Care Management for Long-Term Care Beneficiaries: New Jersey's Move to Managed Care

Jennifer Farnham, Sujoy Chakravarty and Kristen Lloyd

Rutgers Center for State Health Policy, Institute for Health, Health Care Policy, and Aging Research, Rutgers University, New Brunswick, NJ, USA

Corresponding author: Jennifer Farnham, Rutgers Center for State Health Policy, 112 Paterson St., 5th Floor, New Brunswick, NJ 08901, USA

Email: jfarnham@ifh.rutgers.edu

Submitted to: call for papers on the "Consequences of Change in Healthcare for Organizations, Workers, and Patients," a conference sponsored by the School of Management and Labor Relations at Rutgers University and the School of Industrial and Labor Relations at Cornell University to be held January 9-11, 2019

Abstract

This paper examines changes in care management for long-term care beneficiaries with a move in New Jersey to managed care, based on 43 interviews with 78 stakeholders and extensive document/data review. Prior to the transition, case managers were employed in small, local organizations; after, they are employed by a few large managed care organizations. While there were changes in the organizational environment for care managers, we find that there was organizational diversity both before and after the transition to managed care. There has been significant growth in the number of beneficiaries in home and community settings under managed care.

Keywords

Medicaid, managed care, care management, long-term services and supports

Introduction

In New Jersey and in most other places, care managers are key gatekeepers for essential services to individuals who need long-term care. Long-term care services include assistance with activities of daily living such as eating, dressing, bathing, toileting, and mobility. These services can be provided in an institutional setting such as a nursing home, or in a home or community setting by paid or unpaid support personnel (in this setting they are also called HCBS, or home and community-based services). Because users of long-term care services tend to have multiple chronic conditions and challenges with everyday activities, care management is often provided to determine care needs and to help coordinate the various types of care needed by beneficiaries. Case management was mandated in federal legislation authorizing Medicaid payment in community settings for clients who were eligible for nursing home care in the early 1980s, and it remains a feature of systems of care for such clients in the US and around the world (Austin, McClelland, & Guransky, 2006), though definitions of included responsibilities vary (Kane, Penrod, Davidson, Moscovice & Rich, 1991).

Most beneficiaries of long-term care services in the United States will eventually rely on the publically-funded (state and federal) Medicaid program to pay for their care. Medicare, the federal health care program for older adults and people with disabilities, does not pay for long-term care services. State Medicaid programs are increasingly turning to managed care organizations to manage long-term care services (now commonly called long-term services and supports, or LTSS) in addition to other health care services (Burwell & Saucier, 2013; Libersky et al., 2018; NASUAD, 2018), with close to half of states offering managed LTSS (MLTSS) in some form. MLTSS in New Jersey is available to individuals who are determined clinically eligible (requiring high levels of assistance with at least three activities of daily living) and financially eligible (must have limited assets and income).

This study examines the implications of changes in the care management function that occurred in 2014 with the transition from fee-for-service long-term services and supports provided under several federal HCBS §1915(c) waivers to managed long-term services and supports (MLTSS) under one federal §1115 waiver in New Jersey. The implications of these changes are felt by care managers, Medicaid beneficiaries, and other organizations such as providers or community based organizations who serve the same client group as do care managers. The official terminology has transitioned from "case manager" and "case management" to "care manager" and "care management" over time, so we use both. In New Jersey, both before and after the transition to managed care, case/care managers assess client needs for services, authorize services, and monitor services for adequacy. Though direct care workers such as home care or nursing home care aides spend the most time with clients (among LTSS workers), case/care managers exercise control over the types and amounts of care that clients receive.

The locus of employment for case/care managers changed from a group of about 60 county agencies, local nonprofits or small private firms to five managed care organizations (MCOs), each of which serves most of the state (though they vary in size). The content of case/care management work changed as well—MLTSS expanded care management to nursing home residents and MCOs utilize computer technology more extensively to assess, plan, and authorize care. Interviews with a variety of stakeholders yielded multiple perspectives on the effects of the move to managed care on case/care managers, the organizations they left, other organizations that work with the same client group (including MCOs), and Medicaid beneficiaries.

Methods

The authors are part of the project team contracted by the state of New Jersey to conduct an evaluation of the §1115 waiver. Since 2014, the team has monitored relevant state documents and attended a variety of stakeholder meetings where the transition to managed care is discussed. As part of the evaluation, the

team conducted 43 interviews with 78 stakeholders relating to the effects of the change to MLTSS on a variety of stakeholder groups (beneficiaries, providers, community organizations, advocacy organizations, government, and MCOs). Most interviews were over the phone, but a few were in person. There were 21 individual interviews and 22 group interviews. Interviews ranged in length from 45 minutes to nearly 3 hours, with most at around 90 minutes. All but two interviews were audiorecorded, and detailed notes were taken at each interview (by two notetakers where there was no audiorecording). The team produced two reports based on the stakeholder interviews using a grounded theory method (Charmaz, 2006) to determine overall themes (Farnham, Chakravarty & Lloyd, 2015; Farnham, Chakravarty & Lloyd, 2017). For this analysis, the authors have considered stakeholder reaction to the care management function in particular. Table 1 summarizes the interview specifics.

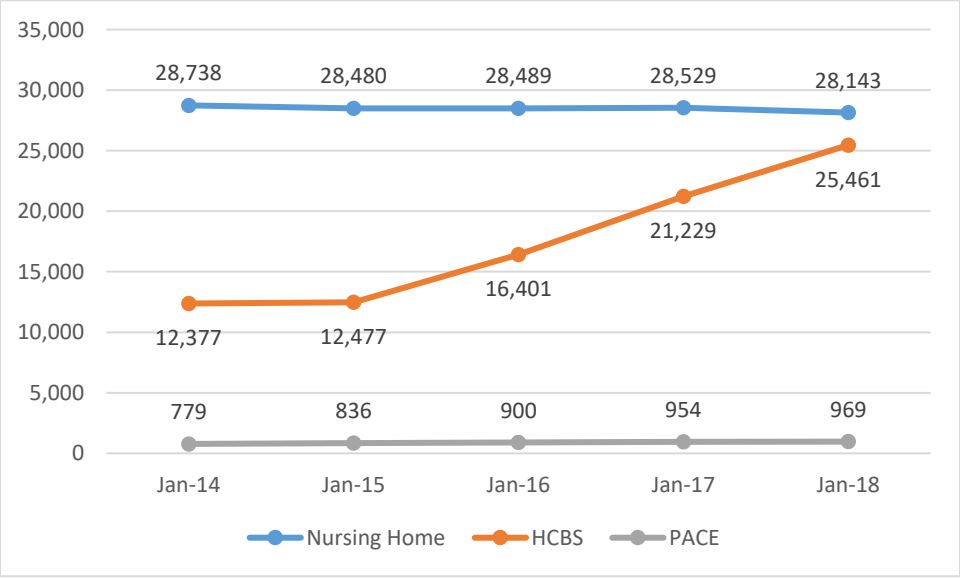
Table 1: Description of Interviews

Characteristics	**Round 1**	**Round 2**	**Total**
Time period	Feb. – Jun. 2015	Sep. 2016-Feb. 2017 (Most in Nov. & Dec.)	
Total interviews	16	27	43
Individuals included	34	69	78 (25 included in both rounds)
Group interviews	10	12	22
Size of group	2-5	2-15	
Individual interviews	6	15	21
Phone	16 (one in-person followup meeting)	24	40

Long-Term Care Beneficiaries

Figure 1 shows the number of long-term care beneficiaries in New Jersey over the past few years. The population residing in nursing homes has remained stable since 2014, while the population receiving home and community based services (HCBS) has grown substantially. New Jersey also has a limited number of Program of All-Inclusive Care for the Elderly (PACE) sites, which have grown slightly over time (most of these beneficiaries live in the community, although PACE will cover nursing home care if needed). According to our analysis of Medicaid data, as of the end of 2015, 80 percent of the new MLTSS HCBS enrollees were existing Medicaid beneficiaries, who have access to limited long-term services such as personal care and medical day care under New Jersey's regular Medicaid plan, which has been under managed care since at least 2011. Between 19,000 and 25,000 people received personal care assistance in Medicaid between 2004 and 2014 (Watts and Musumeci 2018). With the implementation of MLTSS in 2014, MCOs were likely in a better position to identify and enroll these individuals, giving them access to additional services such as home delivered meals, personal emergency response units, and care management.

Figure 1: Medicaid Long-Term Care Beneficiaries in New Jersey, 2014-2018



Source: NJ Department of Human Services, Division of Medical Assistance and Health Services, MAAC meeting Presentation, April 11, 2018. Accessed April 25, 2018 from http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_4-11-18.pdf

Transition from §1915(c) to §1115

Prior to MLTSS under the comprehensive §1115 waiver, New Jersey provided home and community-based services under four §1915(c) waivers. Table 2 shows the number of people in each of these waivers who transitioned to MLTSS. Residents of nursing facilities at the time of MLTSS implementation remain in a fee-for-service arrangement unless they have a trigger event, such as a move to another setting. The largest prior §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 330 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 2: Former Waiver Members Transitioned to MLTSS

Former Waiver	Number Transitioned to MLTSS	Percent of Total
GO (older adults)	10,949	93.2%
TBI (Traumatic Brain Injury acquired during ages 21-65)	309	2.6%
CRPD (Community Resources for People with disabilities—any age)	330	2.8%

ACCAP (AIDS Community Care Alternatives Program, any age for people with AIDS, children under 13 with HIV)	154	1.3%
Total	11,704	100%

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

Table 3 summarizes the changes in care management for Medicaid LTSS beneficiaries that occurred with the change to managed care. Residents of nursing homes receive care management under MLTSS, a service they did not receive under the prior system. This should allow support for nursing home residents to move to home and community-based settings if desired. For HCBS beneficiaries, prior to July of 2014 care management was provided by agencies that contracted with the state of New Jersey to provide case management services for a monthly fee. There were 60-100 of these agencies, compared with five MCOs that now directly employ care managers. There was no change in the care management function for those beneficiaries enrolled in PACE.

Table 3: Care Management for Medicaid LTSS Beneficiaries

Beneficiary Type	**Pre-MLTSS (before July 2014)**	**Post-MLTSS (after July 2014)**
Nursing home beneficiaries	No case management outside of nursing home	Care management provided by managed care organization (up to 240 adult or 48 pediatric special care clients) for new enrollees
Home and community based services (HCBS) beneficiaries	Case manager employed by a county agency or private nonprofit or for profit	Care manager employed by a managed care organization (up to 60 clients living in a home

	organization that contracted with the state to provide case management, for a monthly fee per client (70 clients preferred limit per care manager—not mandatory)	setting and 120 clients living in community alternative residential settings such as assisted living)
PACE (Program of All-inclusive Care for the Elderly)	Care management provided by PACE organization	Care management provided by PACE organization (no change)

Table 4 shows the diversity of agencies providing case management services prior to July 2014. When calculating agency involvement, we only count the agencies who actually provided the case management—in some cases, the state contracted with a county agency which then subcontracted the case management to other agencies. County or municipal agencies (Area Agencies on Aging, County Welfare Agencies, and one city Office on Aging) comprised 41 percent of the case management agencies and employed about half of the case managers. Nonprofit agencies, such as visiting nurses or homemaker organizations and Centers for Independent Living, comprised 26 percent of the case management agencies and employed 26 percent of case managers. Private organizations such as for-profit nursing agencies or home care firms comprised 33 percent of the case management agencies and employed 25 percent of case managers. There was some overlap of case managers among different agencies—four were listed at more than one agency (three were between different private agencies; one was listed under a county and a private agency).

County and municipal agencies provided services to individuals within one county only. Nonprofit and private agencies were more varied, with nonprofits serving individuals in one to three counties (on

average, 1.6 counties per agency) and private agencies serving individuals in one to eight counties (3.4 counties per agency, on average). While none of the nonprofit agencies served individuals in more than three counties, eight private agencies served individuals in five or more counties.

Table 4: Pre-MLTSS Agency Types, Reach, and Numbers of Case Managers

Agency Type	Number of Agencies	Total Care Managers	Average Number of Case Managers per Agency	Average number of Counties Served
County/ municipal	25 provided case management (5 under county subcontract; an additional 7 had state contracts but subcontracted case management to other organizations)	133	5	1
Nonprofit	16 (3 under county subcontract)	70	4	1.6
Private	20 (4 under county subcontract)	67	3	3.4
Total	61 provided case management (68 had state contracts)	270		

Source: NJ Department of Human Services, Division of Aging Services, 2014

Table 5 shows subcontracting arrangements prior to MLTSS implementation. In eight counties (38% of New Jersey's 21 counties, containing 47% of the state's population of people 65 and over) Area Agencies on Aging subcontracted all or a portion of their case management for HCBS waiver services to other organizations. About half of the subcontracts were to county welfare agencies, and about half to private or nonprofit agencies. There were a total of 13 subcontracting arrangements, with 3 counties

subcontracting to more than one agency. Subcontracting was associated with the size of the older adult population—six of the ten counties with the highest numbers of residents 65 and over had subcontracts, and 11 of the 13 subcontracts were in these 10 counties (American Community Survey, 2018).

When MLTSS was first implemented, one of the MCOs subcontracted its care management to a nonprofit nursing agency. However, they quickly decided it would be preferable to employ care managers directly.

Table 5: Pre-MLTSS Subcontracting Arrangements

Subcontract to	Any subcontract		Number of subcontracts
	Number of counties	Percent of counties	
Any agency type	8	38%	13
County/municipality	5	24%	6
Private agency	2	10%	4
Nonprofit agency	3	14%	3

Source: NJ Department of Human Services, Division of Aging Services, 2014

Following the transition to MLTSS, the state contracts with five MCOs (four participated during the transition in 2014 and one began providing services in early 2015). The MCOs vary quite a bit in many respects, including the proportion of beneficiaries served in various settings, MLTSS beneficiary characteristics, their overall Medicaid enrollment, their MLTSS enrollment, and the tendency for beneficiaries to file complaints or appeals against the MCO. Table 6 provides a summary of data by MCO. Two MCOs serve a majority of their MLTSS beneficiaries in home and community settings, while one MCO is mostly concentrated in nursing homes and two are more evenly split. For two MCOs, fewer than half their MLTSS enrollees in HCBS are white. One MCO has a minority of MLTSS enrollees with English as a primary language (in this case, 31% of their enrollees speak Spanish and 32% something other than English

or Spanish). The majority of MLTSS enrollees across all MCOs have a physical disability, but the share ranges from 58% to 74%. The frequency of a dementia diagnosis ranges from 11% to 28%, and the frequency of brain injury from 5% to 38%. There is variability in the extent to which MCOs' community-dwelling enrollees use wheelchairs (18%-30%) or other mobility aids (43%-62%), and whether they have a history of frequent falls (17%-29%). Finally, there is one MCO that has the largest share of both overall Medicaid and MLTSS enrollment, one that has a small share, and three that have intermediate shares. There is some variability among the MCOs with respect to self-reported complaints, appeals and grievances as well as externally reported appeals (Medicaid fair hearings)—this may reflect the population the MCO serves as well as the MCO's performance.

Table 6: Managed Care Organization (MCO)—MLTSS Settings, HCBS Beneficiaries and Enrollee Relationships

Beneficiary Characteristic	MCO A	MCO B	MCO C	MCO D	MCO E
MLTSS Enrollee Settings (January 2018)					
HCBS Setting	28%	49%	56%	46%	73%
Assisted Living	4%	9%	8%	11%	2%
Nursing Home	67%	42%	36%	46%	25%
MLTSS, HCBS Beneficiary Characteristics (sample survey October 2016-May 2017)					
Asian	4%	2%	2%	2%	22%
Black/Af. Amer.	27%	17%	19%	27%	13%
Hispanic/Latino	18%	19%	11%	13%	31%
White	44%	60%	64%	57%	27%

English as primary lang.	71%	81%	91%	84%	38%
Physical disability	65%	68%	58%	74%	67%
Dementia diagnosis	23%	21%	11%	19%	28%
Brain injury (TBI/ABI)	5%	19%	38%	22%	6%
Uses wheelchair	19%	28%	19%	30%	18%
Uses other mobility aids	55%	43%	48%	49%	62%
History of freq falls	23%	24%	18%	17%	29%
Medicaid enrollment and relationship with enrollees					
MLTSS eligible enrollees (July 2015-June 2016)	890	6,053	16,227	7,177	4,057
Overall Medicaid enrollees (2015)	8,512	210,303	833,872	492,951	58,748
MCO-reported complaints, appeals, & grievances (% of members, Jan 2015-Jun 2016)	0.1%	0.2%	0.9%	1.3%	0.6%
Medicaid fair hearing filings, 2016	minimal	101	882	566	minimal

Sources: Setting is from NJ Department of Human Services as of January 2018; HCBS Beneficiaries are from NCI-AD 2016-2017 NJ State report (2018), accessed June 26, 2018 from https://nci-ad.org/upload/state-reports/NCI-AD_2016-2017_NJ_state_report_FINAL_2.pdf (margin of error from 7-10%); MLTSS eligibles and MCO-reported complaints, appeals & grievances from MLTSS Performance Measure Report, 1/1/2017–3/31/2017; Medicaid enrollees from NJ Department of Banking and Insurance, Carrier Enrollment Reports (Calculated from 2015 quarters), accessed April 18, 2016 from http://www.state.nj.us/dobi/division_insurance/lhactuar.htm#HMOReports; Fair hearing filings accessed May 30, 2017 from http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_1_23_17.pdf and http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_10_19_16.pdf .

The work environment for case managers serving Medicaid long-term care clients changed extensively in July 2014. They began to serve nursing home residents (only new enrollees receive care management), and were employed by an MCO serving a large geographic area, rather than a small local organization. We do not know if or how the amount of territory for which specific care managers were responsible was affected by the transition (for example, care managers in a county agency prior to the transition were working within one county). Table 7 summarizes the context in which case/care managers operated before and after the transition to managed care, with respect to the employment environment, the external environment, and job requirements.

Table 7: Case/Care Manager Context Before and After MLTSS

	Pre-MLTSS (before July 2014)	**Post-MLTSS (after July 2014)**
Employment environment		
Organizational location	• County agency (Area Agency on Aging, County Welfare Agency)	MCO

	• Private nonprofit (Center for Independent Living, nonprofit home care organization) • Private company (home care organization)	
Number of organizations employing care managers	61	5 MCOs
Integration with acute health services	None	MCO that employs care manager also covers acute services, allowing some opportunity for care managers to search for providers or assist beneficiaries in obtaining care
Integration with behavioral health services/supports	Limited in most cases, though some case managers were employed by agencies providing some level of support	MCO that employs care manager also covers behavioral health services, allowing some opportunity for care managers to search for providers or assist beneficiaries in obtaining care
External environment		
Reimbursement for care management	About $200 initial month/$95-$125 subsequent (per person per month)	Part of overall capitated fee for all LTSS services

to employing organization		
Quality monitoring	Employing agency, state agency	MCO, state agency, external quality review organization
Service authorization/Util-ization management	County or private waiver agency and private home care agencies (for personal care hours) with approval by state staff	MCO
Subcontracting of case/care management	38% of counties subcontracted case management to other government (24%), nonprofit (14%) or private (10%) agencies	No subcontracting (one MCO tried briefly initially, then brought all care management in-house)
Job requirements		
Required credentials	RN, licensed social worker, or bachelor's degree plus one or more years' experience with population (less than bachelor's may substitute experience)	Same except no provision for those with less than bachelor's degree.
Required client contact	By phone at least once per month, quarterly in person visits (at least two per year in residence)	At least every 90 days for people in community setting (at least two visits per year must be in residence); at least every 180 days for members in

		nursing facilities or alternative residential (such as Assisted Living)
Use of technology in job	Mixed	Required
Interaction with clients not yet on Medicaid	In some cases, provided information and referral regarding clinical and financial eligibility, and possibly support during the application process in communicating with county and state assessment staff to clarify information relevant to the determination. Clients served by state-funded HCBS often stayed with the same agency when transitioning to Medicaid waiver.	None
Determination of aide hours for beneficiaries	Depending on type of client benefit, done by care manager or by by nurse at home care agency with approval by state agency	Done by MCO care manager or MCO nurse, if care manager is not a nurse
Calculation of beneficiary cost share for services	Waiver agency case manager	County welfare agency does as part of eligibility calculations

Stakeholder assessment of the effects of care management changes with MLTSS

Our evaluation reports examine broad stakeholder views of the effects of the implementation of MLTSS on a variety of stakeholders (Farnham, Chakravarty & Lloyd, 2015; Farnham, Chakravarty & Lloyd, 2017). With respect to care management, interviewees discussed their perceptions of the effects of MLTSS on care managers themselves, on the mix of professionals employed as care managers, on other organizations working with the same beneficiary groups, and on beneficiaries.

Effects on care managers

Care manager opportunities and work environment. The transition to MLTSS meant a shift from 61 small, local organizations to five MCOs (two of which operated statewide in 2014, increasing to four operating statewide in 2018). In some cases this may have limited the number of organizations for which care managers could work—prior to MLTSS, 11 of New Jersey's 21 counties had six or more organizations providing case management. However, we did not hear comments from stakeholders about this. We heard varying accounts of how care managers fared in the transition from prior care management organizations. One former employer of care managers felt that salaries and promotion opportunities for care managers had increased, particularly for those who wanted to seek a management role. Another former employer of care managers felt that, while salaries had increased significantly for care managers at MCOs relative to the smaller organizations that had employed them previously, their workload and responsibilities had also increased, and that the culture was more oriented toward minimizing costs (i.e., service use) as opposed to trying to meet client needs. A provider of specialized services serving beneficiaries who had utilized one of the smaller waivers that transitioned to MLTSS noted that some care managers seemed ill-prepared initially to serve the needs of these beneficiaries, noting that they seemed overwhelmed--one so much so that she cried in his office. Over time, he and several of his fellow providers felt that they were able to build successful collaborative relationships with the care managers and

appreciated the improved access to specialists gained through MCO networks with MLTSS. One interviewee from an advocacy organization who interacted with a variety of MCOs felt that the culture differed by MCO, with some being more oriented toward cost minimization and others having a strong emphasis on individualized care planning (for example, taking care to assist beneficiaries transitioning from institutional to community settings in providing their new dwelling with items that would make them feel at home, such as bedding with their favorite sports team logo and food that they liked). This interviewee felt that care managers seemed happier in MCOs that emphasized individualized care planning.

We heard some comments about the effects of technology—from a state official, we heard that some care managers were not able to adapt to the job requirements in MCOs of using technology for tasks like clinical assessment and care planning. A provider described confusion by care managers at using technology, which led to problems with provider authorization and payment.

Professional mix. Some interviewees felt that the MCOs sought to hire registered nurses for care management positions to a greater extent than the former agencies had, because of a change in work organization where care managers under MLTSS had the responsibility of calculating personal care aide hours. The state Board of Nursing requires that this calculation be done by a nurse. Prior to MLTSS, the nurse supervising the home care aide at the home care agency would calculate the necessary hours, subject to state agency approval. One MCO told us they were seeking mostly nurses for care manager positions because of that requirement, and that a shortage of registered nurses made this challenging. Other MCOs acknowledged the requirement of the nurse to do the aide hours assessment, but felt that they were able to utilize social worker care managers, either pairing them with a nurse when necessary or having them focus on cases that did not require the calculation of hours.

Effects on other organizations

Former case management organizations. The organizations that employed case managers under the former waiver system generally continued to exist after the implementation of MLTSS. Many of the people who had worked as waiver case managers became care managers at the MCOs, but some remained with their organization and transitioned their work duties. We heard a few expressions of relief from some who had worked as waiver case managers with respect to being free of the administrative burdens and more able to focus on counseling their beneficiary group. However, some in this category also seemed a bit frustrated, feeling that they had less influence over who was determined clinically eligible (this did not have to do with managed care per se, but rather a change in state division of labor in triaging and referring for clinical examinations). Interviewees at some organizations who continued to serve beneficiaries in other capacities felt that they were still doing the work they had done as case managers, but that they were no longer compensated for it. This was because the MCO care manager would contact them regarding information and resources for the beneficiary.

MCOs in the social safety net. There was also a question of how the MCOs fit into the network of local social service providers. One MCO reported a strong emphasis in searching out care managers who had a documented history as part of the communities they would be serving. However, some advocacy interviewees thought that many of the MCO care managers with whom they interacted appeared less invested in their local network than had the former case managers. County-based financial eligibility staff, who are responsible for making yearly redeterminations of Medicaid eligibility in order to authorize continued enrollment, were familiar with the former case managers and the organizations employing them when the system was largely county-based, and would utilize their connections to inquire with case management organizations when they had difficulty contacting beneficiaries to verify eligibility. After the transition, they reported having trouble connecting with MCO care managers and feared that beneficiaries were dropped from Medicaid as a result. There were efforts mentioned on the part of MCOs

and local social service providers to integrate MCO care managers into the local social safety net. In one county, a county-based organization reached out to the MCOs to invite representatives to meetings of organizations serving MLTSS-related beneficiary groups, and reported that the MCOs were generally responsive to this, and that they were hopeful that some of the former connections could be restored. In a steering committee meeting nearly three years after implementation, attended by representatives of a variety of stakeholder groups, the MCOs were charged with presenting a success story. One focused on the MCOs efforts to build the social safety net in the areas the MCO served, by working with other organizations in local communities where their care managers identified gaps for beneficiaries. So, it seems possible for MCOs to participate in and even enhance the social safety net in the communities where they operate, if their management identifies this as important and allocates resources.

Access and quality. As noted earlier, some organizations working with beneficiaries appreciated improved access to specialists that they felt was due to the care manager having connections with the MCO. A state official anticipated improved ability to do quality monitoring given the smaller number of organizations involved. State officials mentioned having frequent discussions with groups of care managers, which is probably easier given the smaller number of organizations now involved (5 compared with 68). However, providers whose clients had a larger number of beneficiaries per care manager felt in some cases that care managers were not active enough with their client groups, as noted by our interviewees, and exemplified by Ryan (2016): "*the MCOs have not been able to accomplish any sustained consistency in their case management function, particularly for beneficiaries who reside in settings such as assisted living, nursing homes and special care nursing facilities. Providers report that the case managers do not make themselves known to the facility, are only sparsely involved in care planning at the facility, are not familiar with the enrollees' needs and do not share the MCO's care plan. This makes it very difficult, if not impossible, for providers to let a case manager know when there has been a change in an enrollee's status."*

Effects on beneficiaries

Access to Medicaid long-term care benefits. Most interviewees, even those who were doubtful about the adequacy of managed care, seemed to feel that access to Medicaid long-term care benefits was increased under MLTSS because of the single program and increased awareness. State officials enhanced screening procedures for agencies receiving Older Americans Act funding as well as the state information and referral hotline for disability-related inquiries. Fair hearing documents showed that under the former waiver system, people with mental illness or developmental disabilities were excluded from some waivers (a stipulation of specific populations served was required for waiver approval), which is not the case with MLTSS (Gorman, 2013; Harr, 2013).

Ease of access differs depending on whether beneficiaries are already enrolled in Medicaid. For people already enrolled in Medicaid, access is probably easier after the transition to MLTSS, as the MCOs can identify people who are using state plan LTSS such as personal care services or medical day care, or who fit other parameters, and assign a care manager who determines their clinical eligibility and authorizes services. The route to access MLTSS for people new to Medicaid is similar to the prior system. They must undergo a financial eligibility determination by their county welfare agency, including a detailed examination of their past five years of financial activity, to ensure that they have not transferred assets that could have been used to pay for their care. The §1115 waiver streamlined eligibility for most applicants below the poverty line[1] and allowed those above the income cutoff to set up a qualified income trust to send their income above the cutoff amount to the state while still qualifying for MLTSS (not for other forms of Medicaid), changes which should improve access. Applicants must also undergo a clinical

[1] SSI beneficiaries now have to declare that they have not made a transfer of money in order to be eligible, which was not the case prior to MLTSS, when confirmation of their SSI eligibility was sufficient to meet the financial eligibility criteria.

eligibility determination by a state-employed assessor. Once they have been determined eligible on both counts, their MCO enrollment will begin at the beginning of either the next month or the following month, depending on the cutoff date, which varies by month. Upon MCO enrollment, a care manager is assigned and can determine service needs. Some interviewees noted that prior to MLTSS, access to a case manager could begin immediately upon completed eligibility determination (we do not know the extent to which this happened, and stakeholders noted that in the months prior to MLTSS, care management organizations had difficulty staffing because of hiring and training by the MCOs).

Access to provider network. Because of the integrated nature of MLTSS, beneficiaries can ask their care managers for help with their acute or behavioral health needs as well as their long-term care needs, something the former waiver case managers were not in a position to do (except to try to call as a person not affiliated with providers through a contract).

Benefits and potential drawbacks of increased flexibility. The managed care aspect of MLTSS requires MCOs to provide care for beneficiaries, even if they have to enter into a special case agreement to do so. This allows MCOs more flexibility than the prior fee-for-service system, where a statewide rate schedule was developed and providers either participated or didn't—if there were no participating providers, beneficiaries did not get the service. Stakeholders reported an early MLTSS success story in a case where a beneficiary had not been able to find a service because the state rate was too low for their level of care needs. Once the individual transitioned to MLTSS, their MCO recognized that it was in its interest to give the beneficiary the needed service, and they found a provider and negotiated a rate that was much higher than the standard state rate for that service, but still comparable to or lower than the alternate options which were not preferred by the beneficiary or their family.

In some cases, rates may come down under managed care, which appears to have happened with respect to standard MCO contract rates for personal care aides, according to interviews and press reports

(Kitchenman, 2014). Some interviewees felt that this has exacerbated the pre-existing and nationwide shortage of personal care staff (Ochsner, Leana, & Appelbaum, 2009; Osterman, 2017; Stone, 2004; Thomas & Applebaum, 2015).[2] Other interviewees noted that MCOs were able to find agencies/aides in geographic areas that had been historically difficult to staff. MCOs told us they executed single case agreements when necessary to provide services. However, discussion at some meetings seemed to imply that many stakeholders accepted the idea that some geographic areas were impossible to staff. One interviewee told us of a person who came to the attention of local emergency responders because of a lack of needed services—they found that the person was enrolled in MLTSS but had apparently been told that there was no one to serve their area. There is a state quality office that intervenes in such matters with the MCOs, but the beneficiary did not learn of this until after the emergency response involvement, raising questions about whether vulnerable populations have the capacity to advocate for themselves when necessary.

It should be noted that beneficiaries (under both MLTSS and the prior waivers, as well as many regular Medicaid recipients) are able to hire their own direct support staff if they wish to do so, and that the state provides a fiscal intermediary service to handle administrative functions like payroll. The beneficiary's budget is determined by the number of personal care hours authorized by the care manager, at the state-approved rate. The beneficiary can decide to pay a higher rate, which would result in fewer service hours to accommodate the higher cost. This consumer directed system offers the benefit of

[2] In addition to the issue of rates, there were increased requirements in state regulations of agencies providing home care services and a requirement that all home care assistance be provided by certified aides, both of which likely will increase agency costs (Kitchenman, 2013; Kitchenman, 2014; NJ Division of Consumer Affairs, 2015; NJ Division of Consumer Affairs, 2018).

flexibility to the beneficiary, but also imposes the responsibility of hiring and locating alternate support if their staff person is unable to work.

Utilization management. Some consumer advocates were concerned about service minimization or attempted service reductions under managed care. The first MCO contract implementing MLTSS required MCOs to report to the state any reductions in services to beneficiaries who transitioned from the prior waivers, but MCOs argued that they did not have sufficient information to do so. Under the prior system there was no financial incentive to minimize or reduce services to beneficiaries—agencies received a flat monthly fee per person for each beneficiary managed.[3] There were norms, which researchers heard expressed strongly, that people shouldn't get more services than they need. Tools existed before and after the transition to assist in determining needs, though advocates felt they were more strictly adhered to after MLTSS implementation, and that MCOs viewed them as maximums rather than minimums, as the advocates viewed them. Interviews and Medicaid fair hearing documents showed that attempted service reductions did happen, and could be extremely stressful for beneficiaries and their families. Advocates working with Medicaid managed care beneficiaries in New Jersey expressed frustration with medical necessity language used to deny non-medical services. However, fair hearing documents also showed that beneficiaries weren't always getting the services they were supposed to get under the prior system (one beneficiary assessed to need 56 hours of personal care had difficulty keeping staff, and the former waiver providers had not been able to provide all of those hours—the MCO provided the hours but then reduced them (Bass, 2016)).

Relationship with care manager. Consumer advocates expressed some concern that beneficiaries who had been on the smaller waivers previously had care managers who were experienced in working with the

[3] There was also a service cost limit—care managers had to seek approval from the state to exceed the limit. Costs were paid by the state to the agencies providing the services.

specific populations that were the prior waivers' focus. With MLTSS mostly serving older adults, some were concerned that younger beneficiaries were somewhat lost in the shuffle. As mentioned earlier, some providers of LTSS to mostly younger beneficiaries expressed concern early in the transition about the lack of knowledge in care managers assigned to their clients. In the second round of interviews about two years later, this concern had decreased. Among former case managers who still interacted with their client group, results in the latter set of interviews were more mixed and seemed to depend on the MCO or the individual care manager, with some interviewees reporting excessive turnover and/or inappropriate referrals (e.g., the care manager suggesting assisted living when the beneficiary's level of care needs would be too high for that setting, or suggesting nursing homes without trying to figure out how to make things work for the beneficiary in the community). One interviewee mentioned that MLTSS involved another level of oversight for the parent of a beneficiary who received services from the school district and Medicaid—under the prior system, her case manager had been employed by the same organization that provided her child's private duty nursing services, and had thus been easily informed about how her child's care was proceeding. Under MLTSS, the parent was reporting to the school, the private nursing agency, and the care manager, and felt that her burden had increased.

A state official noted that past rules had required waiver case managers to have monthly contact with beneficiaries in order to bill for care management services and that this had been reduced to quarterly meetings with MLTSS; a consumer advocate noted that the former monthly contact may not have actually happened in all cases.

A change in task allocation meant that redeterminations of beneficiary cost share requirements were done by the county welfare agency staff who process financial eligibility documentation, rather than the care manager. County welfare agency staff indicated that their greater scrutiny of medical expenses and requirements for documentation came as an unpleasant surprise for beneficiaries accustomed to handling these matters through their case manager.

Discussion

Our interviews, meetings attended and review of documents showed that there were a number of changes to the case/care management function with the transition of long-term services and supports (LTSS) in New Jersey's Medicaid program from 60-100 small, local organizations to five managed care organizations (MCOs) that operate over most or all of the state (the program is referred to as MLTSS, or managed long-term services and supports).

Most stakeholders seemed to agree that the change to MLTSS increased access to LTSS for consumers—not just because of managed care (where access is facilitated among people already enrolled in Medicaid because MCOs can identify and transition them to MLTSS, and have more of an incentive to do so), but because of the simplification of having a single program and a number of administrative changes made by state officials that improve screening and referrals for the public, reduce the administrative burden for many applicants below the poverty line, and allow higher income individuals to access home and community-based services rather than just nursing home care. Enrollment among beneficiaries using home and community based services has increased significantly after implementation of MLTSS, creating demand for care managers.

Several interviewees indicated improved salaries and promotion potential for care managers under MLTSS. Benefits to clients, other organizations serving clients, and care managers' work due to the integration of long-term, acute and behavioral health services under the MCO were also noted. The increased requirement of use of technology, change in responsibilities, and increased geographic coverage area by care managers in MCOs was difficult for some former waiver case managers.

The most frequent concerns expressed by stakeholders about MLTSS relate to what some fear are potential negative consequences due to altered financial incentives and/or of a different institutional logic (Thornton & Ocasio, 2008) under managed care where cost minimization is a priority, a medical

perspective dominates assessment and care planning, and integration of medical services is pursued over integration with social or community services.

It is important to note that there was significant organizational diversity both before and after the transition to MLTSS. Prior to the transition, case management was handled in a variety of types of organizations—county government (Area Agencies on Aging and County Welfare Agencies), municipal government (City Office on Aging), nonprofit organizations (Centers for Independent Living, faith organizations, home care organizations) and private companies (home care and private nursing services). Some interviewees reported long-tenured case managers who were skilled, caring, and well connected with their communities. However, there were also indications of trouble among some organizations in hiring additional staff when necessary, particularly in the months leading up to MLTSS. The lack of integration of behavioral health also meant that some Medicaid clients were not able to be enrolled in waiver services. The number of contracts and subcontracts involved meant that the state had to oversee quality in a large number of organizations. LTSS providers enrolled through the state and were paid a uniform state rate for each service. Case management organizations were paid a flat fee for each case, but did not have the network responsibility of MCO to provide necessary services by recruiting providers (nor did they benefit by reducing costs).

After the transition to MLTSS, care management is handled by five MCOs (the largest is nonprofit and serves only New Jersey; the four others are for-profit organizations that operate in multiple states). Beneficiaries have the opportunity to choose and change their MCO. Survey and administrative data show that the MCOs vary quite a bit in the types of beneficiaries they serve and the settings in which they serve them. Interviewees noted a variety of cultures across MCOs, with some emphasizing cost minimization and others person-centered care and a commitment to participating in the social safety net in local communities in addition to integrating long-term, acute and behavioral health care. MCOs are all subject

to quality monitoring and minimum loss ratios to ensure that they spend their capitated revenues on services for beneficiaries.

There has long been discussion of the framework of care delivery for people with disabilities, with advocates supporting a social model where consumers decide what services and supports are needed as opposed to a medical model where credentialed professionals determine needs (Gill 1994; Jackson 2018; Oliver 2013; Thomas 2004). A recent study comparing Area Agencies on Aging and Independent Living Centers in a state that was attempting to integrate them into Aging and Disability Resource Centers (New Jersey was a contemporaneous program grantee) found that they were still guided by different professional logics (Keefe, 2018). So, this issue transcends managed care. Where MCO management, state officials, and quality management organizations facilitate a supportive organizational culture, care managers can implement integrated, person-centered and community-based care (You, Dunt, & Doyle, 2016).

Funding

Evaluation of the §1115 Medicaid waiver was funded by the New Jersey Department of Human Services and the Robert Wood Johnson Foundation. The New Jersey Department of Human Services was given an opportunity to review this paper; however, opinions expressed herein are those of the authors and do not necessarily represent the view of the New Jersey Department of Human Services.

References

American Community Survey. (2018). 2010-2014 5-Year Estimates, Table S0103, Population 65 Years and Over in the United States. U.S. Census Bureau, accessed June 26, 2018 from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S0103&prodType=table

Austin, C.D., McClelland, R.W., & Guransky, D. (2006). Linking Case Management and Community Development. *Care Management Journals 7*(4): 162-168.

Bass E. (2016). *Initial Decision, OAL Dkt. No. HMA 20718-15, BR v. United Healthcare*. Accessed April 3, 2017 from https://njlaw.rutgers.edu/collections/oal/html/initial/hma20718-15_1.html

Burwell, B. & Saucier, P. (2013). Managed Long-Term Services and Supports Programs Are a Cornerstone for Fully Integrated Care. *Generations* 37(2):33-38.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. Thousand Oaks, CA: SAGE Publications.

Farnham, J., Chakravarty, S., & Lloyd, K. (2017). *Stakeholder Feedback on Implementation of the Managed Care Expansion in Long-Term Services and Supports (Second Round).* New Brunswick, New Jersey: Rutgers Center for State Health Policy.

Farnham, J., Chakravarty, S., & Lloyd, K. (2015). *Initial Stakeholder Feedback on Implementation of the Managed Care Expansion in Long-Term Services and Supports.* New Brunswick, New Jersey: Rutgers Center for State Health Policy.

Gill, C. J. (1994). A Bicultural Framework for Understanding Disability. *The Family Psychologist* (Fall):13-16.

Gorman, B. (2013). *Initial Decision, OAL Dkt. No. HMA6884-13* (C.A., Petitioner, v. Division of Medical Assistance and Health Services, Respondent). State of New Jersey, Office of Administrative Law. Accessed June 25, 2018 from https://njlaw.rutgers.edu/collections/oal/html/initial/hma06884-13_1.html .

Harr, V. (2013). *Final Agency Decision, OAL Dkt. No. HMA6884-13* (C.A., Petitioner, v. Division of Medical Assistance and Health Services, Respondent). State of New Jersey, Office of Administrative Law. Accessed June 27, 2018 from https://njlaw.rutgers.edu/collections/oal/final/hma06884-13_1.html

Jackson, M. A. (2018). Models of Disability and Human Rights: Informing the Improvement of Built Environment Accessibility for People with Disability at Neighborhood Scale? *Laws* 7(1):10.

Kane, R.A., Penrod, J. D., Davidson, G., Moscovice, I. & Rich, E. (1991). "What Cost Case Management in Long-Term Care?" *Social Service Review* 65(2): 281-303.

Keefe, B. (2018). Can a Unified Service Delivery Philosophy Be Identified in Aging and Disability Organizations? Exploring Competing Service Delivery Models Through the Voices of the Workforce in These Organizations. *Journal of Aging and Social Policy* 30(1):48-71.

Kitchenman, A. (2014, December 8). "Home Health Agencies Want Warning before Reimbursement Cuts." *NJ Spotlight*. Accessed June 25, 2018 from http://www.njspotlight.com/stories/14/12/07/home-health-agencies-want-warning-before-reimbursement-cuts/

Kitchenman A. (2014, July 3). "Bill Would Tighten Oversight of 'Companion Services' for Elderly." *NJ Spotlight*. Accessed July 24, 2018 from http://www.njspotlight.com/stories/14/07/03/bill-would-tighten-oversight-of-firms-that-offer-companion-services-to-elderly-disabled/

Kitchenman A. (2013, September 3). "Debate Centers on Regulation and Oversight of Home Healthcare Services." *NJ Spotlight*. Accessed July 24, 2018 from http://www.njspotlight.com/stories/13/09/04/debate-centers-on-regulation-of-home-healthcare-providers/

Libersky, J, Liu, S., Turoff, L., Gellar, J., Lipson, D., Collins, A., Li, J. & Irvin, C. (2018). *Managed Long-Term Services and Supports* (Medicaid 1115 Demonstration Interim Evaluation Report). Princeton, NJ: Mathematica Policy Research.

NASUAD (National Association of Status United for Aging and Disabilities). (2018). MLTSS Map. Washington, DC. Accessed June 25, 2018 from http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/mltss-map

National Association of States United for Aging and Disabilities (NASUAD) and Human Services Research Institute. (2018). National Core Indicators – Aging and Disability Adult Consumer Survey: 2016-2017 New Jersey Results. https://nci-ad.org/upload/state-reports/NCI-AD_2016-2017_NJ_state_report_FINAL_2.pdf

NJ Division of Consumer Affairs. (2018, May 21). 50 New Jersey Register 1292(a). Accessed July 24, 2018 from https://www.njconsumeraffairs.gov/Adoptions/dirado_05212018.pdf

NJ Division of Consumer Affairs. (2015, November 30). "Changes in the Law Governing Health Service Firms." Accessed July 24, 2018 from https://www.njconsumeraffairs.gov/hcservice, linking to https://www.njconsumeraffairs.gov/hcservice/Documents/Changes-in-the-Law-Governing-Health-Care-Service-Firms.pdf

Ochsner, M., Leana, C., Appelbaum, E. (2009). Improving Direct Care Work: Integrating Theory, Research and Practice. White Paper: Alfred P. Sloan Foundation.

Oliver, M. (2013). The social model of disability: thirty years on. *Disability & Society* 28(7): 1024-1026.

Osterman, P. (2017). *Who Will Care for Us? Long-Term Care and the Long-Term Workforce*. New York: Russell Sage Foundation

Ryan E. A. (2016, August 11) NJHA Comments on the NJ FamilyCare 1115 Comprehensive Waiver Demonstration Application for Renewal. Accessed March 23, 2017 from https://public.medicaid.gov/gf2.ti/af/328098/40881/PDF/-/NJHA_Comments_on_CMW_renewal_application_final_aug_2016.pdf

Stone, R. I. (2004). The direct care worker: the third rail of home care policy. *Annual Review of Public Health* 25: 521-537.

Thomas, C. (2004). How is disability understood? An examination of sociological approaches. *Disability & Society* 19(6):569-583.

Thomas, K. & Applebaum, A. (2015). Long-term Services and Supports (LTSS): A Growing Challenge for an Aging America. *Public Policy & Aging Report* 25(2):56-62.

Thorton, P. H. & Ocasio, W. (2008). Institutional Logics. In Greenwood, R., Oliver, C., Sahlin, K. & Suddaby, R. (Eds.) *The SAGE Handbook of Organizational Institutionalism*. Thousand Oaks, CA: SAGE Publications.

Watts, M. O. & Musumeci, M. (2018). *Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies* (Report). Menlo Park, CA: The Henry J. Kaiser Family Foundation.

You, E.C., Dunt, D, & Doyle, C. (2016). Influences on Case-Managed Community Aged Care Practice. *Qualitative Health Research* 26(12) 1649–1661.

Author Biographies

Jennifer Farnham is a Senior Research Analyst at Rutgers Center for State Health Policy, in the Institute for Health, Health Policy and Aging Research in New Brunswick, New Jersey (USA). Her research focuses on health systems, policies, and practices with respect to treatment of people with chronic health issues.

Sujoy Chakravarty is an Assistant Research Professor and Health Economist at the Rutgers Center for State Health Policy. His research examines Medicaid policies relating to healthcare delivery and financing; effect of market competition and ownership in hospital markets; and health system factors related to racial/ethnic disparities in care and outcomes.

Kristen Lloyd is a Senior Research Scientist at Rutgers Center for State Health Policy, in the Institute for Health, Health Policy and Aging Research in New Brunswick, New Jersey (USA). She evaluates health

system performance improvements in NJ's Medicaid program and investigates environmental determinants of obesity among urban youth.