to ask providers about their billing experiences. This kind of effort can be helpful in sorting through disparate reports. Most of our interviews were complete before we knew about the survey, so we did not ask interviewees about it, but it seems like a promising practice.

Continuous improvement philosophy. State staff strongly stressed the ongoing nature of their work with MLTSS. All of the staff with whom we spoke anticipated continued engagement with stakeholders and facilitation of processes as MLTSS moves along — they saw implementation as a continuing process upon which they seek to improve.

Examples of processes. The following are some examples of the state’s communications processes with respect to MLTSS.

- Steering Committee: Prior to the implementation of MLTSS, the state convened a Steering Committee including a wide variety of stakeholders to advise on the design and management of the program. The Steering Committee issued recommendations in June, 2012. The committee continued to meet prior to and following implementation of MLTSS in July of 2014.
- Monitoring phone numbers and email addresses. The state maintains a number of “hotlines” for consumers and providers to call or email with questions or concerns. These hotlines are closely monitored by state staff for relevant issues.
- Regularly scheduled meetings with key stakeholders.
 - *Conference calls with managed care organizations.* Calls occurred daily early on in implementation, then ramped down slowly to three times per week, then to once per week. As of May, 2015 the calls are still occurring once per week between key staff at each MCO and a variety of state staff. There is a separate call for each MCO to discuss their individual issues and an all-plan call to discuss common issues. The state asks the MCOs to report on a variety of issues (member and provider call topics, call waiting times, staff turnover, claims processing times, etc.) and also uses the calls for intensive troubleshooting of individual cases or systemic issues.
 - *Monthly meetings between the Division of Aging Services and Area Agencies on Aging.* The form of the meeting alternates between phone and in-person every other month. The purpose of the meetings is general communication but MLTSS issues can be discussed here.

- *Medical Assistance Advisory Council (MAAC).*¹¹ The MAAC, required by federal and state law, provides an official forum for regular communication between the Department of Human services and any interested stakeholder. Meetings are announced in advance with agenda posted on the internet; minutes and presentations are published later with the names and organizations of those in attendance, as well as a transcription of discussions. MLTSS has been a frequent agenda item both prior to and following implementation.
- In-person public forums. The state held three public forums in different regions (north, central and south) in October of 2014, a few months after implementation to present an overview of MLTSS and solicit input,¹² and officials anticipate holding more in the future.
- Outreach. State staff have done a variety of presentations for providers and advocacy groups around the state both prior to and after implementation.¹³
- Videos and documents on Web. The state has a variety of resources on the internet for consumers and providers. Resources include a variety of reference documents as well as videos of staff making presentations.¹⁴
- Assisted Living survey. After hearing reports of billing problems in Assisted Living, the state designed a survey to ask providers about their experiences and reported results to the Steering Committee.

Theme 2: Many stakeholders felt that the staged rollout of MLTSS was a best practice.

An interviewee from a managed care organization summarized this as follows:

“talking about best practices ... the way this was rolled out in NJ ... it was a phased rollout ... with the PCA and medical day benefit phased in in 2011. It gave managed care plans an opportunity to encounter a very similar member who was going to come over onto MLTSS and in many cases it was the same person, we were just covering different benefits. I think ... if we get to the point where we can say, okay, this was a success, I think we’d point to that as one of the main reasons why. ... When nursing home residents were by and large carved out of this ... managed care plans weren’t pleased because it was a big membership hit, but I think in hindsight it makes a lot of sense ... gives us a chance to get our foot in the water, managing nursing home residents and not 27,000 of them at once ... but 100 or 200 a month... It’s not so disruptive to the provider community, to the patients, and it puts us on the right path then to learn how best to manage these patients.”

Providers that were allowed to phase in were happy to have a gradual transition to MLTSS, though they still felt unsure what would happen once the any willing provider mandate expires. Providers that were not allowed to phase in generally wished that they had been. The impact on

these providers appeared to depend largely on what percent of their client base was paid by Medicaid. The transition appeared to be the most difficult for providers of any kind having a large share of clients paid by Medicaid. These providers were not accustomed to dealing with managed care claims systems and procedures or the longer time horizon for payments.

Theme 3: MLTSS represents a shift in philosophy of services, toward a model that is both more integrated across different types of care and more rationalized with respect to allocating services and controlling costs. Due to such shifts, organizations have taken on new roles, which creates learning demands for their staff and new processes that require evaluation and possible adjustment. Consumers, while in some cases benefiting from more integrated services, have to adjust to new care team members and may experience a decrease in services in some cases.

Working toward integrated services; challenged by the need for culture change. MCO staff with whom we spoke expressed great enthusiasm for the move of their organizations into LTSS, given the opportunities to more comprehensively address their members' health issues as they add LTSS and behavioral health services to the acute care services they were accustomed to and state plan LTSS services they have been managing since 2011. However, some stakeholders have reported bumps in the road as MCOs took over these functions. A quote from a state staff member that illustrates both the challenge and the promise of MLTSS for MCOs and others follows:

“one of the challenges that I think we are successfully continuing to navigate through is an overall culture change. Health plans were culturally excellent at managing health care — they could figure out doctor and pharmacy and all that ... with the Medicaid plan. It was and continues to be a learning curve as far as the culture of — you are not managing a series of benefits that have codes, digits, and amounts and scopes, you’re managing a person’s life, and you’re putting services in place that help that person’s life be a better one all the way through the spectrum of services that is MLTSS, be it an hour a week of home care all the way up to nursing home care. That culture shift, each plan has had its own aha moments, where they have come to the place where they get, ‘oh, we are managing not just services in a list that have codes.’... Not just organizational change but culture change, and it was a culture change for us here at Medicaid too where we’re navigating the combination of ‘hey, you’re managing a whole person’s life now, you’re dealing with behavioral health, acute care, long-term care, and ... on occasion those things that a person might need that don’t fit into those three boxes’ ... The triage calls, I think that’s sort of the cornerstone ... allow us to gauge that culture shift. Where are plans, how are you getting to the point where you understand a member is a member, it’s a person that you’re dealing with, they’ve got needs, yes, they have services that you have to authorize, there are

claims that have to get paid, but at the end, it's a person whose quality of life you now have in your hands and you have to navigate that."

Determinations of eligibility: Delays due to a more comprehensive reassessment process. MCOs had to reassess all former waiver members as they entered MLTSS. They had 90 days to reassess high-risk members and 180 days to reassess all members. Their reassessments of LTSS eligibility are overseen by the state's Office of Community Choice Options (OCCO),¹⁵ part of the Division of Aging Services that oversees preadmission screening for those entering LTSS. Both the MCOs and OCCO use a standardized tool, NJ Choice, which is a customized version of an interRAI instrument.¹⁶ MCO staff enter information into the NJ Choice tool and upload the information to OCCO so that OCCO can make the ultimate decision as to eligibility.

This was a change from past waiver practice, where reassessments were less comprehensive and in some cases were done by staff in the same agency that provided one or more services to the member, which potentially created incentives to continue to find members eligible even if their condition had improved. Because of this change in practice, even MCO staff who had managed waiver clients in the past had to learn a new process (though some MCO staff came from OCCO and had assessment experience). The state prepared for the change by training MCOs six months before the July transition date, including hands-on experience with assessment for medical day care (not the same as nursing facility eligibility, but with similar concepts), where they looked at coding consistency across staff. However, the state was surprised by the number of assessments coming to OCCO where there either wasn't enough information for OCCO to determine eligibility, or where clients appeared ineligible for MLTSS services based on the information entered into the tool, necessitating a face-to-face visit by OCCO staff to make a final determination (this occurred with about 23 percent, or around 3,400 out of about 15,000 assessments, for both existing and new clients, based on information shared in the May Steering Committee meeting). The state found that in about 90 percent of these cases OCCO ultimately judged the client eligible for MLTSS.¹⁷ The volume of assessments needing a second evaluation by OCCO led to some shortage of staff in OCCO to handle the unexpected workload, which led to delays in the reassessment process. OCCO hired additional staff¹⁸ and also undertook an audit of cases where information entered by the MCOs had made members appear ineligible but OCCO later found them eligible in order to identify the differences between MCO staff and OCCO staff. They used this information from the audit to create additional training and mentoring for MCO staff.

Determination of covered services and hours of service. After determining eligibility, MCO case managers work with the member to create a plan of care, including MLTSS services. Some of these services, such as personal care assistance (PCA) and private duty nursing (PDN), may involve specific numbers of hours depending on the members' needs. The vast majority of

comments we heard about services concerned hours of service for either personal care assistance or private duty nursing. There isn't a national or international standardized, evidence-based instrument to create a service plan or calculate numbers of hours needed to serve members' needs.

PCA Tool. With respect to hours for personal care assistance, the state created (with input from stakeholders) a standard tool that clarifies the tasks that are covered and sets expectations for how far coverage should go (for instance, it clarifies that assistance with dressing generally takes place twice per day, from sleepwear to daywear and from daywear to sleepwear).¹⁹ The PCA tool was implemented in early 2015 and state staff report decreasing complaints about hours since then. Consumer advocates and providers had not seen the tool when we spoke with them, but were generally hopeful that it could help resolve different expectations about hours required. However, we did hear the objection that the tool takes unpaid caregiving as fixed and external in the calculations, rather than as needs that are documented with the tool and then filled by a combination of paid and unpaid caregivers. This means that the tool would need to be redone if the hours provided by unpaid caregivers change, instead of just allocating the hours differently.²⁰

Prior to the new PCA tool, we heard reports of other tools in existence to calculate hours of service, including one based on earlier regulations and developed with input from at least one stakeholder in the home care provider community that topped out at 25 hours per week. Some felt that cuts in hours may have been due to plans using this or other tools that restricted hours.

In addition, some felt that MCOs at times had a policy of a blanket denial for coverage of nonmedical services. We heard from both an advocate and a provider who had experienced MCO denials of LTSS services due to what the MCO termed "lack of medical necessity" when the services aren't medical in nature, but are supportive services provided under MLTSS when consumers do not have family or friends to provide the services. One provider reported widespread cuts for their clients:

"the worse thing, I think, has been the hours that the clients receive have been cut drastically — in most cases, in half ... clients no longer get hours for supports such as laundry and cooking and food shopping, and most of the clients live alone and they have no one to help them do these things ... unless it's for medical care, for bathing, they're not providing hours ... that is their reasoning for cutting all the hours ... it's not medically necessary."

This is troubling given state data on MLTSS clients showing that nearly 90 percent require help with housework and meals, and that 35 percent live alone.²¹ The provider reported that they got little notice of the cuts, which was difficult for both the client and the aide. Clients were reluctant

to ask for a fair hearing because of a fear of having to go to court, and in some cases had negative outcomes such as falls and hospital visits after the cut in hours. Falls resulting in the need for medical treatment and medical emergencies would constitute critical incidents that the MCO is required to report promptly to the state:

“we had a client getting 35 hours, we received a new authorization via fax saying ... as of ... usually it was the day we received it, you’ll be receiving 15 hours now, so we have to call the client and tell them ... the MCO says we sent a letter to the client first so they should already know ... I don’t know if they read their mail or not, but we’re the bad guys telling them, now it’s 15 hours, and they’re blaming us ... they’re like, well, what am I supposed to do? I can’t do this, I can’t do that, I can’t do that and also, we have to tell the aides, you were working 35 hours, now you’re only going to be working 15 and it’s like that day, there’s no warning ... and there’s nothing we can do. We’ve tried the appeal process, and it’s always denied the first two times ... The third appeal would be for the client to go to court and they don’t want to do that because they’re terrified of court, and they can’t even leave their homes anyway, so they always decline, so it stays at 15, or it stays at whatever hours ... we see that there are a lot more falls, more hospitalizations. They are very anxious. We have one client who has been to the hospital like 5 times with high blood pressure, anxiety. I think they’re just anxious, nervous and scared so we’ve noticed ... more people going to the hospital ... they’re only there for a day, and then they come home.”

Private duty nursing. With respect to hours for private duty nursing, there isn’t a standardized tool, which some stakeholders saw as a problem. The costs involved with members requiring high amounts of private duty nursing were probably the primary driver of a new state exceptions policy for members who had expenditure levels that were higher than cost caps in order to stay safely in community settings.

Differing philosophies or priorities regarding LTSS. It appears to us that there have been different ways of conceptualizing LTSS in terms of what services should be paid for by Medicaid and for how many hours, both before and after the transition to MLTSS. Prior to the transition, the case manager and contracted waiver agencies were the key gatekeepers of services, with minimal oversight by the state. Some stakeholders felt that case managers in neutral organizations that didn’t provide services were a better choice than MCO case managers, who have an incentive to reduce costs. Several stakeholders believed that the services and number of hours consumers got prior to MLTSS was largely a function of the particular case manager or the organization they worked for (there were over 100 waiver agencies), with some being very generous and some being fairly strict. Case managers are still the main gatekeeper regarding services, but their organizational context is much more standardized now with five MCOs and the presence of more standard tools to determine eligibility and hours of service. However, there are still some

examples that illustrate the effects on consumers of having different philosophies or priorities influencing their interactions with the MLTSS system.

- 1) *Priorities with home delivered meals: Nutrition, convenience, social interaction and monitoring, cost effectiveness?* One item that has been a topic of discussion between the state, MCOs and other stakeholders is the question of home-delivered meals for members. MCOs have mostly moved to a model of bulk prepackaged meal delivery for members needing this service instead of home-delivered hot meals that would come on a daily basis. The MCOs feel that the prepackaged meals provide higher quality foods for members at a lower cost. Some of the other stakeholders feel that the daily home-delivered hot meals were more convenient for members and provided important functions of social contact for members who may be lonely and also a potential early warning system in cases where a member has a decline in health or functional status. There were reports early in the transition period that in some cases bulk meals were delivered to people who were not able to manage them with respect to lifting, storing, or preparing the meals. This last problem of basic access to nutrition seems to be under control, but the larger philosophical difference remains a topic of discussion.

- 2) *Calculating patient pay liability: Client relationships, responsiveness, and workload issues.* Under MLTSS, county welfare agencies have taken on the responsibility of calculating the patient pay liability for MLTSS recipients.²² Prior to MLTSS, waiver case managers had this responsibility. These case managers saw the consumer regularly, whereas the county welfare agencies generally encountered clients only once per year or so, unless the client had large changes in financial status to report. This has been an adjustment for both the CWAs and consumers, as illustrated by the quotes below. For the CWAs, this new responsibility represents additional work and some stress at feeling that they are not supported by the state²³ or county governments²⁴ in doing that work in a way that best serves consumers and their families. For consumers, in some cases, the CWAs may be more strict about requiring documentation than the waiver case managers were, and may be resistant to recalculating the liability amount as frequently as the consumer may want.

“a case manager has a different relationship with the clients than we do — we’re eligibility workers, you know, not that we don’t have a soft side, we do, but it’s like [pounds surface 3 times for emphasis] paperwork, paperwork, paperwork for us, you know, so I think it was a bit of an adjustment for the client to deal with us ... maybe the case managers weren’t as strict.”

"[name] was on the phone for PR2 correction for 16 minutes. I mean, I went to the bathroom, come back she is still on the phone with the same client yelling at her."

"Client or family will say 'before we didn't need to get the prescription from the doctor, we just need the bill' — I say no, we need both of them to give you the deduction."

[state] "said ... tell the family you're going to do it every 6 months. Well, they don't want to hear that. They're laying out money... some of these families can't wait 6 months for their money."²⁵

"we have to calm them down ... we cannot say well no, wait for next year."

- 3) *Formal or specific credentials versus accessibility.* Under GO, home based supportive services could be provided by uncertified home care agencies. Under MLTSS, home care agencies must be certified. Stakeholders noted the change to us but didn't comment on the meaning. We did not seek out specific agency views on this.²⁶ Certification may ensure greater quality but also involves higher costs for the agency, raising the barriers to entry. In addition, there was a perception by some that the switch to MLTSS involved an elevation in the role of nurses as opposed to social workers in the assessment and case management roles, and that this represented a narrowing of perspectives. One MCO reported replacing social worker case managers with nurses because their perception was that assessments (NJ Choice,²⁷ for eligibility and the PCA tool,²⁸ for PCA hours) had to be done by nurses, and it was disruptive for clients to have an assessor that was not a case manager.

Theme 4: Despite strong continuity of care provisions, consumers and providers faced uncertainty and anxiety with implementation. MCOs were required to continue the services previously in place until the care manager created a new plan of care with which consumers agreed or appealed. However, some consumers faced uncertainty with the wait for the MCO care manager to visit and a smaller number faced anxiety waiting for a follow up assessment by the state Office of Community Choice Options if it looked as though they were not eligible for MLTSS. Providers in some cases experienced payment delays.

MCOs were required to continue each consumer's package of services that were previously in place, including signing single case agreements if existing providers were not contracted with them, until their case manager had visited and assessed the consumer and developed a new plan of care, which consumers had a right to appeal.

From the consumer's perspective, they knew that they were transitioned to managed care effective July 1. However, they did not necessarily know who their case manager was and the MCOs had six months to reassess all members (90 days for high-risk members). So, this led to a period of uncertainty for consumers as they waited to be visited by their new case manager and see what this new system would be like — a system that provides vital services allowing them to live independently or, in some cases, provides a community residential option.

Once the case manager visited the consumer, they went through a detailed clinical assessment process. As mentioned earlier, the change with MLTSS from an abbreviated reassessment to a full reassessment meant that some people who had been found clinically eligible with an abbreviated tool were now found ineligible. There were about 3,400 consumers who, based on the MCO's initial report to OCCO, either looked ineligible or required more information to establish eligibility. About 90 percent of them were ultimately judged eligible, but there were sometimes long waits for an OCCO reassessment and a great deal of anxiety for consumers and their caregivers with these waits because their ability to stay in their home was hanging in the balance.

So, while the state had strong continuity of care provisions for MCOs, the transition was stressful for some consumers.

In addition, while the MCOs were not allowed to cancel services, according to some providers, they were not paid promptly. In all cases we heard about, providers opted to continue services while waiting for payment, but this was a financial stressor for them. In some cases where providers were dependent on Medicaid funds, the state worked with MCOs to provide interim funding while claims were straightened out.

Theme 5: It is too early to gauge the effects of MLTSS on the health of consumers or the provider community. Quality metrics are taking more time to release than anticipated, and the time from initial Medicaid application to services received appears not to be measured.

Delay in metrics. All stakeholders with whom we spoke agreed that quality metrics were important. The state began the program with an initial planned series of quality metrics.²⁹ After the initial quarterly reporting period, they realized that there were differences in the way MCOs were calculating measures in some cases and the MCOs raised concerns about some of the measures. So, the state began a series of meetings to clarify the measures. There is a long lag time for many measures because claims can be filed up to 180 days after services are rendered. In addition, many measures are calculated based on detailed annual audits by IPRO, the external

quality review organization. Some advocates told us they were beginning to wonder when more information would be released about MLTSS quality outcomes.

New detailed quality of life survey. The state is participating in the National Core Indicators – Aging and Disabilities,³⁰ a detailed survey to be conducted from June through September of 2015 with consumers of all LTSS services (MLTSS, Program of All-Inclusive Care for the Elderly (PACE) and Older Americans Act service recipients with similar levels of service needs). Administrative data on consumers will be combined with detailed survey questions about quality of life, health outcomes and satisfaction with services. This survey will not ask about the transition to MLTSS or compare services before and after.

Time from initial Medicaid application to services received (or paid) not tracked. One item that is not currently measured, to our knowledge, is the time it takes from the beginning of the consumer's application for financial/clinical Medicaid eligibility in the system to the time that services are started or payments are started to residential providers, if they have taken consumers while awaiting eligibility. What is tracked is the timeliness of the clinical assessment by either OCCO or the MCO. This is an important metric. However, for new Medicaid applicants this is only part of the picture. Financial eligibility must be established by the county welfare agency, and it is the county welfare agency that makes the final entry triggering the consumer to be picked up by the MCOs.

It is generally acknowledged that the waiting period for new Medicaid enrollees to access MLTSS is frequently longer than in the earlier waiver system³¹ because consumers can only enroll at the start of a month rather than whenever their eligibility is established.³² However, in some counties there appear to be additional delays. Press reports from February 2015 cite delays in Bergen County, while Passaic County officials were not reporting delays.³³ Our interviewees at a different county's welfare agency noted that they were seeing delays — they roughly estimated that while it had taken 1.5 to 2 months for new Medicaid applicants to begin getting services in their county prior to MLTSS, it now takes 4 to 6 months (this is a completely subjective estimate). Some of this delay was due to the aforementioned restriction on start dates with the MCOs. The rest of the delay they were not sure of, but they mentioned system processing concerns with some cases where date mismatches between different areas of the system caused an error. There are ongoing discussions between the county welfare agencies and the state about how to streamline processes among different agencies. The counties rely on very old technology to process applications — a new system was planned in 2006 and contracted for in 2009, but the contract was canceled in 2014 after a series of delays.³⁴ The state Medicaid director reported in October of 2014 that she had asked the counties to report their application backlog to her but that many did not and she believed that they did not have the systemic resources to do so.³⁵ In April of

2015, the acting Commissioner of Human Services noted that the information system used by counties does not allow the state to track applications in process.³⁶ This may mean that it is not currently possible to track this measure.

Contemporaneously with the change to MLTSS, OCCO mostly stopped giving the counties a fax alert for each clinical approval. They now email each denial since there aren't many of them, but to see approvals the counties have to log into each individual case and navigate through the case to view a screen that is newly visible to them. There isn't any alert system or ability to pull reports to see who has been approved. So, from their perspective, this system is very burdensome — ideally, they would check every pending case every day, but they lack the staffing to do this.

This can mean that clients or their families are doing the legwork of communicating between the different agencies. County welfare agency staff relayed a story about a client's daughter who made several calls between the county welfare agency and OCCO regarding her mother's eligibility and who said to them, annoyed, *"I'm not on your payroll!"*

Legislation has been passed in the NJ State Assembly and introduced into the Senate to require payment to residential facilities providing uncompensated services to residents whose eligibility for Medicaid has not yet been determined more than 90 days after an application has been filed.³⁷ According to several interviewees, nursing facilities are more likely to take consumers who are awaiting eligibility for Medicaid, while HCBS organizations generally require eligibility to be established before beginning services. Thus, timely decisions about eligibility are crucial to allow consumers to stay in their homes.

Theme 6: There have been anecdotal reports of reductions in hours of service and eligibility, but there do not appear to be sufficient data to determine whether this is a general trend.

Consumer advocates with whom we spoke and some providers (quote earlier in Theme 3) have seen complaints about reductions in hours of service, but acknowledge that they do not know how systemic such complaints are. The managed care contract requires MCOs to report any reductions in services, but the MCOs do not feel that they have enough information about services the consumer was getting before the transition to determine whether they are reducing services.³⁸ The state does not have enough detail about care plans before and after the transition to determine whether there have been reductions in hours.

Fair hearing data. The state posts final outcomes of fair hearing decisions,³⁹ but does not tabulate them by type or publicly report on filings in process or those that are settled without a hearing. We asked interviewees for their subjective sense of activity with fair hearing requests.

Eligibility: The Division of Aging Services has seen some increase in complaints regarding eligibility determinations, which they feel can be explained by the fact that the process for re-determining clinical eligibility has become more detailed. However, the Division has not been ruled against in court — generally the matter is settled in a way the consumer agrees with before the matter reaches the hearing stage.

Hours of service: Hours fair hearing requests and complaints come in to the Division of Medical Assistance and Health Services. The staff with whom we spoke did not have first-hand knowledge of fair hearing requests, but did not have the impression that there had been a notable increase.

Theme 7: The MLTSS population has very vulnerable members who may be very isolated socially and have difficulty communicating problems with their care.

This was a theme that came up repeatedly. In addition to being physically and/or cognitively frail, MLTSS enrollees may also be socially isolated from anyone who can advocate on their behalf,⁴⁰ and it is for these people that program changes can be very disruptive. Disruptions to these clients also directly affect staff members who work with them or agency employees who attempt to counsel them. In some cases the lowest paid staff members in the system become the safety net for these consumers. We heard reports of aides, who are generally very low paid, continuing to help some of their clients even after their hours were cut because the clients had no one else to help them. It is common to hear reports of certified nursing assistants working off the clock or spending their own funds to help clients, as evidenced in the quote below from a recent discussion among nonprofits and elected officials about working people in poverty in New Jersey:

“I’m a certified nurse assistant ... I’m the face, I’m the person ... that holds a dying person’s hand. I give care to the most vulnerable people in society. I take money out of my pocket to buy them soap, clothing, snacks or whatever, because, at the end of the day, we become their family, all they have.”⁴¹

Staff at a county welfare agency described clients they encounter who are:

“really old or really sick ... sometimes they have their children help them and that is great but a lot of people they don’t have family ... anybody ... to help them.”

A provider described a client who had problems getting an MCO assessment because of his hearing loss, which put the agency at risk of lost revenue as they continued services in the interim:

“he’s hard of hearing, so when the [MCO] nurse actually went to see him, he couldn’t hear the door, and she I think attempted it twice, and because their policy is if you go twice and no one answers the door, then the provider has to do a whole new request ... so for this client it took 5 months ... We were still continuing services, we lost some, I think, 2 months, because they don’t want to backtrack it, so we’re in that process right now, trying to backtrack the authorization for that one client.”

Theme 8: There has been a large increase in self-directed services contemporaneous with the transition to MLTSS.

State officials and MCO staff report a large increase in self-directed services, where consumers or their caregivers hire, train and manage their service providers. The increase has been about threefold in total across consumers getting MLTSS and state plan only services (the increase is not necessarily due to MLTSS, it has just happened at around the same time). There has been a self-direction option for people receiving state plan PCA services for some time. Under MLTSS, chore services, home based supportive care and non-medical transportation can also be self-directed. Interviewees were not sure exactly why the increase has occurred, though influences include at least one MCO that actively promotes it to members and a state staff member who has been very effective at explaining and promoting the option. Self-direction of services can be a good option for people who have personal connections with others who can perform their care, and in some cases can help fill gaps in provider networks with respect to knowledge regarding culturally competent care (language, foods, etc.) or geographical areas that have a shortage of providers. It can also allow for more flexibility and, depending on the situation, reliability, as the quote below demonstrates:

“there is a tremendous amount of anxiety taken off natural support family members because they can say, the lady who lives next door, we know she’s going to come — with the agency it was always a toss up. It also works a lot better for the clients because ... if you’re an active person, and don’t want to go to bed at 7 o’clock at night ... very often the home health aide agency says it’s either 7 o’clock or ... no service ... best story I have on that is the lady in her mid-30’s who has spina bifida and who’s working and she said ‘by the time I get home from work it’s 6:15 and my agency would say we have to send someone at 7 to put you to bed’ and her point was ... ‘it’s the middle of the summer. I haven’t been to bed with the sun up ... since I’m seven years old’ ... so now ... she’s able to pay her next door neighbor, who’s willing to come across the hall at 11 o’clock at night and put her to bed, and her quality of life and her evenings have gotten a lot longer.”⁴²

The consumer advocates we spoke with felt it was very important for consumers to have options, but wanted to make sure that consumers had the option of high quality care from either agencies or self-directed caregivers. Many providers didn't have much of an opinion on self-direction, though at least one provider was very concerned about potential quality issues and the potential for consumer abuse with this option. The potential of consumer abuse exists with agency aides as well, but where consumers have a personal relationship with the aide, as in many self-direction arrangements, they may be more reluctant to fire the worker or report abuse if as a result they fear hurting a loved one or damaging their relationship with others.

State officials report that with the increase in self-direction cases they have moved a staff person into compliance and monitoring, and that the MCOs are also involved in quality oversight. The state staff person conducts surprise home visits and facilitates discussions if there is concern about the quality of a situation or the consumer's ability to self-direct.

Theme 9: Providers have experienced an increase in administrative burden to become credentialed and contracted, obtain authorization for services, to file claims, and in the amount of time to receive payment under MLTSS.

"It's my new job" – one small provider describing how the transition to MLTSS has affected them. They were not sure if they will take on the same number of clients from Medicaid as they have in the past. While the administrative work with waiver clients had been manageable prior to the transition, ten months into the transition it was very burdensome, with no signs of improvement and some looming cost pressures in the future, as MCOs had warned providers that the way things were was not sustainable and changes would be forthcoming in the structure of payment. The provider was hopeful that high quality could be seen as valuable, but felt unsure.

Old vs. new overview. There was an increase in workload for providers as they moved from a single payer fee-for-service system to a multi-payer system. Prior to MLTSS, providers had to undergo one credentialing and contracting process to become a state provider and had a predictable claims process in terms of knowing how to submit claims and receiving payment within 10 days of submission. Under MLTSS, providers must contract and be credentialed separately with each MCO as well as requesting service authorizations and filing claims with each MCO. Generally, New Jersey stakeholders described provider transition experiences similar to those in other states (Kasten et al. 2013) and similar to a description of New Jersey PCA provider experiences with the shift to managed care in 2011.⁴³

Claims. Claims are supposed to be paid within 15 days, but there has been disagreement about which claims are affected by the 15 day rule, with MCOs saying that this time period is for clean

claims (that is, claims that are not rejected or denied) and providers believing that MCO standards for a clean claim are, in some cases, unreasonable and not standard across MCOs or even within the same MCO over time and among different staff. For instance, one provider described having claims for PCA services delayed. When she called to find out the reason, she was told that it was because claims for PCA services at this MCO now required the license number of the aide. She resubmitted the claims with the license numbers and, when she called to figure out why they were still delayed, the person she reached knew nothing of a requirement to include the aide license number. The state has a unit dedicated to provider relations and manages any complaints closely. However, they are aware that providers are cautious to complain because they don't want to hurt their relationships with the plans, so they also require reporting on claims from the MCOs and look for other ways to hear about potential problems (stakeholder meetings, etc.).

Contracting. We heard a mixed picture on contracting. Some providers, even those in the any willing provider category, reported hearing from MCO staff that networks were closed when they attempted to sign up. We also heard reports of contracts returned to MCOs and not acted upon. The Health Care Association of New Jersey, which represents long-term care facilities and assisted living providers, sent a letter to Medicaid and MCOs outlining a number of concerns with the contracts they reviewed in March of 2014 including contract time frames, unspecified payment terms and lack of continuity of care provisions for residents should the provider be terminated from the MCO network after the any willing provider period had passed.⁴⁴ Neither the MCOs nor the state reported problems with network adequacy, except in cases where providers did not exist. However, unlike with acute care, network adequacy standards are not well established for LTSS, so the state does not have much to reference in designing requirements. We had one anecdotal report from a provider organization who had been contacted by a person who claimed to not be able to find services for a child with a disability — in this case, it was not that the MCO had no providers, but that the contracted providers claimed to be unable to provide services to her child.

Authorization of services received. We heard a mixed picture on authorizations as well. MCOs told us they generally authorized for 6 months to a year for MLTSS clients. However, some providers described having to get authorizations more frequently, sometimes as often as monthly, for the same services. It may be that these providers were thinking of clients only on state plan services who had not been assessed to have a nursing facility level of care.

Progress in standardization. Prior to MLTSS rollout, DMAHS staff facilitated development of a series of standard codes for MLTSS services, which has made claims processing more predictable than it would have been if each MCO had their own set of codes. MCOs appreciated this effort and there is further work underway to standardize the credentialing process for providers.

Theme 10: Providers feel uncertain about what their future looks like with MLTSS.

Providers of all types told us that they are afraid that MCOs will focus on selecting providers with the lowest prices, with an ultimate result of lower quality providers. So far, none of our interviewees reported that provider quality has declined. However, we did hear from multiple sources in the home care industry that recruiting quality aides is more difficult with rate pressures and, for some agencies, decreasing hours per case. This fragments the aides' work days, forcing them to spend increasing time traveling between clients, and makes home care less competitive with other kinds of low-wage work, such as fast food or retail, that occurs in one place and requires less investment on the part of the employee in training, licensing and background checks. We have heard that all but one of the nonprofit home care providers have withdrawn from the Medicaid market and that some home care agencies and adult day centers have ceased operations since the transition to managed care in 2011. We did not hear that these withdrawals or closures have negatively impacted the overall supply of these services. There are some geographic areas (generally more rural areas) that have gaps in these services, but we are not sure whether recent closures have affected these areas. There were rate cuts to PCA in 2012 by the MCO serving the largest share of Medicaid patients.⁴⁵ The amount of the cut was reduced from 10 percent to 4.5 percent.⁴⁶ Legislation requiring state oversight of any rate cuts was introduced in 2012 and passed in 2014 but was not signed by the governor.⁴⁷ New legislation on the matter was introduced in 2014.⁴⁸

MCOs told us that they do not see a consistent relationship between costs and quality among their provider populations (i.e., they see high quality, low cost providers as well as other combinations). They feel that some of the providers are too small to provide optimal services (e.g., an alternate aide if the usual aide is unavailable) and would prefer to see some consolidation among organizations, though not a reduction in supply of services. A consumer advocate stakeholder reported hearing from an MCO contact that the MCOs find it burdensome to contract with and monitor large numbers of small providers.

Theme 11: Some stakeholders see potential for increased coordination of services from integration of acute, long-term and behavioral services with MLTSS.

The MCOs, in addition to tracking claims and other administrative data, are also tracking member success stories with MLTSS. One of the MCOs shared a number of their stories with us. Several of the examples involve people who had unmet acute care needs in addition to their LTSS needs. MCO care managers are in a good position to navigate the MCO system to be able to find acute, LTSS and behavioral health providers and, if necessary, speak to providers about taking on a

particular client. A waiver agency case manager trying to do the same legwork would be at a disadvantage with respect to access to information and communication with providers. On the other hand, MCO care managers probably do not have an advantage with respect to locating other community resources (some stakeholders felt they were probably at a disadvantage compared to the waiver agency case managers). All the MCOs are working on documenting community resources.⁴⁹ One MCO described entering social services providers into its general provider database so that they are available to be viewed as resources by employees. Another is using a separate application for the same purpose.

MCOs also described arranging their workforces to integrate acute, long-term and behavioral staff. Examples included training and risk screening information for staff on the acute side to refer to MLTSS case staff, case management for people using state plan services like adult day and PCA, seating staff working in these different substantive areas near each other, and having acute and behavioral health case managers dedicated to MLTSS to support field case managers whose members are using non-MLTSS services.

Theme 12: Some stakeholders see potential for managed care to bring increased quality oversight to LTSS.

All MCOs we spoke with said they were evaluating quality among providers, with mentions of tools used to evaluate providers as well as incentives for quality care in the works. One MCO executive told us:

“There’s a new dialogue now ... about the quality of the service those providers are offering. We immediately think about, is this an agency we are comfortable with from a clinical point of view or not, and that’s not something that the fee-for-service system ever asked ... we’ve got clinical case managers and clinical managers in house who are looking at these providers ... particularly with this vulnerable population, the member may not be in a position to judge the quality of the services that are being rendered, and that’s a big part of our job.”

This interviewee later told us of the decision to stop working with (at least temporarily) a provider due to concerns raised in a site visit.

State officials generally thought it was early to assess either the quality of work of the MCOs or the ability of the MCOs to oversee provider quality, but did seem to think that there was opportunity to better manage quality in moving from over 100 agencies doing case management to a few MCOs with better infrastructure and data mining capabilities.

Theme 13: Stakeholders expressed concern over the state’s capacity to oversee and monitor MLTSS.

We heard some concern about the state’s capacity to oversee and monitor MLTSS from a variety of stakeholders. Stakeholders familiar with other states’ programs noted that Tennessee has about 400 staff (unverified estimate) to oversee an MLTSS population of 31,200 while New Jersey has about 100 staff (unverified estimate) to oversee about 14,500 MLTSS enrollees (some of these same staff also work with the 25,500 LTC enrollees outside managed care — in Tennessee, all nursing facilities are part of MLTSS).⁵⁰ Norms for oversight and monitoring haven’t been established, and it is difficult to assess staffing levels (Jackson et al 2013), but there is concern nationally that state governments are strained (Lipson et al 2012).

When additional staff were needed to oversee MCO eligibility assessments, they had to be hired on a temporary basis due to a state hiring freeze. State capacity affecting MLTSS can go beyond those directly working with the program — in February 2014 the Senate Health, Human Services and Senior Citizens Committee wrote to the state Board Of Nursing expressing concern at delays for professional certification for home health aides due to staff shortages at the Board of Nursing, which causes financial hardship for the individuals and in some cases a loss of investment by the individuals and possibly agencies in the training they have received when they find alternate employment due to the wait.⁵¹ We heard that there has been some improvement since the time of the letter though the use of temporary employees and overtime.

Other Findings

This section contains observations that we thought merited mention but that weren’t a general theme to be described above.

County welfare agency link to MCOs. County welfare agency staff in one county reported a loss of communication with case managers due to MLTSS. Previously they knew who the waiver agencies were and would contact them if necessary to get renewal paperwork to the client. Now they do not know who to contact at the MCOs. One of the MCO stories we received involved a mix-up where a client’s social services benefits were almost cut off because of address changes due to a hospitalization and post-acute rehabilitation stay in a facility. Regarding MLTSS, MCOs could target the staff within the county welfare agency who are responsible for managing applications and renewals for clients who are aged, blind and disabled and communicate contact information so that information can be shared if necessary. This may be happening in some counties; at least one MCO emphasized encouraging case managers to make connections in the counties and communities they serve.

Referral options needed for consumers who must establish a Qualified Income Trust to access services. County welfare agency staff described seeing a lot of cases where consumers need to establish a Qualified Income Trust to access services. When consumers have the resources to hire a lawyer or have family or friends to help them, the process is relatively smooth, though the agency's attorney is seeing an increasing number of trusts drawn up incorrectly by attorneys that then require follow-up communication and redrafting. Where consumers are alone, without financial resources, and possibly dealing with serious chronic medical issues, the necessity of drawing up the trust and naming someone to administer it is a serious problem for them. The county welfare agency cannot be the trustee, nor can a long-term care facility. The state has a template and instructions on the internet, but this isn't helpful for everyone and the welfare agency staff need somewhere to refer people.⁵² One stakeholder pointed out proposed CMS rules calling for a Beneficiary Support System for Medicaid Managed Care⁵³ and suggested that, for MLTSS recipients, AAAs could be an example of an organization that could provide this function.

Need for companionship. One of the MCOs reported investigating how to get volunteers to provide companionship for members for things like just talking, playing cards together, etc., to enhance their benefit package. PCA aides provide some companionship but their hours are supposed to be dedicated to performing tasks that help the member rather than providing companionship. Research and media accounts have documented the isolation that community-dwelling people with functional limitations can feel.⁵⁴

Conclusions and Next Steps

Though early indications in terms of numbers served in HCBS since MLTSS began seem promising, most stakeholders thought it was too soon to know the impact of MLTSS on consumers or even on providers. There have been definite short term adjustments for all stakeholders. There are anecdotal reports of service reductions due to the rationalization of processes with MLTSS, but it is not clear how widespread these are. Quality measures are still mostly forthcoming due to a need to wait for claims periods to expire and to ensure harmonization of data across MCOs. Some items appear not to be measured or planned, such as the time from application to services received (or reimbursed, if institutions take consumers who are in the application process), and any reductions in services with MLTSS.

The state has a philosophy of continuous improvement and a multifaceted stakeholder communication process, but it is challenging to design processes that take into account the disparities among stakeholders (e.g., the preponderance of older adults on MLTSS and the greater resources of some provider organizations). Many felt that the fact that some providers

were allowed additional time to adjust to MLTSS (e.g., the grandfathering of existing fee-for-service nursing facility residents and the initial any willing provider arrangement for nursing facilities) was a best practice, and one MCO stakeholder commented that, though the MCOs were initially unhappy about the loss of members with the fee-for-service carve-out, it was probably better for all involved to have a gradual adjustment. Consumers and providers who were not allowed the opportunity to remain in a fee-for-service arrangement generally wish they had been allowed the opportunity. All providers feel uncertain about what the future will bring for their ability to provide care.

Many stakeholders feel that there is a potential for managed care to provide better integration of acute, behavioral and long-term services and supports and also a potential for improved quality oversight of these services. However, there is also concern, as there is nationally, about the capacity of state government to oversee MLTSS. New Jersey has faced challenging budget conditions and a hiring freeze, which meant that new employees needed to manage the oversight process had to be hired on a temporary basis. The state has a strong communications infrastructure with organized stakeholders and by all accounts is responsive to issues raised by providers and consumer advocates. However, given the vulnerability of many consumers on MLTSS, there is concern about consumers who may be disconnected from resources and unable to communicate problems with their care. There are also stakeholders desiring opportunities for more systemic discussions with the state and other stakeholders.

Our final stakeholder report is due to the state on June 1, 2017. Between now and then, we will be taking feedback on this initial report, continuing our meetings with state staff and other observations of MLTSS processes, and having additional conversations with stakeholders, with a mix of people we have spoken with previously and new contacts. If you would like to provide input for our final report, please contact the primary author at jfarnham@ifh.rutgers.edu or 848-932-4675.

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Appendix: MLTSS Interview Guide

1. How do you think MLTSS implementation has gone so far?

(Note: Subquestions 1.1-1.8 were distributed only to MCO interviewees)

- 1.1. *Number of MLTSS enrollees -- how many were you serving before with acute care and services like PCA and adult day, versus consumers who are totally new?*
- 1.2. *Do you receive prior LTSS utilization or other relevant history for people transitioning from FFS to MLTSS, or does it all start fresh with the case manager assessments?*
- 1.3. *Case managers; assessments. How are the assessments going? Number of case managers and educational/experience backgrounds (how many were providing LTSS waiver case management before)? Turnover in case management staff? Able to visit consumers within time frames defined by the state?*
- 1.4. *I understand that the state has designed assessment tools for clinical eligibility and PCA hours (NJ Choice). How are these tools working?*
- 1.5. *Are you seeing appeals of clinical eligibility determinations or service/hour of care determinations?*
- 1.6. *How are things going with establishment of provider networks? Where are the gaps (service wise, region wise, etc.)? What are the reasons for these gaps? How are self-directed services fitting in with this?*
- 1.7. *How are things going with transitions out of facilities to community settings?*
- 1.8. *Are you seeing consumers hit the cost caps with community services? What happens in these cases?*

2. Have the changes with MLTSS benefitted any population or patient groups? Have they caused difficulty? How?

- 2.1. *Are consumers receiving services under MLTSS that they did not receive before? Conversely, are there services they were getting before that they are not getting under MLTSS?*
- 2.2. *How was continuity of care affected by the implementation of MLTSS?*
- 2.3. *How have determinations of functional eligibility changed with the implementation of MLTSS? Has this affected access to services (positively or negatively)?*
- 2.4. *How are authorizations for services (any service in MLTSS dictionary) or hours of service (e.g., PCA (personal care assistance), private duty nursing, or any other service where hours may vary) different under MLTSS? Has this affected access to services (positively or negatively)?*

- 2.5. *Has there been a change in the hours of service that consumers receive under MLTSS?*
 - 2.6. *Has there been any change in the opportunity for consumers to direct their own services under MLTSS?*
 - 2.7. *How is the process of transitioning from facilities to community settings different under MLTSS?*
 - 2.8. *Are you aware of any cases where it is more difficult to keep people in community settings under MLTSS? How typical is this?*
 - 2.9. *How have determinations of financial eligibility changed with the implementation of MLTSS? Has this affected access to services (positively or negatively)?*
3. **Since MLTSS was implemented, have you noted any problems or improvements in the health of specific population groups that you work with?**
 4. **Have you seen any changes in the LTSS providers since the changeover to managed care began in 2011? How do you think MLTSS is affecting the various LTSS providers that serve consumers?**
 - 4.1. *Have there been changes/expected changes to payment rates received by providers under MCOs? What has this meant for providers and consumers?*
 5. **Have you seen new clinical or community partnerships that have developed to support MLTSS?**
 6. **What do you think are the key data that should be examined regarding the effectiveness of MLTSS? Are these data being collected? If not, what would the data source(s) be?**
 7. **Are there additional supports or improvements that are needed to make MLTSS successful? If so, what are they?**
 8. **Is there anything else relevant to the evaluation of MLTSS that I haven't asked you about?**

Endnotes

¹ According to state officials, staying with the existing medically needy program would only have allowed consumers to keep \$367 per month in income, which is not enough to pay for living expenses in New Jersey. State officials chose the Miller Trust option (requiring consumers to establish a trust) over a 217-like hypothetical spend-down (which would similarly expand the amount of funds consumers could keep without requiring a trust) because several other states were examples of this. Of the 217-like states, none have MLTSS, so there was no precedent for this. For more information on these topics, see Walker L and J Accius. “Access to Long-Term Services and Supports: A 50-State Survey of Medicaid Financial Eligibility” AARP Public Policy Institute, 2010 and Watts MO and K Young. “The Medicaid Medically Needy Program: Spending and Enrollment Update.” Kaiser Commission on Medicaid and the Uninsured. December, 2012. In addition, AARP advocated for the trusts (Kitchenman A. “More Seniors in NJ to Get Access to Home-Based and Community Services.” NJ Spotlight, July 25, 2014).

² Arye L. MLTSS Presentation to the Medical Assistance Advisory Council. April 13, 2015. Accessed June 29, 2015 from http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_4_13_15.pdf.

³ Musumeci M. “Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers” Kaiser Commission on Medicaid and the Uninsured. November, 2014; Saucier P, Kasten J, Burwell B and L Gold. “The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.” Truven Analytics, July 2012. Musumeci discusses 18 states that have filed waivers containing MLTSS and another three using §1932 state plan amendments (SC, VA, WA). Saucier et al. note an additional three states not mentioned in Musumeci’s review (MA, NC, PA), all of which use some combination of waivers.

⁴ The Community Care Waiver — see <http://www.state.nj.us/humanservices/ddd/services/ccw/> (accessed June 19, 2015).

⁵ Burwell B and J Kasten. “Transitioning Long Term Services and Supports Providers Into Managed Care Programs.” Prepared by Truven Health Analytics for the Centers for Medicare & Medicaid Services (CMS), May 2013; Lipson DJ, Libersky J, Machta R, Flowers L and W Fox-Grage. “Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports.” AARP Public Policy Institute, July 2012.

⁶ CMS. “Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs” May, 2013; Jackson B, Rivard P, Seibert J, Rachel J and T Whitworth. “Quality in Managed Long-Term Services and Supports Programs. US Department of Health and Human Services, November 2013; Mann C. “Long Term Services and Supports Delivered Through Medicaid Managed Care Programs.” CMCS Informational Bulletin, May 2013; Rivard P, Jackson B and T Stokes. “Performance Measures in MLTSS Programs: Research Brief.” US Department of Health and Human Services, November 2013; Summer L. “Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs.” Kaiser Commission on Medicaid and the Uninsured, April 2013.

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⁸ See pp.99-101, Centers for Medicare & Medicaid Services, Special Terms and Conditions (STCs), Number 11-W-00279/2, New Jersey Comprehensive Waiver Demonstration, New Jersey Department Human Services Division of Medical Assistance and Health Services, October 1, 2012 through June 30, 2017. Accessed June 18, 2015 from http://www.state.nj.us/humanservices/dmahs/home/CMW_STCs.pdf.

⁹ Thomas DR. “A General Inductive Approach for Analyzing Qualitative Evaluation Data.” American Journal of Evaluation 27(2): 237-246, June 2006.

¹⁰ For example, some provider associations are better funded and staffed, and some consumers and providers are more educated and affluent. Language spoken, health status, and citizenship are other things that may affect the ability of consumers or providers to share their perspectives.

¹¹ See <http://www.state.nj.us/humanservices/dmahs/boards/maac/> (accessed May 11, 2015).

¹² See http://www.state.nj.us/humanservices/dmahs/home/MLTSS_Stakeholder_letter_10_09_14.pdf (accessed May 11, 2015).

¹³ See Day, Nancy “Managed Long Term Services & Supports (MLTSS),” presented May 22, 2013 at the Health Care Association of New Jersey’s Annual Assisted Living Conference. All conference presentations here <http://www.hcanj.org/events-education/seminar-presentations/>; specific presentation here <http://www.hcanj.org/files/2013/10/seminars-alc2013-5.pdf> (accessed May 11, 2015).

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- ¹⁴ A general listing of resources can be found at http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html; training videos and presentations are located at http://www.state.nj.us/humanservices/dmahs/home/mltss_training.html (accessed May 11, 2015).
- ¹⁵ See <http://www.state.nj.us/humanservices/doas/home/directory.html> (accessed May 11, 2015).
- ¹⁶ See <http://www.interrai.org/instruments.html> (accessed May 11, 2015). interRAI instruments are based on evidence-informed clinical practice and data collected by a network of researchers in over thirty countries — more information about the organization can be found at <http://www.interrai.org/organization.html> , including a list of members.
- ¹⁷ As of the end of June, 2015, 167 individuals enrolled in an MCO have been denied eligibility after an OCCO reassessment. Some are still in the fair hearing process and may still be found eligible. The state provides guidance to MCOs in the discharge process and delays any termination of benefits until a safe transition has been facilitated for the member. Fewer than ten individuals in Assisted Living or Community Residential Settings have lost eligibility through the reassessment process.
- ¹⁸ Due to a state hiring freeze, they had to use temporary positions.
- ¹⁹ In a New York Times article about a lawsuit over home care cuts in Medicaid, a client describes having to sleep in her clothes when her home care service was reduced (Bernstein N. “Medicaid Home Care Cuts Are Unjust, Lawsuit Says” New York Times, July 15, 2014).
- ²⁰ The person making this objection was viewing the PCA tool as part of the overall assessment and care planning process, rather than as a narrow tool designed merely to calculate the need for paid hours. We are not sure how others view the tool. If the PCA tool is the only method used to assess and document the member’s need for assistance in the care planning process, this would appear to be a gap, because it leaves out the unpaid services on which many members rely.
- ²¹ Presentation by Nancy Day to the MLTSS Steering Committee, January 29, 2015.
- ²² See New Jersey Department of Human Services, “NJ FamilyCare Qualified Income Trust (QIT) Frequently Asked Questions (FAQs), Updated March 12, 2015” for discussion of the three types of personal responsibility forms (accessed June 5, 2015 from http://www.state.nj.us/humanservices/dmahs/clients/QIT_FAQs.pdf). The PR-2 form “Instructions for Completing the Patient Pay Liability Worksheet PR-2”, accessed May 29, 2015 from http://www.state.nj.us/humanservices/doas/forms/PR-2_inst.pdf.
- ²³ For example, a change in procedure described in the media as an attempt to incentivize faster social services applications by county welfare agencies by paying them for the number of applications completed as opposed to the number received (see Kitchenman, A. “Christie Budget Doesn’t Fund Permanent Fix for Social-Services Computers,” NJ Spotlight, April 21, 2015) was described by interviewees at one county welfare agency as a cut in payment for their work because not all applications received are completed for a variety of reasons.
- ²⁴ Grievances for Essex County can be found at <http://www.cwa1081.com/archive.html> (accessed June 26, 2015) and include shortages of staff, postage, supplies and poor physical working conditions. Our interviewees from a different county also felt that their county did not provide sufficient resources.
- ²⁵ The instructions for form PR-2 referenced in note 16 above say only that the form must be recalculated at least annually and that the CWA does not have to recalculate it every month unless the MLTSS participant’s income changes or there is an announced change in the personal needs allowance and room & board. Medical expenses not covered by Medicaid change the effective income of enrollees because they are an allowed deduction, so one could read the form as requiring the CWAs to recalculate the PPL every month, but our CWA interviewees recalled state employees suggesting that they tell enrollees they would only do it every six months. They believed that the waiver case managers had recalculated it monthly if the enrollee wanted that, but they did not feel this workload was manageable for them. State officials we spoke with believed that the amount should be calculated monthly if necessary and had no knowledge of any advice to restrict recalculations.
- ²⁶ Perspectives may be found in the following two media accounts: Kitchenman A. “Bill Would Tighten Oversight of ‘Companion Services’ for Elderly” NJ Spotlight, July 3, 2014; Kitchenman A. “Debate Centers on Regulation and Oversight of Home Healthcare Services” NJ Spotlight, September 5, 2013.
- ²⁷ According to the NJ MCO Contract, section 9.2.3, either a nurse or a licensed clinical or certified social worker may complete the assessment. See <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf> (accessed June 26, 2015).
- ²⁸ The PCA tool does have to be completed by a nurse (March 2015 presentation from Department of Human Services on file with authors).

²⁹ See the Quality Strategy as of June 12, 2014 at

http://www.state.nj.us/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf (accessed June 19, 2015).

³⁰ See <http://www.nasuad.org/initiatives/national-core-indicators-aging-and-disabilities> (accessed June 18, 2015).

³¹ It was already a long process prior to MLTSS, partly because of the ongoing system processing issues discussed elsewhere, but also because the 5 year look-back period into applicants' finances can be very lengthy, at times because applicants cannot produce documentation of monetary transfers. With the comprehensive waiver, applicants under 100 percent of the federal poverty level can attest to not having made asset transfers in the past five years in lieu of producing documentation. State waiver reports to CMS on file with the authors show that about 100 applicants per quarter across the state are able to self-attest, thereby avoiding a comprehensive investigation by county welfare agency staff. For the county welfare agency staff we spoke with, this change did not save them much time because of the low number of self-attestations.

³² Consumers must be clinically and financially eligible by the 25th of the month in order to enroll by the first of the next month; if eligibility is established after the 25th day of the month, enrollment cannot begin until the first of the following month. NJ Department of Human Services, 'Frequently Asked Questions (FAQs) for Providers' (November 2014).

³³ Diskin, C. "Delays seen in approving home care for North Jersey elderly." *The Record*, February 25, 2015.

³⁴ See Kitchenman A. "Christie Budget Doesn't Fund Permanent Fix for Social-Services Computers," *NJ Spotlight*, April 21, 2015 and Kitchenman A. "Outdated Technology, Application Backlogs Hinder FamilyCare Enrollment" *NJ Spotlight*, May 13, 2014.

³⁵ See comments by Valerie Harr in the October 6, 2014 meeting of the Medical Assistance Advisory Council http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_10_6_14.pdf (accessed June 19, 2015).

³⁶ See Kitchenman, A. "Christie Budget Doesn't Fund Permanent Fix for Social-Services Computers," *NJ Spotlight*, April 21, 2015.

³⁷ A3928, 216th legislature "Uncompensated Pending Medicaid Beneficiary Payment Relief Act" introduced December 4, 2014 and passed by the Assembly on March 26, 2015. Referred to Senate Committee May 7, 2015 (S2895). See also Kitchenman, A. "Slow-Moving Review Process Snags Medicaid Payments to Nursing Homes, Patients," *NJ Spotlight*, March 6, 2015.

³⁸ Specifically, while they have a copy of the previous care plan, it is in a textual format that doesn't easily facilitate comparisons and, in addition, they are not able to verify that the client was actually getting the services in the care plan.

³⁹ See <http://www.state.nj.us/humanservices/providers/rulefees/decisions/> (accessed June 18, 2015).

⁴⁰ The MLTSS Member Profile presented by Nancy Day at the January 29, 2015 MLTSS Steering Committee showed that 35 percent of members lived alone and 54 percent had impairments in the ability to make daily decisions consistently and safely. The most frequent self-reported disease is Alzheimer's or dementia, with 36 percent of members reporting this. Nearly 90 percent of members required help with housework and meal preparation, and 27 percent needed assistance to use the phone.

⁴¹ Devika Smith, speaking on June 3, 2015 at a roundtable discussion of nonprofit organizations and elected officials about the struggles facing working families. Accessed June 4, 2015 from https://www.youtube.com/watch?v=1VbCBA5Y_OU.

⁴² This consumer may not be on MLTSS, but is using the same kind of PCA services provided under MLTSS. The interviewee who related the story was discussing examples of consumer direction and, as noted in the quote, this was the best example the person thought of. The principles of independence and flexibility are illustrated here, which apply to people needing PCA services whether they are enrolled in MLTSS or not.

⁴³ See http://www.hhssanj.org/assets/pdfs/PCA_program.doc (accessed June 26, 2015), which discusses a variety of factors causing reduced revenue and increased costs for agencies in the move to managed care.

⁴⁴ See "HCANJ Medicaid Managed Care Organization Network Participation Agreement Comments" accessed June 3, 2015 from <http://www.hcanj.org/files/2014/06/HCANJ-CAN-comment-letter-on-United-Healthcare-MCO-contract-c.pdf>.

⁴⁵ See Kalet, H. "Horizon NJ Health Slashes Medicaid Reimbursements for Home Healthcare" *NJ Spotlight*, September 5, 2012.

⁴⁶ See Tyrell, J. "Bill Aims to Block HMO Cuts in Medicaid Reimbursements" *NJ Spotlight*, October 12, 2012.

⁴⁷ Senate Bill 2241 (2012-2013) and Assembly Bill A3409 (2012-2013), history available from <http://www.njleg.state.nj.us/bills/BillView.asp> (accessed June 3, 2015-no direct link available, use site to look up bill numbers).

⁴⁸ Kitchenman, A. "Home Health Agencies Want Warning Before Reimbursement Cuts" NJ Spotlight, December 8, 2014.

⁴⁹ Ohio requires managed care plans to develop resource guides: "2.h.iii.j. The MCP must identify community, social, and recovery support services that are available at the county level and develop a resource guide which contains a listing of the support service agencies and contact information that is easily accessible by care managers, members, and providers. The resource guide must be updated as new contacts are identified by the MCP. The MCP is encouraged to collaborate with other MCPs in the service area to develop a unified approach to contact and partner with community service agencies." See Managed Care Provider Agreement (7/1/14-6/30/15, amended effective 2/10/15), Appendix K, Quality Care, p.19 of 24, accessed June 26, 2015 at <http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/SFY2015-ManagedCare-PA.pdf>.

⁵⁰ Staff numbers for NJ and TN were reported by the interviewee and are unconfirmed. Tennessee MLTSS enrollees and program information are from Saucier P, Kasten J, Burwell B and L Gold. "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update." Truven Analytics, July 2012. NJ MLTSS enrollees are for April 2015, as presented in June (accessed June 18, 2015 from http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_6_15_15.pdf).

⁵¹ See copy of letter at <http://www.homecarecouncilnj.org/Sen%20Health%20Comm%20ltr%20to%20BoN%200214.pdf> (accessed June 19, 2015).

⁵² According to state officials, staying with the existing medically needy program would only have allowed consumers to keep \$367 per month in income, which is not enough to pay for living expenses in New Jersey. State officials chose the Miller Trust option (requiring consumers to establish a trust) over a 217-like hypothetical spend-down (which would similarly expand the amount of funds consumers could keep without requiring a trust) because several other states were examples of this. Of the 217-like states, none have MLTSS, so there was no precedent for this. For more information on these topics, see Walker L and J Accius. "Access to Long-Term Services and Supports: A 50-State Survey of Medicaid Financial Eligibility" AARP Public Policy Institute, 2010 Walker & Accius (2010) and Watts MO and K Young. "The Medicaid Medically Needy Program: Spending and Enrollment Update." Kaiser Commission on Medicaid and the Uninsured. December, 2012Watts & Young (2012). In addition, AARP advocated for the trusts (Kitchenman A. "More Seniors in NJ to Get Access to Home-Based and Community Services." NJ Spotlight, July 25, 2014).

⁵³ Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 431, 433, 438, et al., Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules. Federal Register, vol. 80, no. 104, June 1, 2015. Accessed June 26, 2015 from <http://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf>.

⁵⁴ See Span, P. "At Home, Many Seniors Are Imprisoned by Their Independence" New York Times, June 19, 2015.



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