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Stakeholder Feedback on Implementation of the Managed Care Expansion in Long-Term Services and Supports (Second Round)

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Executive Summary

In July 2014, New Jersey brought four §1915(c) home and community based services (HCBS) waivers into managed care with its comprehensive §1115 demonstration waiver, creating the program in managed long-term services and supports (MLTSS). As of March 2017, the state reported that 43% of the Medicaid long-term care population was in HCBS, up from about 28% in August of 2014.

This report is part of Rutgers Center for State Health Policy's evaluation of the demonstration waiver, and is designed to describe the viewpoints of stakeholders regarding managed long-term services and supports (MLTSS). It is based on two sets of interviews with a variety of stakeholders as well as review of program-related documents and observation of meetings relating to MLTSS.

A total of 78 individuals participated in either individual or group interviews between the two rounds of interviews. From September 2016 through February 2017, 27 interviews were conducted with 69 people. From February to June of 2015, 16 interviews were conducted with 34 individuals (reported in Farnham, Chakravarty & Lloyd 2015). We also had shorter informal conversations with a handful of additional individuals.

Interviewees included representatives of state agencies involved in MLTSS implementation, managed care organizations participating in MLTSS, advocacy groups for older adults and younger people with disabilities, providers of LTSS and their provider associations, and agencies or associations of agencies that work with MLTSS enrollees in a variety of contexts and in some cases provided case management services under the former §1915(c) waivers (e.g., county welfare agencies, Area Agencies on Aging, Centers for Independent Living and Special Child Health Case Management).

Our report includes a detailed examination of the stages through which consumers pass as they access services through MLTSS, with a discussion of stakeholder views of each stage (sections 1.1-1.7).

We noted some improvements in stakeholder perceptions from the first to the second round of interviews, including care management, the duration of MCO service authorizations, relations between consumers and county welfare agencies, relationships between MCOs and other community resources, and the development of the Supports Plus Private Duty Nursing option so that consumer enrolled in Division of Developmental Disabilities programs do not have to disenroll from those programs in order to obtain private duty nursing. However, stakeholders still feel that many of these areas have an ongoing need for additional improvement.

We found a variety of perspectives that pointed to a number of potential advantages and disadvantages thus far with the implementation of MLTSS when compared with the prior fee-for-service waivers, as well as a number of concerns. Some of the disadvantages and concerns are not due to managed care per se but are rather related to general system design issues. These perceptions could, and likely will, change as the system matures in New Jersey, as we know that many of the disadvantages or areas of concern are being reviewed for improvement.

Perceived Advantages of MLTSS

- Increased inclusivity, particularly for people with behavioral health conditions and developmental disabilities.
- Improved screening for eligibility, resulting in more referrals.
- Integration of physical, long-term and behavioral health care.
- Removal of waiting lists or the need to reserve waiver slots.
- More visibility of MLTSS with a single program and attention to the system change, leading to more referrals.
- More people enrolling, as shown by an increase in numbers of enrollees as well as the percentage of the Medicaid population enrolled in MLTSS.
- Easier navigation and administration with a single list of services.
- Care management for members in nursing homes.
- MCOs are required to provide care, by increasing rates if necessary, a feature not available in a fee-for-service system. However, advocacy may be necessary to notify the MCO that a consumer has not been able to access services, which can be difficult to muster in populations that have both financial constraints and health problems.

Perceived Disadvantages of MLTSS

- Potential longer wait for services due to the requirement that MCO enrollment only occur on the first of each month (it is unclear what the difference is in practice as there could have been delays for other reasons before).
- Uncertainty for those who transitioned from the prior waivers and had their care management organization change (relevant only during the initial transition).
- Administrative burdens, rate decreases, and payment delays for providers.
- Coordination of benefits problems, which have complicated billing and caused payment delays.
- Service reductions or more difficulty obtaining equipment or supplies due to increased utilization management.
- Less frequent required contact with care manager.
- Capitated rate setting, which is more complicated than rates for individual services.

Areas of Question/Concern

- The role of the state in oversight and management—while stakeholders noted a high level of appreciation for state responsiveness, they sometimes thought the state should increase efforts to talk with stakeholders in addition to MCOs, identify systemic issues, and pursue corrective action against MCOs (such actions are generally not public information).
- Transparency—stakeholders were concerned that capitated rate information and detailed quality data, including information on service reductions, is not generally available.
- PCA tool—while stakeholders were pleased to have a standard assessment tool for personal care assistance services, there are concerns about the validity of the guidelines in the tool and the way the tool is implemented by MCOs.
- Current MLTSS legal/economic environment—stakeholders were concerned with a lack of regulatory clarity, financial incentives that they did not believe were aligned with care objectives, and what some perceive as a lack of a true free market among the MCOs because one of them is quite dominant.
- Care management—stakeholders agree that care management is the foundation of MLTSS and have concerns about turnover among care managers, the scope of care manager activities (which some perceive to be smaller under MLTSS than the prior waivers), and a lack of person-centered care planning that some stakeholders have observed in some cases.
- Delivery system issues—stakeholders are concerned about system fragmentation that remains due to many contacts needed for enrollees new to Medicaid, a delay before MCO enrollment, lack of payer data integration when enrollees are also served by Medicare or

private insurance, and a perceived lack of incorporation of provider knowledge in care planning or service improvement. They are also concerned with the level of certification required for MLTSS care managers and agency-employed aides, which some feel has increased unnecessarily. Finally, there are concerns about the position of MLTSS in the social safety net, with care management taken out of social service agency settings and put into MCOs—while there has been more health services integration this way, there have been some questions about integration with local social services and whether that has declined.

To some degree, perceptions vary by stakeholder role. Providers feel negatively impacted in several ways—rate decreases, payment delays, and the increased administrative burden of working with 5 MCOs instead of one single state payer. Providers and advocates sometimes feel that state staff don't include them enough in system discussions, or that state staff defer to MCOs on matters where they feel the state should take a more active role. We did hear positive mention of MCOs helping locate specialized acute care providers for members served by specialized long-term service providers.

Advocates, though generally pleased with the changes listed as advantages above, encounter people who are having problems with MLTSS and detailed many issues with still-fragmented systems, service reductions and gaps, lack of proper care management, lack of data-sharing and transparency, and to some degree the lack of advocate involvement in stakeholder and policy discussions.

MCOs reported being generally satisfied with their relationships with the state and others. Together with advocates, they think that the fair hearing process is too lengthy. Some find the requirement that a nurse must conduct some types of assessments to be limiting in terms of the staff they can utilize and would prefer to see more social worker involvement. Some would like faster feedback about quality initiatives to allow them to address any problems in a more timely way.

State staff are determined to make the program work with the resources they have available and remain committed to a philosophy of continual improvement. Advocates and providers generally seem to feel that problems that they identify to state staff are addressed and usually resolved, but in many cases feel that there was too much effort expended on their part and that the average consumer, particularly the vulnerable populations that tend to be receiving MLTSS, would not be able to mount such efforts on their own. Advocates and providers seem to feel that state staff are not particularly receptive to listening to issues that stakeholders feel may be a potential or future problem, unless they become actual problems. Regarding comments by

providers and advocates that state staff meet more often with MCOs than other stakeholders, MLTSS-related staff note that they are charged with regulating MCOs and thus need more time with them. They feel that they offer avenues for providers and advocates to communicate; however, providers and advocates often seem to feel that these avenues are not sufficient to have thorough discussions. Advocates and providers were generally pleased with a quality subgroup to the MLTSS Steering Committee established in late 2016 and early 2017 to discuss moving beyond the any willing provider arrangement for nursing homes.

All stakeholders feel that data that might provide answers to some advocates' concerns about how quickly people are able to access services, gaps in services, and participants' well-being have been slower in coming than is desirable. The state continues to work to address such questions. Experts have noted the difficulty of measuring quality in LTSS, so New Jersey is not unique in experiencing this issue (Thomas and Appelbaum 2015).

Overall, our stakeholder interviews provided anecdotal examples of enrollees who were better off under MLTSS than under the prior waiver system as well as enrollees who were worse off under MLTSS. Interviewees discussed different cultures in different MCOs as well as different experiences within the same MCO depending on the staff involved. It is clear there is a potential for greater flexibility in provider rates with MLTSS than under a fee-for-service system, but concerns about LTSS workforce adequacy have persisted. Some stakeholders are concerned about the incentive that MCOs have to minimize costs and utilization, even with the medical loss ratio requirements in the contract. Though there appears to be more oversight of the MCOs than there was under the previous system, transparent quality data has been difficult to develop (something that affects all states utilizing MLTSS, as noted in Dobson et al. (2017)), which is of concern to many stakeholders.

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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 demonstration 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) and setting (community, facility, etc.), 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 enrollees¹ and meet other requirements,² 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, and even within an MCO, based on the particular providers the patient is using or the MCO staff with whom the enrollee interacts.

Rutgers Center for State Health Policy (CSHP) was contracted by the New Jersey Department of Human Services to evaluate the demonstration. CSHP has published two reports thus far that relate at least in part to the managed care expansion into LTSS services: one regarding initial stakeholder feedback on MLTSS (Farnham, Chakravarty & Lloyd 2015) and an interim evaluation report analyzing the effect of the waiver on access to care, quality, and costs of care (Chakravarty et al. 2016).

Purpose of this Report

The Waiver Special Terms and Conditions requires the examination of several hypotheses.³ This report will discuss our second round of collection of stakeholder feedback on the implementation of the managed care expansion into LTSS, and partially addresses Hypotheses 1 and 3 of the evaluation:

Hypothesis 1: “Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.”

This hypothesis had two subordinate research questions:

- Research Question 1a: What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care for adults and children?
- Research Question 1b: What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?

Hypothesis 3: “Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.”

This hypothesis also had two subordinate research questions:

- Research Question 3a: What is the impact of the projected spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
- Research Question 3b: What is the impact of eliminating the transfer of assets look-back period for long term care and home and community based services for individuals who are at or below 100% of the FPL? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?

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. In many cases we cannot adjudicate differences in perspectives due to a lack of data. Where possible, we draw upon relevant data to examine the extent to which stakeholder experiences may be generalizable. 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. 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.

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 stakeholders are 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 2016, 19 states are implementing MLTSS (16 statewide and 3 in select regions), while 4 states have MLTSS programs in active development and 5 are considering MLTSS (NASUAD 2017). Most Medicaid MLTSS waivers have been approved in the past few years—the first was approved in 1989, the second in 1998, five from 2000-2010 and the rest later. 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 (see Musumeci 2014 and Saucier et al. 2012 on these waivers). 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. In January 2016, New Jersey’s dual eligible special need plans (D-SNP) for consumers eligible for both Medicare and Medicaid became fully integrated, meaning that they cover both acute and long-term services (Ensslin & Kruse 2016; Verdier et al. 2015).

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 (Burwell and Kasten 2013, Lipson et al. 2012). 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 (CMS 2013, Jackson et al. 2013, Mann 2013, Rivard et al. 2013, Summer 2013).

In October of 2016, the National Quality Forum endorsed the Home and Community-Based Services Consumer Assessment of Healthcare Providers and Systems (HCBS CAHPS) Survey.⁵ New Jersey is one of one of 13 states to participate in the National Core Indicators—Aging and Disabilities (NCI-AD) Adult Consumer Survey in 2015-2016,⁶ and one of 6 states to select the rapid-cycle survey to receive results more quickly. MLTSS is one of the programs evaluated in the survey. New Jersey Medicaid’s Quality Strategy outlines 40 quality metrics for MLTSS (DMAHS 2014), and waiver renewal documents released in 2017 summarize the state’s quality and monitoring activities.⁷

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 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 1: Former Waiver Members Transitioned to MLTSS

Former Waiver	Number Transitioned to MLTSS	Percent of Total
GO (older adults)	10,949	93.2%
TBI	309	2.6%
CRPD	330	2.8%
ACCAP	154	1.3%
<i>Total</i>	11,704	100%

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

As of March, 2017, the state reported that 43% of the Medicaid long-term care population was in HCBS, up from about 28% in August of 2014. The nursing facility population (comprising fee-

for-service and MLTSS) decreased by nearly 1,500 individuals between August 2014 and March of 2017.⁸

Methods

The primary method of collecting information regarding stakeholder feedback was through key informant interviews. However, the evaluation team also met regularly with state staff implementing MLTSS, attended a variety of meetings with stakeholders to gather background information, reviewed information reported by CMS, documents posted during the budget process, fair hearing outcomes, and monitored news and social media for relevant items. We have also examined data from secondary sources where relevant to our inquiry.

Interview Subject Recruitment

The research protocol was approved by the Institutional Review Board at Rutgers. Twenty-seven interviews (most by telephone) with 69 key informants were conducted from September 2016 through February 2017, with the bulk of interviews occurring in November and December of 2016. Most subjects were recruited by CSHP or suggested by other interviewees, though a small number contacted CSHP after reading the first stakeholder report (see Farnham, Chakravarty & Lloyd 2015). Twenty-five of the individuals interviewed in the second round had also been interviewed in the first round. The true overlap is probably greater than the numbers would suggest because in some cases, similar people were interviewed when people changed organizational positions, or similar types of organizations (e.g., providers) were included. Still, we did achieve a broader reach compared with our first report, which contained 16 interviews with 34 individuals from February to June of 2015 (see Farnham, Chakravarty & Lloyd 2015). A total of 78 individuals participated in either individual or group interviews between the two rounds of interviews. We also had shorter informal conversations with a handful of additional individuals.

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 disabilities, providers of LTSS and their provider associations, and agencies or associations of agencies that work with MLTSS enrollees in a variety of contexts and in some cases provided case management services under the former §1915(c) waivers (e.g., county welfare agencies, Area Agencies on Aging, Centers for Independent Living and Special Child Health Case Management). Some interviewees are members of the MLTSS Steering Committee and receive information there in addition to receiving information from consumers, caregivers, providers or other stakeholders. However, we also included informants not represented on the Steering Committee--30 of those included in interviews were not Steering Committee members, state or MCO employees. Some of the 30 are county employees. 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 Conditions⁹ 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. As the interviews progressed, information from earlier interviews was used to create new 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 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. Themes were identified using an inductive process (Thomas 2006). For the analysis, researchers considered all data collected up to the time of this report, not just the second set of in-depth interviews conducted immediately prior to the creation of this report.

Findings

Organization of Findings

Our discussion of findings is organized in three sets of sections. The first set (numbered 1.1-1.7) discusses stakeholder views as they pertain to the steps through which consumers generally pass as they access services through MLTSS, with provider experiences, state oversight/management and stakeholder relations at the end. Next (section 2.0), we include a discussion of changes noted from the first round of interviews to the second round. Finally (section 3.0), we summarize the ways in which stakeholders seem to feel that MLTSS is advantageous or disadvantageous when

compared with the former waivers, and areas of question or concern. Readers interested in an overall summary of stakeholder reactions to MLTSS may wish to skip to section 3.0.

1.1 Eligibility

Information and Referral/Screen for Community Services

Consumers or others seeking information on long-term care services may access information in a variety of ways. There are several potential pathways to receive a referral for a determination of clinical eligibility. People already receiving Medicaid and enrolled in a Medicaid MCO may be assessed for clinical eligibility by their MCO. People not yet receiving Medicaid may be given a referral to the Office of Community Choice Options (OCCO) by any of the following: 1) A county-level Area Agency on Aging (AAA) or Aging & Disability Resource Connection (ADRC)¹⁰ or a Division of Disability Services Information and Referral Specialist,¹¹ after a brief screening for potential eligibility (called a screen for community services);¹² 2) a county welfare agency once Medicaid financial eligibility is determined, for those seeking long-term care services; or 3) a hospital that expects to discharge a person to a nursing home; or 4) a nursing home for any new admission, because all admissions must be screened for eligibility.

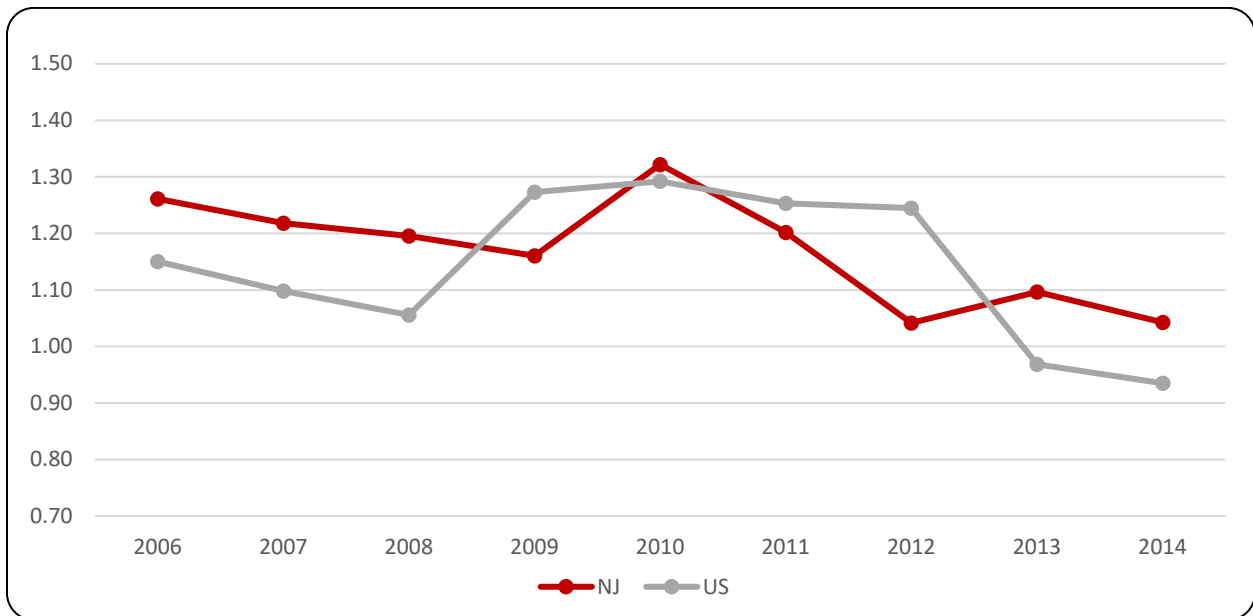
One AAA interviewee told us that the new screening process had led the organization to identify more people who are eligible for MLTSS: *"[inquiry about particular service] is a trigger to do the screen and do that process, so we're finding a lot more people that qualify for MLTSS than we had in the past."*

The Department of Human Services would like to ensure that people who are applying for long-term care services through a county welfare agency are able to receive options counseling through their local AAA/ADRC for other services for which they may be eligible. They have encouraged county welfare agencies to share applicant information with AAAs/ADRCs (rather than just providing a referral) so that the AAAs/ADRCs can follow up, rather than waiting for consumers to come to them. In March of 2016, the department held an LTSS Eligibility Summit to discuss sharing of information, and a release form is available along with the Medicaid application, which became available to download online for the first time in 2016.¹³ Advocates are happy with the online availability of the application because it makes it easier for consumers to apply for Medicaid. Staff at a county welfare agency commented that they miss having the reason that long-term care is needed, which had been on the prior application and helped them understand the client's situation. There also is not yet a Spanish version of the new application posted. While not denying the benefit of the ease of a mail-in application, county welfare agency staff noted that their face-to-face interactions had sometimes unearthed situations that became referrals to Adult Protective Services, and they wonder how such situations would be recognized now.

It is important to note that the process of identifying or notifying eligible consumers and enrolling them into long-term services and supports has been an area that the state has sought to improve for a long time. One advocate who has been a long-term observer of the process noted that there is still a need for *“some way of helping people understand better that if you are trying to get into the Medicaid program that’s going to pay for your home-based services—this is your pathway in, and that is not clear ... people don’t get it.”* There was some discussion in this group interview of the state’s very comprehensive ADRC web site, which these advocates thought had too much information to be usable.¹⁴ Delays in receiving home-based care can accelerate the need for nursing home care, which is generally more expensive to individuals and the state.

AAAs around the country are dealing with reduced or flat budgets while the population they serve has increased. A 2014 survey of AAAs in the US found that less than one-fourth had a funding increase in the prior two years. They are dealing with the resource shortfall by not replacing staff who leave and restricting the clients they serve, among other things (National Association of Area Agencies on Aging and Miami University, Scripps Gerontology Center 2014). Figure 1 shows the staffing at AAAs in New Jersey and nationally from 2006 to 2014 relative to the population of people 65 and over.¹⁵ Over that time, the staffing relative to the population declined. New Jersey had an average of 1.23 AAA staff per 1,000 people 65 and over from 2006-11 but the average ratio was only 1.06 from 2012-2014 (a decline of about 14%--created by a decline in AAA staffing of 4% coupled with an increase in the population of people 65 or over by 17%). For the US as whole in the same period, the average ratio of staff to population declined from 1.19 to 1.05. The state unit staffing for aging programs in New Jersey declined by 24%, from 220 in 2006 to 167 in 2014 (Administration for Community Living n.d.).

Figure 1: AAA Staff per 1,000 People 65 and Over



Sources: Administration for Community Living, AGing Integrated Database (AGID), State Profiles Tables, American Community Survey 1-year estimates

Our interviews revealed two stakeholder groups who feel somewhat disempowered with changes that appeared to come with MLTSS with respect to referrals for clinical eligibility: elder attorneys and special child health caseworkers.

- Elder attorneys were previously able to refer clients directly to OCCO by filling out a request for evaluation. Now they have to send their clients to the AAA/ADRC to get a referral, and find that their clients sometimes get confused in the discussion of a variety of services and do not come away with the referral: *“I have had many clients who went to the physical ADRC office with instructions from me ... I would coach them ... don’t lose your focus ... get the screen that will lead them to send the PAS nurse to your house ... and many times, because of people who are well-meaning, they would not come out of that interview having gotten [it] ... there were just too many other things they were trying to sign them up for, and none of them were the thing they were there ... to do.”* The timing of clinical eligibility determination is one of the factors that determines when Medicaid begins paying for services, so any delay can affect clients financially.
- Prior to MLTSS, special child health caseworkers did case management for the CRPD waiver and worked closely with state staff who oversaw the program. Now, special child health caseworkers must refer clients to the DDS Information and Referral line and these staff ask screening questions to determine whether to refer to OCCO. Several caseworkers feel a disconnect here, and also feel that children who would previously have been

screened and found eligible are screened out in this process. While it is possible to call back and get a referral to OCCO, it is a more burdensome process for the family. Several case managers contributed to the following exchange about the difference: *“Before you were talking directly to ... the administrators and the nurses who were responsible for providing the oversight of the program ... who went out and looked over our documentation and actually went physically into the homes and met the families and saw the kids ... it was very much direct, the people who lived the program ... now ... not as vested with these families ... lack of engagement ... there seems to be a script they go by ... a set of questions ... looking at the child and answering the questions may be two different things ... what they’re not asking is what they need to look at ... I had a family that I referred and the child’s [guardian] ... completely did not portray the child as the child was ... she can do this, she can do that ... I’m like, she’s nonverbal, her IQ is this ... she can go to the bathroom if you lift her up and put her on the toilet ... and they immediately screened her out ... can do everything on her own ... they never even finished asking the questions.”*

Others agreed that communicating with parents about their child’s needs was complicated: *“I myself can be on the phone with the parent ... always going to say how wonderful their child is, and how healthy their child is ... could have 10 million things wrong with them, and they’re not going to say that ... that’s an issue ... I’ll go out and do a home visit just so that I can really see, do they need it? ... mother called ... [said she] needed help with housekeeping ... took me 45 minutes on the phone to get it out of her what was going on with her child.”*

In the meeting we attended with special child health staff from 12 counties from all regions of the state in late 2016, there were still questions about the process and the right of families to request an assessment:

Speaker 1: *“[screening staff] directly told me no [person could not be evaluated]”*

Speaker 2: *“spoken with [screening staff] as well ... they can screen, but it doesn’t mean that the parent isn’t entitled to have an evaluation done, they can still request an evaluation, which if I really feel, I mean there’s some parents that, they just want nursing care ... but if I really feel, I’ll say to the parent, you have a right to request an evaluation anyway”*

Speaker 3: *“Do the parents who don’t have you know that? Because if you’re going to call and they’re going to say I really don’t think so”*

Speaker 2: *“I don’t know.”*

There was also a sentiment among caseworkers that some families were getting lawyers to assist them in accessing the program. In November of 2016, DMAHS filed a request with CMS to define the level of care for adults and children in MLTSS because the adult definition as applied to children meant that some children in higher income families may be able to enter the program (Davey 2016). The one public response filed indicated concern that requirements were changing from the former CRPD and TBI waivers, imposing stricter level of care requirements (Saidel 2016). State data show that the age category of 0-21 years has experienced an MLTSS enrollment growth rate equal to or greater than other categories--from 141 enrollees in July 2014 to 387 in July 2016. The slowest MLTSS enrollment growth rate was in the 22-34 age category—from 257 enrollees in July 2014 to 501 in July 2016 (DMAHS 2016). It is possible that some who would have enrolled in the program previously now have reduced access and that others may have increased access, resulting in a net increase—the data we have do not allow us to assess this. In addition, stakeholders mentioned that there is a larger issue driving stakeholder perceptions here, which is a gap in services for families with children requiring total physical care beyond an age where that is standard, and whose income is too high to qualify for Medicaid (with Medicaid, they could qualify for a home care aide). These families incur extremely high financial and often physical costs to their own health in providing that care. State staff noted that many MLTSS programs do not cover children and that they have tried to serve children where resources allow, such as creating the Supports Plus Private Duty Nursing option. Stakeholders were very happy with the creation of this option, which allows people (children and adults) to access private duty nursing services without withdrawing from Division of Developmental Disability services (because people cannot be on two waivers at once).

Assessing Clinical and Financial Eligibility

In order to be eligible for MLTSS, consumers must be both financially eligible for Medicaid and meet clinical eligibility standards, which require a nursing facility level of care.¹⁶ Clinical eligibility is determined directly by or with oversight from the Office of Community Choice Options (OCCO),¹⁷ under the Department of Human Services, Division of Aging Services. Financial eligibility is determined by county welfare agencies.¹⁸

Some observers note long time periods for people to get themselves through all the eligibility hurdles, with one advocate noting that *“this bifurcation of clinical and financial with nobody who’s held accountable for both creates all these potentials for applications going awry.”* Staff at a county welfare agency (CWA) told us in both the first and second round of interviews that there is no notification for them when clinical eligibility has been established. Their general procedure is to refer people for a clinical assessment after financial eligibility has been established, though

clinical eligibility can be established before or concurrently with financial eligibility. Prior to MLTSS, the CWA had received fax notification of clinical eligibility for each case, which had potential pitfalls in terms of the fax not being received or logged properly. Around the same time as MLTSS implementation, CWA staff were given access in the state data system to the screen that notes the progress of clinical eligibility, but it is a manual process to go into each application and page through to that screen. They report doing the search at least weekly on their pending caseload, and can check if someone reports to them that the clinical piece is done. The county welfare agency must do a final procedure to notify the state Medicaid agency that all eligibility is complete. MCO enrollment will be effective the first of the next month, or the first of the following month if the date falls too late in the current month. This is a longer timeline than with the earlier waiver system, when clients could, in theory, receive services immediately once eligibility was established. In practice, there may have been delays in assigning a case manager, finding providers, and so on—one interviewee who formerly worked as a waiver case manager said delays with the GO waiver could be lengthy. As far as we know, the time from either application or completion of eligibility to commencement of services has not been tracked either before or after the implementation of MLTSS. Enrollees are eligible for state plan services (including personal care assistance or medical day care) once both eligibility pieces are complete, but the enrollee, caregivers or providers have to contact the Division of Disability Services to authorize services—the MCO cannot help until the client is on their rolls (see discussion of Receiving Services while Awaiting MCO Enrollment on p.15).

As noted above (page 10), there has been discussion of MLTSS eligibility as it applies to children versus adults.

For people already on Medicaid before they have long-term care needs, their MCO can perform a clinical assessment for OCCO to approve. The person also must document their financial situation with the county welfare agency, either by going through a lookback period of their assets or, if they are below 100% of the federal poverty line, attesting that they have not transferred assets in order to become Medicaid eligible (see more discussion in next section on self-attestation regarding asset transfers).

Self-Attestation Regarding Asset Transfers

The comprehensive waiver allows people below the federal poverty line to self-attest that they have not transferred any assets over the past five years, rather than undergoing a full lookback examination, which is burdensome for both the applicant and the examiner. The state has audited samples through the fourth quarter of 2016 and found no errors. The state hopes to expand the program up to 300 percent of the federal benefit level when the comprehensive waiver is renewed (Department of Human Services 2017). People applying for Medicaid for the

first time with a need for long-term services will encounter this form while having their financial eligibility determined. Those already on a different form of Medicaid can be given the form by their MCO. The process is explained by Medicaid Communication No. 16-01 (2016).¹⁹

Having the MCOs in a position to identify and initiate the movement of eligible people to MLTSS has the potential to improve the system of care for enrollees, though advocates and CWA staff report some bumps in the road in getting people classified correctly. One advocate reported seeing many cases within the first year after implementation where the MCO established clinical eligibility and believed their enrollee was on MLTSS, sending them a card and welcome letter, but because the financial eligibility was not completed, the state still had them coded in whatever their prior Medicaid program was, leading to a potential problem in accessing MLTSS services. CWA staff reported receiving forms and having to review them and sometimes send them back because they were not appropriate cases (not actually in the right income category, not a resident of their county, etc.). MCOs reported that people seemed to be transitioning correctly, and that, as far as they knew, the system was working (if people were not changing status, MCOs would not be paid the MLTSS capitated rate for them).

Advocates in our interviews and in written comments to CMS are concerned about the ignorance of the public as to what constitutes an asset transfer and potential implications if people attest incorrectly, particularly if eligibility is expanded to higher income applicants (Archer 2017). CWA staff were also concerned that people may inappropriately attest, as they see cases where people make claims that are later proven untrue by documentation.

Qualified Income Trusts (QITs)

QITs allow people who are over the official income limits for Medicaid financial eligibility to spend down excess income if it is going towards long term services and supports. QITs replaced the medically needy designation, which was only available to people living in nursing facilities. Stakeholders widely agree that the expansion of the spend-down ability to those living in other settings is a good policy and some had advocated for the trusts (Kitchenman, July 25, 2014). However, advocates and CWA staff we spoke with think that the QITs are too complicated and would like to see another method to allow this (see Pearl 2015). State staff told us in our first round of interviews that the medically needy option would not allow people in community settings to keep enough income to pay for their expenses, and QITs were the only other option for which there were other example states at the time that QITs were established (see Walker and Accius 2010; Watts and Young 2012).

In our first round of interviews, CWA staff reported that some people didn't seem to have anyone to do QITs for them. In our second round of interviews, the same staff had not found these

concerns and the facility provider associations had not heard of facilities having problems due to people who could be Medicaid-eligible except for a QIT. The CWA staff did still think that the QITs were too complicated for many people and that it was difficult and time consuming to explain to them what to do. CWA staff and an attorney reported that banks may not understand or be willing to open the accounts (see Pearl 2015). CWA staff reported that mistakes by both the public and attorneys representing them in setting up or funding the accounts can lead to delays in eligibility.

State data presented to the legislature showed that from December 2014 until March 1, 2016, there have been 1054 QITs established (about 1/3 of QIT applications are estimated to be approved)—763 (72%) are for people in nursing homes, 218 (21%) are for people in Assisted Living, and 73 (7%) are for people living at home. Under the previous system, the 291 people outside nursing homes would not have been able to qualify for Medicaid to help pay for long term services and supports unless they entered a nursing facility. The CWA staff we spoke with did not know why so few QITs were approved; state staff noted that the applications with QITs may be withdrawn or denied for reasons unrelated to the QIT.

Renewal

Once enrolled in Medicaid, beneficiaries must renew their clinical and financial eligibility every year. The clinical eligibility of MLTSS enrollees can be confirmed by the MCO with OCCO oversight, while the financial eligibility must be renewed through the county welfare agency. County welfare agency staff told us during the last round of interviews that prior to MLTSS they knew the waiver case managers and were able to contact them to assist with follow-up if the enrollee did not return renewal documents. In our second round of interviews, this CWA has made some contacts with the MCOs (another county agency has organized quarterly meetings with county and MCO staff). However, they still feel that communication is not as good as it had been previously and that this decrease, coupled with an incentive to county welfare agencies for timely renewal, leads to people being terminated from Medicaid and potentially having interruption of services. An interviewee based in another county agreed: *“when the county did the case management ... if we knew there was a problem with the financial eligibility or the redetermination hadn’t been finished, the workers would let [county staff] know ... no gap in services ... recently [late 2016] ... there was a gap in services, the client didn’t know to reach out to the care manager, the care manager didn’t reach out to the client, and the client reached out to [emergency responder] when no one showed up to take care of her, and everybody did a phenomenal job getting everything done, but it was [several] days that this lady had no one to wash her, change her linens, cook for her, shop for her, all those kind of things ... not someone who should have been walking around without supervision ... if she hadn’t found her way here, what might have happened? Maybe that’s something that needs to be set up—when the financial*

is being closed because they haven't heard from a consumer, maybe the case manager needs to reach out to that consumer to see why they haven't responded ... we had one where the lady was on MLTSS in a facility, went home ... still sending documents to the facility ... she was getting care but then she got cut off because she didn't return documents ... communication—I don't think the system's figured out the best way to communicate—so many different layers, so many pieces to it.”

A former waiver case manager in a different county felt that their scope of waiver case management activities had been broader than that of the MCOs under MLTSS, and included helping clients with Medicaid renewal applications as well as applications for other types of programs. This person's perceptions of what MCOs do under MLTSS is based on conversations with former co-workers who have moved to MCOs as well as requests received from MCOs to this person's organization.

MCOs have shared some stories with us, and some are mentioned in the annual reports filed by the state with CMS, that suggest the scope of care manager activities. One story shared with us described an enrollee who came close to losing benefits due to “a mix up in mailing addresses”²⁰ after a series of temporary moves due to hospitalization, recuperation at the home of a caregiver, and a nursing home stay. MCO staff assisted the enrollee with assembling, completing and submitting the documents “with two days to spare.”²⁰ Another story describes an MCO care manager who helped an enrollee with an application for home weatherization after contacting the enrollee's County Office on Aging (DMAHS 2016).

We cannot assess conclusively with the information available whether or not renewal of financial eligibility is more problematic under MLTSS (and, if so, whether that could be attributed to MLTSS as opposed to other changes such as incentivizing timely renewal). It would seem, however, that the risk of accidental nonrenewal due to factors such as health crises, problems with reading/writing or lack of mobility to retrieve and respond to mailed documents would be significant in this population, and that it would make sense for MCO care managers to be aware of the importance of both the submission of clinical renewal information (for which they are responsible) and the submission of financial renewal information (for which the member is responsible, but assistance may be required).

1.2 Receiving Services while Awaiting MCO Enrollment

Potentially Longer Wait for Waiver Services. As mentioned earlier, after eligibility is determined, there is a longer required wait time for MCO enrollment under MLTSS than there was for waiver agency enrollment in the prior system. MCO enrollment is effective on the first of the next month or the first of the following month, with a cutoff date that varies depending on holidays, etc.,

while in the past the waiver case manager could begin immediately, though it is not clear to what extent they did. Stakeholders estimate that the extra wait time for MCO enrollment is about 2 weeks to 1.5 months (not counting any differences in time to assess or get services into place, which some feel adds additional time).²¹

Fee-for-Service Option Prior to MCO Enrollment. Once Medicaid eligibility is determined (clinical and financial), clients are eligible to receive state plan services on a fee-for-service basis even before enrollment into an MCO. The state plan includes acute health services as well as personal care assistance and medical day care (both require a doctor's authorization and approval through the Division of Disability Services). Providers must be enrolled as fee-for-service providers, separate from any agreements they may have with MCOs. It is not clear how widely known this access is (we could not find any written documentation discussing this option). State staff tell us that there are about 250-300 people (not just MLTSS enrollees, but all Medicaid beneficiaries) enrolled in personal care services on a fee-for-service basis and that the average enrollment time is about 6 weeks. They also noted that not all personal care providers want to participate because they know it is likely to be a short-term assignment. According to state staff, enrollees are not given anything in writing but are supposed to be informed verbally about this option by the county welfare agency. One county employee we spoke with mentioned this option, but indicated a potential barrier with provider participation: *"I think this system, because we added the extra step with the MCOs, people are waiting longer to get services ... you can get state plan services—not all the providers know about that or, I guess, don't want to do—I don't know how much paperwork is involved."* The ABD application notes prospective eligibility for unpaid covered medical services retroactive to the application (it does not mention the gap of time between application and MCO enrollment, or how to access benefits, but such language could be a clue to enrollees or advocates to inquire).²²

1.3 Plans of Care/Service Assessments/Equipment/Care Management

Plan of Care. Once an applicant is enrolled with an MCO, the care manager must contact the enrollee within five business days to schedule an appointment to complete the plan of care, which must be done within 45 days of enrollment.²³ The plan of care establishes which MLTSS services the enrollee will receive as well as documenting the enrollee's goals such that the care manager can tell what services to search for or authorize (if the service is contracted).²⁴ For instance, an enrollee may want to attend church, which may require transportation. In addition to services that are paid for by the MCO, care managers may also connect members with community services that are not with contracted providers. All MCOs are supposed to make community referrals—the 2015 NJ FamilyCare Annual Report notes that field staff at United Health Care use the Healthify application to locate resources (DMAHS 2016). Brodsky and Garcia-Bunuel (2016) and Hamos et al. (2017) discuss relationships between MCOs and community-

based organizations (not specific to New Jersey). Several interviewees thought that MCO care managers they had encountered were less well connected with community resources than prior waiver case managers.²⁵

- *“MCOs definitely seem less clued in to ... community supports and outside supports outside of their organizations. Some do a better job than others ... a lot more work that could be done there with MCOs just building relationships with ... social service providers in areas where their members are residing, seems to me that there’s a little bit of a lack of that ... less than there was before ... coming from that health insurance model ... not used to doing some of that social service type work and making those connections ... I definitely think that they could connect more with all kinds of resources that are around them, you know, transportation, employment initiatives, libraries ... I think Global Options ... seemed like they had a better handle on those things.”*
- *“With Global Options, the care managers were just—felt to me so much more invested in their community, and the resources that were available in the community, and making those connections with their clients. They were not just about delivering PCA services.”*

On the other hand, MCOs recounted instances of people coming over from other waivers who were not being well-served—particularly those with behavioral health needs that had not been identified. One MCO had a member who transitioned from Global Options with no identified psychiatric history. The member had visited the ER for various complaints once or twice a month prior to the transition and had been admitted twice for psychiatric problems. The MCO was able to stabilize the member with intensive psychiatric support.

Electronic Presentation and Signature. Several of the MCOs do their care plans electronically, with members signing on screen. Some stakeholders are concerned that this does not give members or caregivers an opportunity to see what is being written into the plan: *“they get a care plan on the computer, they have to sign a computer, they cannot get a printout of the care plan ... the care manager has no ability to provide them with a copy of the care plan that they are signing in that home and I don’t think I’ve ever had one who actually got a physical copy, they’ve been told they have to call and request it... and when they’re signing, can’t see what they’re signing.”* MCO interviewees noted that having people sign on paper would not necessarily improve the issue that stakeholders raise as people can be rushed through paper documents as well, or could sign and find that earlier pages were changed later. MCO interviewees generally confirmed that the plan is not printed out at the member’s home but is sent later. Some stakeholders felt that the plans were not automatically sent (as the MCO contract requires) and that it was difficult to obtain a copy.

Service Assessments. Some services, such as personal care assistance (PCA) and private duty nursing (PDN), require additional assessment to determine eligibility and/or the number of hours to be authorized.

Concerns about Reductions in Hours. Most of the cases encountered by legal advocates have to do with reductions in hours of service. It is not possible to easily assess how frequently reductions occur because while most MCOs report that care plans are kept electronically, there is not currently a standard format for care plans to allow the calculation of differences from one time to another.²⁶ The initial MCO contract covering MLTSS required MCOs to report any reductions from prior care plans, but the MCOs felt there wasn't enough information in the prior care plans to do this. Subsequent efforts to require reporting have been complicated by questions of what constitutes a true reduction—for instance, if a member desires more hours and the MCO refuses, there can be a complaint documented about this disagreement over hours, but this is different than the MCO deciding to reduce hours.

There appears to be a difference in the criteria that advocates view as necessary for a reduction compared with state or MCO staff. Advocates argue that reductions in hours are not justified unless a client's condition has improved in some way, while state/MCO staff argue that hours are determined by a fair application of assessment criteria, and that current assessors should not have to justify their difference from a previous assessment.²⁷ There is also a difference in the way that stakeholders interpret the same set of actions by MCOs—advocates often seem to feel that reductions are done in an arbitrary manner or with motivation to reduce hours, and that MCOs may come in with a “lowball” offer which they are then willing to increase if the client complains. Advocates note that they only see a select number of cases and have no way of knowing how representative these cases are. Based on final agency decisions, state staff seem inclined to view a willingness to increase hours as evidence of thoughtful consideration and a willingness to listen to members. State staff may be familiar with cases that are referred to the Office of Administrative Law (OAL)—fair hearing requests come first to the relevant department (in this case, DMAHS), which decides whether to transmit it to OAL as a contested case. The decision to transmit may reflect the department's opinion that there is nothing more it can do. Fair hearing decisions illustrate that the department can be persuaded that there is a problem with an MCO process, as shown in Harr (2015) after an initial decision by Gorman (2015), which questioned the lack of hearing participation by MCO staff who had assessed the member as well as an inconsistency in the amount of the desired reduction. However, there are also cases where the Medicaid director overturns Administrative Law Judge decisions. Advocates have told us that the database of decisions is not complete (i.e., that cases in which they have participated are missing), and we did not attempt an analysis of all decisions.

The provider community seems to be split on the issue of whether reductions in hours are a problem with managed care (PCA services moved to managed care in 2011). All providers we spoke with in both rounds of interviewing agree that there have been rate reductions in some cases and that these have been harmful, and one noted that in addition to the hourly rate reductions, services that used to be separately billable in the fee-for-service system, such as the requirement that home care agencies create a plan of care and have supervisory visits, are now expected to be built into the rates paid for PCA care under managed care. However, not all providers believe that hours reductions are a problem. In fact, some believe there is probably overutilization of hours in some cases (providers from whom we have heard this have largely exited Medicaid due to rate reductions). More common are the following views:

- Acknowledging that overutilization may be an issue in some cases but wasn't everywhere, one provider interviewee noted: *"they were so concerned about fraud and abuse ... and I'm sure there were agencies out there that were exaggerating hours, but I also think that members [consumers] suffered from that concept that everyone was doing that ... so, in the beginning [2011, when PCA went in to managed care], you saw them ... cutting hours and cutting hours, and then you saw an increase in hospitalizations, because members had less hours ... they're falling, or there's not someone there to remind them to take their medications ... higher amount of scheduling issues because we have to split people's hours ... more and more home health aides are leaving this industry ... I have a huge turnaround rate ... increased 30% since 2011."*
- Another provider interviewee noted a mixed picture with MLTSS: *"we've seen a mixture ... it really varies, we've seen some cases where we think the provider should be getting more, in some cases we've seen that they were getting too few and there was an increase, which is positive. We're really paying attention to PDN hours ... make sure they're not cut too far back ... mixture of up and down. Some of the ones that have been decreased just don't make sense."*

We did hear one anecdotal report of a person with a large number of hours from a state staff member: *"[enrollee] in clinical decline ... getting probably almost 90 hours of service a week ... basically at this point bed bound, can barely speak ... aides ... have helped him do just about everything ... he's got technology that meets his needs, his family is getting respite services—he lives with his [relative] who is elderly ... doing better than he had ever done before ... well cared for, well maintained in the community ... he's doing a lot better now than having his [relative] do his personal care ... the most demeaning part of it ... now she doesn't have to—he is getting enough services from his managed care company so that anything she's doing for him is purely voluntary ... I think that highlights a lot of our folks who are doing better because of MLTSS, because there is more of a comprehensive approach to care than there ever was in the old days."*

Specific Time Frame of Hours Can Be Important. One example from an MCO shows that it is not just the number of hours but when the hours are filled that can make a difference. This MCO had a member with falling incidents. They analyzed what time of day the member fell, and were able to adjust the aide's time so that the aide was present during the times of day that had proven riskiest for the member. They had good results with this approach, without increasing hours. They were not opposed to an hours increase if that were necessary, but it didn't seem that it was.

Concerns about Receipt of Hours Awarded. Even when members are awarded a certain number of hours of service for private duty nursing or personal care assistance, they will not receive those hours unless a nurse or direct care worker actually fills the hours. Concerns about the adequacy of the nursing and personal care workforces predates the implementation of MLTSS. There have been documented instances of rate reductions by some MCOs for personal care assistance (see Kitchenman, December 2014 and Department of Human Services 2014, p.28), and such reductions seem likely to exacerbate staff shortages. One MCO told us that they had not reduced rates.

While the MCOs we spoke with discussed using special agreements where contracted providers were not available, we heard concerns from stakeholders about hours going unfilled and also that cuts in hours can make members less attractive for staff. Some felt that hours that went unfilled without immediate negative consequences could become justification for reducing hours. One stakeholder spoke of a case where: *"they've been approved for a certain number of hours, but then they can't find a nurse to do all of those hours ... issue about how many nurses there are, and then the rate ... the managed care organization is paying the nursing agency... MCO then tried to reduce the hours to say well you don't need those hours."* Bass (2016) is an example of a case where an individual was approved for 56 PCA hours under the GO waiver but was only receiving 35 hours prior to MLTSS because of difficulties in finding staff. The MCO was eventually successful in increasing the filled hours for the member, but then reassessed her in July 2015, reducing her hours to 35. The judge ordered the hours restored, saying, among other things "The implication of [MCO's] testimony was that petitioner did just fine with fewer hours; that if she needed the extra help so desperately petitioner would have taken a more flexible and tolerant approach to insure that she had complete coverage. But petitioner strongly and persuasively disagreed, sharing that when she cannot secure an aide, she often spends an entire weekend alone in bed, without food" (Bass 2016). The judge was overturned by the department, which was not convinced that the needed tasks could not be done within the assessed hours, which had been increased by the MCO from 25 to 35 (Davey 2016). The department, it should be noted, did

not imply that the prior receipt of 35 hours justified the reduction but, rather, stated that the assessment tool did, and that there was no need to explain the reduction from 56 to 35 hours.

Private Duty Nursing. State staff report that a standardized private duty nursing tool is under development, an idea that most stakeholders welcome. Fair hearing documents show that at least one MCO uses a tool.²⁸ Former waiver case managers for children getting private duty nursing reported that some of their former clients had experienced cuts in hours, but said that they were ultimately able to get the hours restored by contacting advocacy groups: “3 of my families ... were told that they were going to cut hours or ... take them off [i.e., deny eligibility for services]... none of them ended up having any of those things happen but ... it was very, very stressful and upsetting.” Another stakeholder echoed the description of family stress over uncertainty about cuts: “Even if it’s not cut, there’s ... a threat where the nurse worries the family into thinking that there’s a really good chance that it will be cut, so the family spends a lot of time worrying about it ... the family ends up, obviously, being very frightened about it.” Advocates who assist with appeals report an uptick in reductions of PDN hours, an issue they had not seen prior to MLTSS. Information from the New Jersey Division of Banking and Insurance seems to confirm an increase in appeals related to private duty nursing in 2015, although it is difficult to judge the magnitude of the increase because of the small number of cases (Chakravarty et al. 2016, Chapter 2). One provider of PDN with whom we spoke seemed to feel that they were able to persuade MCOs when nursing was needed; another interviewee with knowledge of multiple providers throughout the state (quoted earlier on page 19) noted that PDN was a service they were watching, where there had been mixed results in terms of hours reductions, and that they had seen some that did not seem to make sense.

We heard some concern from stakeholders that there were people who the state would deem ineligible for private duty nursing because the needs weren’t skilled enough but for whom an agency would not be willing to provide an aide because their needs were too high: “we’ve had nursing agencies out there and the nursing agencies were not putting a home health aide in there – we can’t ... too medical.” We questioned state staff about this and they were unaware of any case where someone went without service due to a disagreement between the state (or MCO) and an agency—they had only observed cases where the member or family, and not the agency, were insistent upon a nurse.

Personal Care Assistance. The state implemented the personal care assistance tool (PCA Tool) in early 2015. Previous versions developed for state plan PCA services had offered a maximum of 25 and then 40 hours, although stakeholders told us that users did not always adhere to these maximums (there were processes to authorize more hours if necessary). The new tool offers a possibility for a more generous award. Enrollees are assessed by a nurse with

respect to ADLs and IADLs, with time awarded based on the amount of assistance required (adjusting for time provided by other supports, such as family members).

In our first round of interviews, stakeholders were pleased with the idea of the tool and the state reported fewer complaints regarding hours awarded after implementation. Some stakeholders expressed satisfaction with the tool in our second round of interviews, and even some who thought it needed improvement also thought it was better than what MCOs were using before. However, some stakeholders (advocates and a provider) report seeing MCOs using the average amounts contained in the tool as maximums rather than a guide that could be raised or lowered with explanation: *“the person doing the assessment feels that they’re locked into those numbers ... [interviewer mentioned that guidelines say assessors can go beyond suggested amounts with explanation] That’s what it says in the training and that’s what it says on the form but in practice, I don’t think we’ve ever seen one that has gone beyond the amount of time in the guideline ... [speaker 2] seen some where they have exceeded it for very specific reasons, but by and large the nurses treat them as maximums ... hearing not too long ago where the nurse was basically admitting ... even if she didn’t actually observe or take into account the person’s specific needs, she just used the time frame on the tool ... if it’s not being practiced as a guideline and it’s rather being practiced as a maximum, then the clients are the ones who bear the brunt of that ... we have substantial cross examination of people doing the assessments saying that they are sticking to the ... tool pretty religiously.”*

In addition, some question the validity of the benchmark times provided by the tool, noting a lack of information with respect to tool development or validation. *“Where do these numbers come from? Who says that it takes ... minutes to prepare a meal? ... Why are we using an average number? ... if you’re paraplegic, it probably takes more than 10 minutes.”*

Several advocates noted that the tool does not cover all the activities that aides are allowed to do and may lead assessors to forget that some activities are covered *“...it doesn’t cover everything it should cover ... accompanying someone to ... appointments is not on there ... it’s wrong in terms of what can be looked at.”*

Finally, advocates feel that the tool is applied inappropriately in that informal supports the person has (that is, friends, family or roommates) are taken for granted as able to provide care whenever they are generally home, without regard to their own needs, limitations, the standard of care they provide, or the toll care provision may take on them (or what state labor law would say about how many hours a day a person should be expected to work). One advocate gave the example of a frail spouse who would not let their frailer spouse, for whom they provided care, sleep in a soiled diaper, but would take the person to the bathroom several times during the

night. The MCO also expected the caregiver to care for their spouse for a number of hours during the day, and thought that other family members, who lived in the same residence, should be doing some of the work. However, these other family members worked during the daytime hours and could not have done the nighttime assistance without an awkward and quality-of-life reducing change in sleeping arrangements. Another advocate gave the example of a roommate of a younger person with a disability who the MCO expected to provide personal care for their member at certain times—this was not the kind of relationship the member had with their roommate.

Many interviewees talked about their puzzlement at reductions in hours when there had been no change in the member's condition. One provider described a client whose hours were reduced on the fourth reassessment with the tool, by the same person. Because the agency has to do a bowel regime with the client several days a week, this has reduced their hours on the other days, reducing the amount of time the client is able to be out of bed on those days. The client is appealing and there were not, as yet, any adverse changes in the client's health. The change happened shortly before our conversation. *"I have seen numerous reductions in hours, what I have yet to see from any of the providers [MCOs] is an increase ... the most odd one ... client since ... [early] 2014 ... a young man [between 20-40] with quadriplegia ... with no explanation they reduced him ... no change in condition ... because of the bowel movement, that takes x number of hours ... we have no room to play with those days, so we had to reduce him in other places ... went through the new formula 3 times with no change [in hours] ... same person assessing ... he lives with ... elderly parents ... some days, they can't get him out of bed ... before he might be able to get out of bed for 6 hours ... takes time to get him out ... about 20 minutes ... out and ... in ... and that only gives him maybe about 1 hour and a half where he's actually out of bed [now, after the change] ... it's not just a comfort thing ... that's how you get bed sores ... unless someone gets him out of bed and sees them, because he can't feel it."*

Self-Direction. The Division of Disability Services (DDS) oversees the self-direction (i.e., the direct hiring and supervision of support staff by consumers or their family) of personal care assistance (PCA) as well as chore services, non-medical transportation, home-based supportive care (assistance with IADLs like shopping, money management, light housekeeping and laundry), and the purchase of non-routine items (used by one MCO to purchase window air conditioners for members having adverse health effects from the heat, to maintain their community residence instead of considering an institutional setting). These services can be received through an agency or self-directed by hiring anyone other than a legal guardian to perform the services. Some stakeholders (often, but not solely, providers) have concerns about quality with self-direction, because aides hired in this manner do not have to be certified and supervised as agency aides do. State staff report that there is monitoring of the program including home visits. According to

state staff, about 80% of self-directed participants hire a family member. DDS has a tool to evaluate suitability for self-direction as well as documentation notifying workers that there are background checks and that their pay is taxable. Workers under self-direction are still covered for worker's compensation in the case of injury as well as liability for injury to clients. Taxes are withheld unless the total amount paid for the year is below \$600, in which case the worker is given a 1099 form. In our first round of interviews we heard some concern from advocates for low-income people that workers didn't always understand the ramifications of their new income, which could make them ineligible for benefits they rely on. In our second round of interviews, we heard from providers who were concerned about certified staff going to work under self-direction and then losing their certification because they weren't working under nursing supervision. The share of members using self-directed PCA services under MLTSS is still fairly small--1,145 in August of 2016, about 6% of the total residing in community-based settings (DMAHS 2016, 1115 Waiver Annual Report). It does appear to be growing in numbers, though the change as a percentage of MLTSS enrollees is small—a year earlier, there were 675 participants, which was about 5% of community-based MLTSS enrollees (DMAHS 2015, 1115 Waiver Annual Report).

Equipment. We heard several comments about durable medical equipment being harder to obtain now due to a lack of contracted suppliers or restrictions on what is covered.

Advocates criticize the use of “medical necessity” language to deny services or equipment that by their nature are not medical. An administrative law judge's denial in a 2016 fair hearing case reads as follows (Strauss 2016): “I CONCLUDE that petitioner does not qualify for a power wheelchair with a power seat elevation feature. Although petitioner makes a compelling argument as to how his feature would enhance the quality of her life and her independence, those important missions do not meet the standard of medical necessity [emphasis in original] as defined by [MCO policy]. By her own description, she already receives assistance with the tasks she describes.” This consumer and their caregiver are then locked into that personal assistance and, unless they can afford the technology, prevented from accessing something that could allow the consumer to work toward being more independent, which was one of the goals of the proposed purchase.

One of our interviewees described her family member qualifying for a lift chair under the GO waiver. Under MLTSS (with which the interviewee was generally satisfied), the MCO only pays for the motor for the chair. The interviewee couldn't figure out how to get that reimbursed, because the chair is sold as a unit with the motor.

Care Management. The HMO contract provides care management requirements and also requires analysis of utilization, including over and under-utilization.²⁹ Care management includes the plan of care, an annual NJ Choice assessment, and service assessments as necessary, plus minimum mandated contact with members. The amount of contact depends on the member's setting—at least every 180 days for members in a nursing home or community alternative residential setting (this includes assisted living, adult family care, community residential services, comprehensive personal care home, and adult mental health rehabilitation (AMHR) community residential programs), including at least one interdisciplinary team meeting per year at the facility (this may be by telephone). For members in pediatric special care nursing facilities or in community settings, face-to-face contact must occur at least every 90 days, with at least two visits per year in the member's residence. There are also requirements on caseloads—care managers may have no more than 240 members in a nursing facility, 120 in an alternative community setting (like assisted living), 60 receiving home and community based services, and 48 receiving pediatric special care nursing facility services. In addition, care managers must be available for members to contact.

Former waivers required monthly phone contact and quarterly face-to-face meetings. Some former waiver managers said they also reviewed service utilization monthly.

Concerns about Contacting Care Manager. Interviewees expressed a variety of concerns about members and care manager contact, from consumers not knowing they had a care manager to experiencing trouble contacting the care manager:

- *“the first case manager ... didn't have a card, she was too new. She gave a phone number and an email and this family was told, because I was sitting there, that if she didn't answer the phone it would roll over to her supervisor and somebody would always answer the phone. No one answered the phone; the email was incorrect. There was no way for this family to access that care manager—none ... I had a family who had a problem, I told them to call the ... member advocate for MLTSS specifically ... this person ... never called the family back—multiple phone calls ... even after a call from the supervisor, a call from Quality Assurance, we still never heard back from [the member advocate]—unbelievable.”*
- *“a scenario, happens, not sure how to correct this ... clients sometimes don't know that they have a care manager—they receive no monthly phone calls and some report having been on MLTSS for months and haven't spoken to anyone ... client who has been eligible since [Month X], 2016 ... [caregiver] tried to contact every number at the MCO without response, county social service person tried to reach MCO and also couldn't reach anyone. It was not until the state was made aware of the situation that they finally were able to connect with a care manager in [Month X+3], 2016. Once they spoke with someone, the*

care manager explained that no services could be provided because of the client's location and lack of aides willing to go there. The client is on MLTSS but receives no services at all—this is partially the reason they receive no regular contact from a care manager, because no services were physically being provided. So, it's kind of like a catch-22."

- *"dealt with a few individuals who just didn't even know who their managed care organization was or who their care manager was, and I don't know where that breakdown happened ... I think we all found that alarming ... you'd think if you had routine communication from the plan ... that they would know and remember that ... definitely seen some cases where perhaps the MCOs could do a better job of just having more constant contact, however that could occur ... maybe that always happens with certain populations, but that seemed to surprise everyone, including our staff who come from [organization that worked with the MLTSS-eligible population]"*

MCOs have made different choices about how to structure care manager contact. One MCO wants to make sure that members always get a live person who can address immediate needs, and never get lost in voice mail—so, members call into a call center and their message is relayed to their care manager. While this is an understandable philosophy, not everyone likes this setup: *"difficulty in contacting their care manager, we hear about that because they can't just call the office like they used to ... and get their care manager, now they have to contact the 800 number and go through a process and it's a little bit more difficult."*

Concerns about Care Manager Turnover/Characteristics/Skills/Level of Engagement. Some interviewees reported extensive turnover among care managers, particularly early in the transition:

- *"I have ... probably 3 families who had, within the first maybe 15 months, 4 case managers ... after having the same one for 12 years ... really big problem ... one of them didn't last, I don't even think a month ... there's no continuity."*
- *"I've also had similar experiences ... one of my most critical cases ... 4 in the first 3 months ... the mom was so frustrated because ... nothing about his case was relayed, so the new care manager comes in and an hour and a half, question after question after question ... then the newest care manager that was assigned ... [member is] highly allergic to cigarette smoke ... oh, we don't have any care managers that smoke ... well, this care manager ... I was in the house—she was, to say unkempt was an understatement—reeked of smoke, and I had to physically stop her from walking in the house, and then she opens up her laptop—she's standing on the front porch—and her laptop is caked with food ... they sent somebody else—it took about 2 weeks."*

Other interviewees did not see a problem with turnover. One caregiver with more than one family member in the prior and the current system said *“what I personally see is less turnover among care managers—now I’m not saying that they don’t need more, but I don’t see care managers, like, quitting en masse or whatever... continuity of care has increased.”* This person had experienced inconsistent quality with prior waiver care managers. We heard differing reports from interviewees who had lost employees to MCOs. They both thought that MCOs paid well, but one reported that the workload was too high and that people they knew had felt pressured to reduce services, so they had observed MCO care managers quitting due to stress and dissatisfaction. The other said *“I’ve not heard one of my ex-nurses say I’m unhappy.”* This person did note that some had left care management positions (in some cases taking different positions with the MCO) because they tired of the home visits and travel required of care managers. She also noted that among her client population, several of their care managers transitioned from the waiver agency to the MCO and remained the same. Another interviewee who had observed care managers both before and after the transition to MLTSS saw differences among the different MCOs: *“in certain plans yes, a lot [of turnover; others have a] more stable workforce ... would square ... with the organizational culture ... people that I’ve dealt with, even as far down as care managers, just seem to be happier at some of the managed care organizations versus others, and less overworked.”*

Some were concerned about care managers who seemed focused on reducing hours, and felt that this particularly affected younger people with disabilities, who might feel pressured to accept fewer hours in order to stay in a community setting, or be forced into an institutional placement: *“younger individuals were significantly impacted ... really high need ... want to stay home, in the community ... [someone they knew] transitioned to MLTSS ... Getting a caseworker to come out, first, was challenging. When they did finally come out, immediately ... did he really need all those hours, why can’t [relative] be more involved. As they got more involved with his case, the case manager actually said to him ‘I think you’d be better suited in a nursing home.’”* [other speaker] *“That is a sentiment that has been echoed across the state ... all of us have intervened in many instances where the case manager has told individuals or given them pamphlets for Assisted Living Facilities when they don’t meet the level of care for Assisted Living [their level would be too high], or was pushing nursing home placement ... the polar opposite of what MLTSS is supposed to be ... those are the cases that we knew about ... we get involved, we get it resolved, but that’s the squeaky wheel that gets oiled ... people who don’t know anybody, don’t know the path to take ... what’s happening to them?”* [other speaker] *“We know who to call, but the average person—if we’re not with them, they don’t know how to get these issues resolved, they just suck up and deal with whatever answer the MCO gave to them ... once we intervene, usually resolved ... I’ve got to drop names and then stuff happens ... shouldn’t come to that.”*

There were concerns about the ability to understand care managers with an accent that was markedly different than the member or member's family:

Speaker 1: *"the language barrier is horrendous--the [English-speaking] mother can barely understand ... and she gets so stressed out trying to communicate."*

Speaker 2: *"I had the same thing with the first care manager that 3 of my families got -- none of them could understand her. I kept saying to them 'that's not something you can really complain about.'"*

Speaker 3: *"I had that ... my family did complain, and they got a new care manager ... the next morning."*

One provider reported having tracked back problems in payment to actions by the care manager: *"the biggest reason why we're not getting paid is, we have clients who are authorized for service ... case worker has not updated their internal system with the authorization ... we'll get something back ... denied because we're showing there's no authorization, even though I'm holding an authorization in my hand ... the case managers have acknowledged this problem ... promised it would be resolved, and it still hasn't ... [name] on numerous occasions telling me, 'I was supposed to do that and I didn't ... when I'm doing the work on the computer, there's a pull-down menu for the code, and I pull down and I keep clicking on them until I find one that the computer will accept for this client, and then I click submit.'"*

Concerns about Care Continuity with Temporary Change in Setting. Some stakeholders expressed concern that if members were out of service for 30 days or more (say, with a hospitalization and rehabilitation stay), their authorizations lapse and it takes time to get services re-established, meaning that members may be discharged without needed support: *"people who are on MLTSS with home care services, if they go hospital and subacute, they face this same 30 days [for MCO to assess and put authorizations in place] when they return to the community, because the care managers won't go and see the person while they're in a facility ... can be discharged and not have services for 30 days post-discharge."* State staff noted that the issue of authorizations dropping during a protracted absence from services occurred with the previous system as well, and suggested that responsibility lay with providers to communicate in a timely way--the experience of the state staff was not with consumers going without services but, rather, with providers complaining about rejected claims when they provided services after authorizations had lapsed.

1.4 Appeals/Grievances/Fair Hearings

Within MCOs. Many advocate and provider stakeholders feel that MCO internal appeals and grievance procedures are not meaningful because 1) the documentation provided by the MCOs

generally communicates only the decision and does not indicate how the specific complaint has been considered, and 2) these procedures do not generally result in changes. Our interim report noted that a DMAHS presentation of MCO-reported data of 255 appeals found that in more than 90% of cases, the denial of service was upheld (Chakravarty et al. 2016: 37-38). We are not aware of any benchmarks regarding the rate with which denials should be overturned. MCOs, for their part, feel that a low rate of overturned decisions means that the original decision was a good one, and feel constrained in communication by boilerplate forms designed with input from the advocacy community that they believe are burdensome for consumers. It is our understanding that these templates are designed to contain a minimum of information, including contact information for advocacy organizations, and are not designed to restrict MCO explanation of decisions.

MCO Member Advocates. We heard complimentary remarks about member advocate staff in one MCO in particular. These staff were reported to help nontraditional providers enroll in the MCO's network when consumers did not want to switch to another provider, and generally to resolve issues with members.³⁰ The MCO contract requires that member advocates attend interdisciplinary team meetings (required when consumers are approaching cost caps) along with the MCO care manager and various state employees.

MLTSS Quality Monitoring Unit.³¹ Advocates speak very positively of the responsiveness and effectiveness of the MLTSS Quality Monitoring Unit, both in addressing individual situations and in addressing some systemic issues through stakeholder communication or revisions to the MCO contract. However, they believe the existence and contact information for the unit is not adequately communicated and that most consumers do not know of the unit's existence.

NJ Division of Banking and Insurance. The New Jersey Division of Banking and Insurance manages the Independent Health Care Appeals Program (IHCAP),³² which offers independent external review of adverse utilization management decisions. Advocates report that this option is only for services requiring medical review—with respect to MLTSS, generally only private duty nursing decisions are appealed here. Advocates reported satisfaction with the process and results for private duty nursing disputes.

Fair Hearings.³³ Fair hearings are an important due process right for consumers. Advocates believe they are often successful in overturning adverse decisions through this process, but also believe that the process is lengthy and complicated and that there are too few data collected or shared about filings and outcomes. They noted that data would not be available in New Jersey to do a comparable analysis to one done in New York (Bogart et al. 2016). MCOs and providers also noted the length and complexity of the fair hearing process. We do not know of available data to

assess the time to resolution. Interviewees reported that it is not unusual for cases to take six months to resolve.

Medicaid fair hearings are generally handled by the Office of Administrative Law (OAL). Petitioners notify state agencies that they would like to request a fair hearing (for MLTSS, the agencies would be DMAHS on services/equipment or DoAS on eligibility). The agency can decide whether they want to hold their own hearing or send the case to OAL.

Some MCO interviewees believed that enrollees or advocates sometimes try to use the process to delay what the MCO views as justified cuts in services. Advocates note trouble in getting necessary documentation from the MCO to help clients. Advocates told us that, due to the length of the process, sometimes a scheduled reassessment comes during the course of a fair hearing case, which requires more requesting of documentation and review on their part. Often the final agency decision is to order a new assessment, which is not appealable and doesn't necessarily settle the issue, but may just restart it.³⁴ Advocates have expressed concern that some MCOs settle fair hearing cases after the process has begun, putting pressure on them to withdraw so that these cases do not show up in any records.³⁵

Advocates describe clients getting worn down by the process or being too intimidated to begin or continue the process, even though they feel that they have been harmed. A provider association noted that patients worried that challenging the MCO could result in them losing even more hours. Our previous report quoted a provider whose clients were generally too intimidated to go to court (Farnham, Chakravarty and Lloyd 2015: 12). Advocates agree with this, noting that *"for the clients who have to go to court ... that can be a real hardship ... for some of our clients, just getting to and from a hearing is really hard—physically hard, certainly mentally difficult ... and then taking the witness stand and having to explain, under oath ... talking about their using the toilet ... it's a very unpleasant experience for them and at least in some instances I've had clients who express significant anxiety ... and I've had clients who will ... take whatever it is they throw out ... because they'll do anything not to go to court [another advocate present at the interview agreed]."* We noted examples of judges accepting phone testimony (Bass 2016) and asked advocates if that was an option. They told us that some judges do allow that, but that they feel it is better for the establishment of consumer credibility to attend in person if possible.

There is limited access to information on fair hearings. There is a database that contains some cases but advocates have told us that some of their own cases are missing when the search for them, so they are not sure what determines the database entries.³⁶ DMAHS has presented some information about fair hearing dispositions at the October 2016 MAAC meeting, but gathering the data represented a manual process for them. From January through July of 2016, 592 of 3,069

fair hearing requests (19%) involved an adverse decision by an MCO (MLTSS or any other Medicaid program).³⁷ For the MCO-related hearings that are filed, 5% to 10% of cases proceed to an initial or final decision, 11% of the time people fail to appear (no reason why known), and 60% are withdrawn (no reason why known). The remaining percentage (19-24%) was not explained, and these cases were probably still pending.³⁸

1.5 Provider Experiences

In general, providers have been negatively affected by the move to MLTSS because of the increased administrative burden of becoming credentialed, contracted, obtaining authorizations and filing claims with several MCOs instead of a single state payer. In addition, all provider interviewees report a longer wait time to receive payment under MLTSS. There are many reports of rate reductions, as well, by our interviewees and others (see Kitchenman, December 2014 and Department of Human Services 2014, p.28).

Authorizations. We had widespread reports of improvements in the authorization process compared with our last report, when interviewees complained of short authorization terms requiring more frequent requests for reauthorization than they thought necessary or efficient. In this second round, interviewees generally reported authorization terms of 6 months for long-term services, sometimes after an initial 30 day period.

Care Management: Some providers had hoped to participate more in care management with managed care, but they have not generally found this to be the case. One HCBS provider spoke of their disappointment that they perceived no engagement by the MCOs beyond authorizing and paying for services and thus felt that the system of care had not really changed : *"I don't think ... we're really fully integrated, there's this master care plan that we're all engaged in ... we're getting a fee-for-service, it's just through a managed care plan now ... [interviewer: do you see any movement toward integration?] I don't ... there's been numerous discussions ... we have initiated a number of, what we felt could be interactions that could ... work together ... with the plans ... look at a way to get this holistic view of the member... [no] followup to move that forward ... [services are] disjointed ... we could create more value ... lack of interest right now ... disappointing."*

Some residential providers have similar concerns, as noted in Ryan (2016): *"While we understand how difficult it is to hire, retain, train and evaluate case managers, 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."

We heard the above concerns from larger facilities serving a general population needing custodial care. A couple of smaller, specialized residential providers reported improvement from our first interview to our second, with more stability and consistency in care management staff for the clients they served. These providers are very actively engaged with their population and probably initiate a fair amount of contact with the care manager, so they may not be as dependent on outreach from care managers to establish a relationship. They have found care managers helpful in locating specialist providers for their clients, which was more of a problem under the fee-for-service system where few specialists participated.

One promising practice is a pilot program done by Horizon with Bayada, where home care aides report on changes in condition, which sends an alert to the care manager to check on the member (Manger 2015). Over a six month period with between 200 and 300 hundred members, Horizon got an actionable change in condition report for about one in six members, which presented many opportunities to improve member conditions. Changes could be physical or environmental—one report was about bills piling up and potential depression after the death of a member's spouse. The care manager was able to get family involved to pay the bills. In general, they felt the pilot was very successful in identifying and closing gaps in care. While promising, other stakeholders wonder how transferable the pilot will be to other providers who may be less advanced technologically.

Claims/Payments. Other than issues with rates, problems with claims and payments appear to be the largest issue for providers. Providers generally report an increase in the amount of time to receive payment under MLTSS compared with the prior system, even with a claim that is paid after the first submission, which they report occurs less frequently under MLTSS (see comments to CMS from Kent (2016) and Ryan (2016), which note that problems have occurred with all MCOs). Several providers believe that timely payment of claims should be a publically-released performance metric for MCOs.

Coordination of Benefits. In preparation for MLTSS, the state facilitated a workgroup that developed standardized codes for MLTSS services, so that providers would not have to deal with multiple systems. Stakeholders were happy with this concept and in most respects it worked very well. However, there were unforeseen consequences in the aftermath of the Jimmo v. Sebelius decision in which CMS clarified that services that had not been understood by many to be eligible for reimbursement under Medicare were, in fact, eligible (CMS 2013). In some instances, this affected the codes selected for MLTSS services and meant that providers had to submit a

Medicare denial prior to submitting for Medicaid payment to comply with fraud provisions. This is a problem for providers who are not Medicare providers, providing services that aren't covered by Medicare. Because they are unable to procure a denial, they have been unable to be reimbursed. A workgroup is working on the issue. Even for providers who were able to procure a Medicare denial, this turned claims filing into a manual process because the denial (although they only need to get one per year) has to be attached to each claim submitted in that year. This is more burdensome for all parties involved.

Small Providers. Some managed care issues affect all providers. However, in some cases experiences appear to be worse for smaller providers who have less experience with managed care or lower volumes. For example, one of the MCOs instituted a process requiring home care aide license numbers to be submitted on claims for personal care services. The process was highlighted by the state in its NJ FamilyCare 2015 Annual Report as a best practice. A large-volume provider spoke positively to us about this process both as a principle and with respect to implementation. They had not had any issues implementing the change and felt that the MCO provided sufficient explanation beforehand. Two smaller providers had trouble implementing the change, with both experiencing claims denial and trouble getting help on how to correctly implement the change in processing. One of these providers we spoke with in our first round and we do not know if they were able to resolve the issue. The second provider we spoke with in our second round. They had gone back and forth with MCO technical support over the course of a year with the claims initially rejected because the license number was not formatted correctly (support staff eventually told them to try adding leading zeroes to bring the number to a certain number of digits). Once the problem was corrected, the claims were rejected for not being submitted in time, and the provider now has to pay to have them arbitrated.

Another small provider highlighted helpful actions by an MCO with regard to billing (they noted elsewhere, however, that their current rate of reimbursement was below their costs and what they had received under GO, and that they never were paid what they felt they were owed during the continuity of care period): *“they work with us very well when it comes to making sure we understand ... one of their ... people had come down to show our person that does the billing—actually came on site to help get everything set up to do the electronic billing, so they’re very accommodating in that way.”*

Contracting. We did not hear many comments about contracting this time, although smaller or nontraditional providers reported some issues with countersigned contracts not being returned after they had submitted a signed contract to the MCO, or burdensome contracting practices. For example, one county provider reported that, while several of the MCOs had a reasonable process, one of the MCOs wanted the individual social security numbers and personal contact

information of county leaders in order to put a contract in place. This provider was not serving any members of that MCO at the time and declined to contract with them.

Credentialing. The state is moving toward a single system for credentialing providers and plans to implement this in 2017.³⁹ This should decrease the burden on both providers and MCOs with respect to this function, which involves verifying the credentials of providers.

Rates. All providers we spoke with in both rounds of interviewing agree that there have been rate reductions in some cases and that these have been harmful (see Kitchenman, December 2014 and Department of Human Services 2014, p.28 on rate reductions for personal care services). One provider told us that *“in New Jersey, the stagnant and inadequate rates for the delivery of home care services have been systematically ratcheted down and are now at an unsustainable low. For the past 20 years, reimbursement has been decreasing. Rates were too low in the 1990s when an hourly rate for the delivery of personal care services was at \$16.00 and, since the transition to MLTSS, health plans have reduced rates to as low as \$13.50 per hour.”* Another provider noted that in addition to the hourly rate reductions for personal care assistance, services that used to be separately billable in the fee-for-service system, such as the requirement that home care agencies create a plan of care and have supervisory visits, are now expected to be built into the rates paid for PCA care under managed care—in other words, comparing the hourly rate reductions for personal care over time will underestimate the revenue reduction experienced by providers. We have heard from two nonprofit providers, both of which have withdrawn from Medicaid, that MCOs should look at overutilization of hours, which could provide support for a rate increase. Rate pressures, coupled with longer delays in payment under MLTSS, have made it difficult to recruit and retain qualified staff and exacerbated pre-existing workforce shortages.

Potential Consolidation of Providers. We have heard indirectly from provider and advocate interviewees who were present at meetings where they recall hearing comments made that both the state and the MCOs were hoping for provider consolidation to increase efficiency, improve consistency, and reduce fraud. Providers support the idea that unscrupulous providers should leave the market, but wonder who is actually withdrawing from the Medicaid market, and feel that local community knowledge and other community benefits will be lost if providers become too large or revenue-driven. One provider noted the following in our first round of interviews in early 2015: *“I don’t know how [provider agencies] could be following the regulations and dealing with \$13 an hour when they don’t have significant other funding to make up for it ... we’ve created a situation that can only get worse, there can only be less access to home and community-based care, and those providers that are left standing after a while are not going to be stellar ones ... we do things like we provide scholarships for aides to go to nursing school, we provide*

scholarships for their kids to go to college, we give them loans if their car breaks down—those are nice things, but they're also good business, because aides would come to us ... several of them ended up being nurses with us, and going back and getting master's degrees, and one's running an agency now ... if an aide's car breaks down, she can't get out and do cases, so we'd loan them the money to get it fixed--we've gotten every penny of those loans back. So these agencies that are struggling to do it the right way do a lot of things for the community that aren't apparent on an MCO list ... we gave our aides training in Alzheimer's—we got the Alzheimer's Association to come in and do weeks of extra training ... all kinds of things nobody paid us for ... we had a big volunteer shopping program we don't get a cent of funding for, but it was done because it was a good thing, we were mission driven. Those are things that have to go by the wayside when you can't even pay your staff anymore.” By late 2016, this agency was largely withdrawing from Medicaid, and it is our understanding that most nonprofit providers no longer provide aides under Medicaid and that some have downsized significantly or combined with for-profit providers.

1.6 State Oversight/Management of MLTSS

Continuous Improvement Philosophy. As discussed in our previous report, state MLTSS staff⁴⁰ have a philosophy of continuous improvement, where they revisit and improve processes continually. Revisiting is done with ad-hoc or more official workgroups or committees. Process changes are communicated both informally and in memos to stakeholders as well as publically through Medicaid Communications and biannual revisions to the MCO contract. Ongoing communication with various stakeholder groups is seen by state staff as key to successful management: *“we are in communication with stakeholders, with providers, and with the MCOs constantly, and then issues come from all different directions, from members calling. And then, because we have that ongoing contact, we're able to address and identify issues ... [speaker 2] if you had to look at lessons learned for other states, you can't just turn the key and walk away, and I think we have found that if we were not in such close contact, I'm not sure we would be where we are.”*

Clinical Eligibility. State staff at the Office of Community Choice Options (OCCO) monitor MCO assessments of clinical eligibility and make the final decision to approve or deny eligibility. If they cannot make a determination based upon the information provided by the MCO, state staff do a face-to-face visit with the applicant. OCCO staff also manage clinical eligibility determination for anyone not yet on Medicaid at the time of MLTSS application, as well as anyone entering a nursing home (because nursing home stays rapidly deplete financial resources and are likely to lead to a future Medicaid application).

Critical Incidents. MCOs are required to report promptly to the state a list of 30 potential critical incidents.⁴¹ Each MCO has a form for its providers to report incidents to the MCO, which include contacts for adult and child protective services and the NJ Office of the Ombudsman for Institutionalized Elderly.⁴² They are also required to track, review and analyze the incidents to address quality and safety issues. We discussed earlier in this report how an MCO analyzed a member's falls and adjusted the hours an aide was present to improve safety for the member (see page 20). Critical incidents are one of the quality metrics reported by the state to CMS on a quarterly basis.

Contract Management. The primary method through which MLTSS is formalized is language in the MCO contract, which covers a six month period.

Regular Revisions. The contract between the state and MCOs runs from January through June, with regular changes made based on issues that have arisen. For example, early in MLTSS implementation the state encountered problems with reviewing MCO clinical eligibility assessments due to gaps in the information entered for their review. Subsequent contracts set a performance standard for MCOs with regard to assessment quality.

Contract vs. Regulations. Though we did not hear of state staff discussing contract design directly with advocates, advocates told us that they appreciate the state's responsiveness in designing revisions to address situations they have encountered and reported through the MLTSS Quality Monitoring Unit. However, they also generally feel that regulation through contract, rather than official regulations that are subject to public comment and judicial interpretation, is problematic. In response, state staff note that the regulatory process is time-consuming and would limit their flexibility to respond to issues that arise—one state official noted *"This is like the great American onion, and as we peel the onion we do find issues—new policy kinds of considerations that we have to make, and we proceed at that point to address them."* Some providers are also concerned in that state regulations require home care agencies to do the same assessments that are done by the MCOs. As of late 2016, we heard that these regulations were being revised.

Sanctions and Corrective Action Plans. Sanctions such as notices of deficiency, fines, and corrective action plans are used by the state when necessary, according to state staff. Sanctions on MCOs can be imposed by Medicaid (DMAHS) or the Division of Banking and Insurance (DOBI). State staff tell us that these have occurred under MLTSS, but do not occur frequently. Such sanctions are not public information.

Quality Monitoring and Provider Relations. The state maintains two units designed to resolve problems that occur with providers and consumers under managed care—the Provider Relations Unit and the MLTSS Quality Monitoring Unit. Each unit has dedicated phone numbers and email addresses and a small number of staff, and tracks inquiries and complaints. The Quality Monitoring Unit oversees the MCO Quality Metrics that are reported by the MCOs, the work of external quality review organizations, and the NCI-AD, designed to measure consumer experiences with long-term services and supports. In addition to these quality assurance activities, the state plans to audit some additional cases beyond the NCI-AD sample, to ensure continuous quality inquiries throughout the year. Stakeholder comments regarding these units are discussed in more detail below.

1.7 Stakeholder Relations

Communication with MCOs. State MLTSS staff communicate with MCOs through a variety of methods.

Triage Calls with MCO Management. State staff maintain a regular biweekly schedule of conference calls with MCOs specifically to discuss MLTSS. At the inception of MLTSS the calls were daily—the frequency has been reduced gradually over time, as issues to triage have become less frequent, to several times per week, then weekly, then every other week. The MCOs report on some standardized measures regarding their interactions with consumers and providers as well as analysis of critical incidents that have occurred and any other item they wish to discuss. State staff bring up issues that have been raised by stakeholders or that state staff have noticed. The state specifically asks MCOs to discuss things that are going well in addition to discussing problems in order to document best practices. MCOs appeared to be generally satisfied with their relationships with the state—one MCO commented that the state holds plans accountable and is a solid partner to work with.

Quality Meetings. Separate from the triage calls, staff from the MLTSS Quality Monitoring Unit meet monthly with representatives from each MCO to discuss the collection and calculation of quality metrics. These meetings began a few months after the transition, when the state recognized that there were differences in how MCOs were calculating required metrics.

Training with MCO Care Managers. In addition to the triage calls, which are held with MCO MLTSS management level personnel, state staff offer training sessions for care managers. Until early 2017, these were held twice per year to minimize burden on care managers. However, in order to make the sessions more interactive, with time for care managers to raise issues for discussion, the sessions were increased to every other month early in 2017. State staff note that it is important to communicate with MCO personnel at all levels. In addition to in-person training,

videos and other materials are available on the state's web sites for MCOs and other stakeholders.⁴³

MCO Consumer Advisory Committee Meetings. State staff sometimes attend meetings of MCOs' consumer advisory committees on MLTSS. The committees are required by the MCO contract.

Communication with Other Stakeholders. The state MLTSS staff meet more frequently with MCOs than with other stakeholders, which is sometimes noted negatively by these groups. However, the state notes that its MLTSS staff are responsible for regulating MCOs and thus require more time with them.

Providers. Providers appear generally satisfied with the Provider Relations Unit (mentioned earlier in the section on oversight/management) and feel that the staff are responsive. They feel that at some times the staff are underresourced, however, extending response times if systemic problems are occurring that drive a large number of inquiries. In addition, they expressed that it can be difficult to get the state to move from addressing individual problems to seeing systemic issues: *"The state should reach out to the provider community on a much more frequent basis to see how things are going ... the plans have a biweekly call with the state—the provider community does not have that, and never has, so they're able to tell their side of things but we don't get to tell them—we have to ... request meetings and go a different route to relay how the actual patient is being impacted, and I think that's a problem ... everyone was saying [MCO name] thing was an issue and no one was paying attention to it—it literally took all the associations to be quite, quite aggressive and persistent to get their message heard that it was a big problem—it wasn't a one-off issue, and that was very frustrating because we could tell ... systemic issue."*

In addition to this dedicated unit, state staff conduct outreach by making presentations at provider association events and post reference materials online.⁴⁴ Provider associations participate in the MLTSS Steering Committee and, where relevant, with subcommittees or workgroups on particular issues. Early in MLTSS implementation, upon hearing problems about billing problems in Assisted Living, the state mounted a survey of provider experiences on the issue and reported results in the Steering Committee.

Consumers/Advocates. The MLTSS Quality Monitoring unit (mentioned earlier in the section on oversight/management) is highly regarded by advocates as very responsive and helpful when a consumer has a documented problem. However, stakeholders tend to feel that its existence is inadequately publicized to the general public and that staff there as well as staff

above the unit can be too deferential to the MCOs and not willing to characterize issues as systemic, or consider potential (as opposed to actual) quality issues: *“at the state level in Medicaid, we see a lot of deference to the MCOs, that I know now, in interacting with people in other states ... I think the same level of deference is not happening in other places ... I guess the feeling is that ... because there’s contract language, that really the plans have a lot of latitude in interpreting the contract ... I will say in almost all the cases have resolved to the member’s benefit and the member has gotten the service that they needed, but I just feel that many times it just takes a lot of advocacy—not just with the managed care organizations, but with the state, to enforce the contractual provisions, and hold the MCOs to their obligation ... I think that is a very high-level, systemic issue.”*

Area Agencies on Aging. The Division of Aging Services conducts monthly meetings with Area Agencies on Aging to discuss all the agencies’ efforts, including their screening for community services for MLTSS. Meetings are in-person every other month⁴⁵ and by phone during the intervening months.

Steering and Other Sub-committees. The state maintains a quarterly MLTSS Steering Committee with representation from MCOs, providers, consumer advocates, the Office of the Ombudsman for the Institutionalized Elderly, county welfare agencies, Area Agencies on Aging, Centers for Independent Living, county offices for the disabled, and a healthcare worker’s association. The original membership was drawn from the Medicaid Long-Term Care Funding Advisory Council of New Jersey. In 2016, the committee heard presentations from Adult Protective Services and the Office of the Public Guardian for the Elderly. The Steering Committee also convenes subcommittees as necessary. In 2016, the state reconvened the quality subcommittee to discuss how to move beyond the any willing provider (AWP) provisions for nursing homes without compromising quality.⁴⁶ There is also a provider workgroup looking at coordination of benefit issues with state staff who oversee MLTSS and the Medicaid Fraud Division as well as the MCOs.

Stakeholders are pleased to have a Steering Committee, and advocates were happy to have a representative from legal services added to the committee in 2015. Some participants would like to see the Steering Committee take a more active role in steering the program, with non-state chairs, similar to the Medical Assistance Advisory Council (MAAC). State staff note that the Steering Committee was not designed to continue indefinitely, but added that they find it useful and do not envision disbanding it.

Stakeholders reflected positively on the quality subcommittee examining the any willing provider (AWP) provisions. Initially there was some dissatisfaction among consumer advocates because it

became apparent during the first meeting that the state had already discussed the issues with provider associations. However, in subsequent meetings, consumer advocates seemed to feel that their points of view had been considered and those we spoke with appeared very satisfied with the process.

Public Outreach. The main form of public outreach for MLTSS, along with other aspects of Medicaid, is the Medical Assistance Advisory Council (MAAC), which meets four times per year and is open to the public. The MAAC is required by federal and state law. Meetings are announced in advance with agendas 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.⁴⁷

In addition to the MAAC, the state held three two-hour public forums in the north, central and southern regions of the state in October 2014 to present an overview of MLTSS and solicit input, described as follows (Day 2014): “DHS will now be holding three “Feedback Forums” to allow advocates for older adults, people with physical disabilities, caregivers, and home and community-based service providers the opportunity to share their thoughts about the MLTSS rollout. Attendees will also get an update on the MLTSS statewide implementation that will focus on access to services; person-centered care approach; developing plans of care based on care needs and members’ rights and responsibilities; provider relations; and quality management.”

Stakeholder Comments

Partnership. Many stakeholders were complimentary about the state’s relations with stakeholders. An example, from a provider group: “*the state’s done their best work in the stakeholder ... process ... most recently, with understanding the limitations on going fast and working with folks ... we’re more than just vendors, we’re partners, and I think the state’s realized that with their recent quality metric work and committees to bring us a modified any willing provider network strategy.*”

Role of Consumers in Providing Systemic Feedback. Some feel there is not enough input from consumers and that the makeup of the Steering Committee, in particular, is too light on consumers or consumer advocates. A representative from legal services was added in 2015 to the Steering Committee. One consumer representative, who has been involved in providing the state feedback over time, commented that the state listened in the early planning stages to consumer concerns about transitioning the entire nursing facility fee-for-service population to MLTSS, and that the state has continued to evolve in its thinking about how to better serve both consumers and caregivers: “*They really listened to the consumer part which is ... very important ... wasn’t just me ... there were consumers from the Department of Developmental Disabilities,*

the Department of Disability Services ... caregiver organizations throughout the state had consumers putting input in, and they really listened ... big plus ... [state staff] looking for how MLTSS can assist caregivers, that's absolutely excellent—they weren't even discussing that in the beginning, I don't think. So, absolute progress here."

When asked about how consumer involvement has changed over time, this interviewee noted that there had been attrition of consumer participants over time due to declining health, but that they didn't believe this constituted a problem because there were consumer advocates present. They also noted that participation is taxing for consumers—not only physically, but mentally due to program complexity: *"must have been a good 10-15 of us, way back in [several years ago, before discussion of MLTSS] ... since then, many ... have stopped coming—part of it is because many of them were handicapped, and they're getting older and they can't, so it would be nice if there were more consumers, but the reason why I don't feel that's an issue is because we have AARP there, we have the ombudsman there ... we have the TBI [organization] there, we have consumer advocates there—not necessarily consumers ... when I first started ... I started putting together a list of, like, what OCCO stands for ... because everybody in the room knew but ... I didn't know all of that ... 8 pages long, my list now ... you would not believe the initials of all the programs there are, so when they're talking about it, from a consumer perspective, I have that sheet in front of me all the time so I know what they're talking about, and each month I'm adding more to it, so it could be complicated for a consumer."*

Accessibility of System to Consumers. As suggested by the quote above, state and federal Medicaid policy can be complicated even to those who are familiar with it. Some felt that the system was not accessible enough for consumers, many of whom may have difficulty communicating in some way.

2.0 Discussion—Improvements Noted from First to Second Round of Interviews

Care Management after Transition. Some agencies—particularly former waiver agencies--reported initial confusion by consumers as to how identify or contact their care manager. After the initial transition, agencies are not seeing questions about this. This doesn't necessarily mean that people are easily contacting their care manager, but does mean that they are not contacting their former waiver agency for help with this issue, and probably reflects reduced confusion.

Authorization Duration. In our first report some stakeholders reported some short term authorizations for long-term services. We did not hear reports of that in the second round—stakeholders reported that MCOs generally offered six months of LTSS services for MLTSS clients before requiring reauthorization.

Relationships between Consumers and County Welfare Agencies. Our first report noted some dissatisfaction expressed by consumers at the documentation requirements by county welfare agencies newly responsible for processing adjustments to client incomes for expenses such as medical supplies—apparently, some waiver agencies had not required documentation beyond receipts (e.g., prescriptions). By our second round of interviews, county welfare agency staff reported that consumers had adjusted to their requirements.

Improvement in Knowledge among MCO Care Managers. One provider stakeholder who had observed care management before and after MLTSS felt that initially, things did not go well: *“that has definitely changed, because initially it was a disaster, but as they’ve become more knowledgeable, you can see the difference ... they know more about what services are under MLTSS and what is covered and not covered and what would be approved and not approved, so I am seeing that that has improved—I mean, a lot.”*

Relationships between MCOs and Other Community Resources. Many stakeholders feel that there is still a serious gap here, but we did hear of some progress with respect to some MCOs attending county-level meetings of service providers, which should help to make the safety net more robust by strengthening relationships.

Addition of Supports Plus Private Duty Nursing. When MLTSS first began, advocates were concerned that people with developmental disabilities were being disenrolled from other programs in order to access private duty nursing, but then could not access programming from the Division of Developmental Disabilities. State staff created a private duty nursing option in the Supports Program, another aspect of the 1115 waiver, so that consumers could have access to both sets of services.

3.0 Summary: Stakeholder Views of the Advantages and Disadvantages of MLTSS with Respect To Access to Care, Quality of Care, Costs, or Care Setting

We are not able to make an overall statement based on stakeholder interviews about the impact of MLTSS, but we are able to provide a summary of stakeholder views of the advantages and disadvantages of MLTSS as compared with the previous system of four separate §1915(c) waivers, as well as areas of question or concern raised by some stakeholders where agreement did not seem sufficient to categorize them as a disadvantage, or where it wasn’t always clear whether the issue was caused by MLTSS. Such views refer to MLTSS as it has been implemented up to this point—while some views refer to something that has come and gone (e.g., disruption caused by the initial transition), other views could change as the program evolves over time. In other words, future summaries of stakeholder views could look different. In addition, stakeholder views are variable at any point in time—while we did our best to capture a variety of viewpoints,

it may be that including a different set of stakeholder interviewees could potentially change these results.

Advantages

- Waiver Inclusivity. Prior to MLTSS, the Global Options waiver target population of individuals 65 and older and individuals ages 21 to 64 with physical disabilities sometimes was interpreted as excluding people for whom behavioral health or developmental disabilities were the primary diagnosis. Now there are no such exclusions. While the earlier policy was overturned at least twice on fair hearings,⁴⁸ advocates are pleased with the change, believing that it has increased access to care.
- No Slots/Waiting Lists. There is no longer a need to reserve or wait for waiver slots, increasing access to care.
- More People Enrolling. Many interviewees had the subjective impression that more people are enrolling in MLTSS than under the §1915(c) waivers. This appears to be borne out by data shown by Medicaid showing an increasing percentage of the Medicaid population enrolled in MLTSS—from 0.7% in 2014 to 1.8% by the end of 2016.⁴⁹ This appears to reflect positively on access to care under MLTSS.
- Better Screening for Eligibility. Area Agencies on Aging/Aging and Disability Resource Centers, the certified Information and Referral Specialists at the Division of Disability Services, and MCOs (for their non-MLTSS members) now explicitly screen those seeking information about long-term services and supports for potential eligibility. One AAA interviewee told us that they were identifying many more people than before because of the screening. There were, however, a few comments from interviewees who had helped people navigate in the past regarding concerns that these screenings could inappropriately discourage some potential enrollees as well.
- Integrated Physical, Long-Term, and Behavioral Health Care. MLTSS carved in behavioral health services along with physical and long-term services, so that MCOs are managing all types of services (with the important exception of many Medicare or private insurance-paid services that are accessed by some enrollees). Most stakeholders feel positively about this change, but also feel that it is too early to assess overall the extent to which it has increased access to care, quality, setting or cost. There are anecdotal examples of enrollees benefiting from integrated behavioral health care and from providers who noted help from MCOs in accessing specialist acute providers—something that had been a problem under the previous waiver system. One provider noted *“I don’t see a problem with the HMOs doing the case management—in fact, I kind of like that they’re doing it because they [the care manager] have access to the insurance company ... things turn around quicker because they work for the HMO ... the medical director from the HMO will*

look at things, especially when they're a little out of the usual, and you get a quicker response."

- More Visibility for Home and Community-Based Services. Two advocates who work with people in need of long-term services and supports feel that MLTSS has led to greater awareness of the availability of home and community-based services among nursing home staff and county welfare agency staff, which may lead to more referrals and thus greater access to care.
- Easier Navigation/Administration with a Single List of Services. Many stakeholders are very happy that enrollees now have a single list of services available to them. The past waivers all had somewhat different service packages, meaning that at times enrollees didn't fit perfectly into any of them, frustrating enrollees, care managers, and state administrators. As one state interviewee told us: *"[MLTSS] is comprehensive—the person is looked at in total, as a whole, and services are given kind of multi-modal, instead of this comes from one agency, this comes from another, and sometimes the rules conflict, and one program that's giving you services makes you a liar to another one. This program I have to tell this to get services, this program I have to tell this, and as people are clinically declining or having crisis, nobody can remember what's what. I think the thought of having a care manager administer everything has probably been one of the greatest things—and again, we're still pushing the envelope on what that looks like—I think the higher the level of clinical need we're able to have in the community, the more the menu has to increase ... there are people living in the community right now that would have gone to a nursing home just two years ago, three years ago."* GO (Global Options) was a combination of several earlier waivers for the older adult population, so New Jersey has been working on streamlining and consolidation for some time. From a state perspective, waiver administration is more streamlined, freeing up resources for other tasks.
- Members in Nursing Homes Get Care Management. Though there were some mechanisms prior to MLTSS to identify nursing home residents who wanted to return to community settings, under MLTSS each nursing home resident has a care manager. However, ratios of members to care managers are high for nursing homes, and some have commented that the care management in this regard is not very effective (Ryan 2016).
- Requirement that MCOs Provide Care. As noted by Davey (2017), "Unlike the fee-for-service (FFS) system, the MCOs are accountable to deliver the full Medicaid benefit to their beneficiaries, whether it is through participating provider contract arrangements, documented relationships, or single-case agreements when participating providers are not available or willing to contract with the MCO." Though such arrangements are not tracked in reported metrics, we have heard MCO staff and state officials mention the MCOs making single case agreements with "nonpar" (i.e., nonparticipating in the regular MCO network) providers when necessary. The state, under the fee-for-service system,

sometimes had trouble recruiting providers and could not offer enhanced rates for cases or geographic areas that were difficult to staff. One MCO spoke of how they had used this flexibility to help their member access services that he was unable to access prior to MLTSS: *“we’ve been able to get creative ... with some of those providers ... we had a member who was a young man, and when he was ... a minor, he had attended a DD day program ... He couldn’t attend any longer as an adult ... [FFS] Medicaid wasn’t able to pay for the service for him ... it wasn’t technically medical day, because that facility wasn’t licensed as a medical day ... they have a specific social day care rate of \$30 per day or something that this provider never would have accepted for the complexity of the member ... we were able to say “What rate do you want?” and we’ll call it social day and we’ll set up a contract and we’ll pay you at that rate ... and it stayed within budget ... so now he’s got a solid community placement, where I think [his] mom was pretty stressed out before.”*

However, unless the MCO is very proactive (as in the aforementioned example) enrollees must notify the MCO of trouble locating care—that is, while there is more accountability, there is a burden on the enrollee to hold the MCO accountable. Our quote on pages 25-26 provided an example of someone who was apparently enrolled in MLTSS but who the MCO did not contact. The state helped facilitate contact with the MCO, but the person still did not receive services because the MCO said there were no providers in the area. We do not know whether the enrollee gave up at that point or whether further advocacy occurred. Thus, while this requirement has the potential to increase access to care, it is not clear to what extent it does so. There is a performance measure regarding the number of MLTSS members accessing MLTSS services (see DMAHS 2015 1115 Annual Report), but this would include members in addition to the kind of example mentioned above (those who have disenrolled, are in an extended hospital/rehab stay, people billed with the wrong codes, etc.).

Advocates note that people may be slow to complain, even to those they know—one knew a member who finally told her after 2-3 months that she was having gaps in her care: *“She often went without any care over the weekends. So there was times when she literally just sat in her chair, and would sit in her own feces until her [relative] could come over and take care of her, because there was days where she had no coverage. I would say to her case manager, ‘How is this okay? What are you doing about—you’re just ignoring the fact that she doesn’t have service. This is not okay’ ... It was probably a good 2-3 months before [client] had come to me to say this was a problem ... she was starting to have skin breakdown issues ... don’t know if contributed to her passing, or the stress of it ... not long after we got the issue resolved that she passed away.”* This member had been given brochures for assisted living when that was too low a level of care for her, and

may have feared having to move to a nursing home if she complained. One MAAC meeting attendee noted that Wisconsin provides a Medicaid benefit of up to \$2,500 per year for consumers or their caregivers to receive training in how to advocate for themselves and felt that this kind of benefit could be helpful for New Jersey beneficiaries.⁵⁰

Disadvantages

- Potential Longer Wait for Services. After eligibility is determined, there is a longer required wait time for MCO enrollment under MLTSS than there was for waiver agency enrollment in the prior system. However, it is important to note that we do not have measures of the extent to which this impacts the timing of services to consumers, which is of key importance. Some stakeholders we spoke with estimated that the extra wait time is about 2 weeks to 1.5 months. Other stakeholders noted that there could be delays in the prior system as well if case management capacity was insufficient. State plan benefits (which include personal care assistance and medical day) are available in the interim on a fee-for-service basis upon provider application to the state with documentation of medical necessity, but consumers may not be systematically informed of this (there is no notice in writing to beneficiaries and no mention of this option on state web sites), which may limit access.
- Transition Uncertainty. The transition period to MLTSS in 2014 involved a period of uncertainty and therefore stress for both consumers/families and providers.
 - Members had to wait up to 6 months to be reassessed. During this time, there were strict continuity of care requirements but consumers could not call their former case manager with any new issues—instead, they had to reach out to their MCO, possibly before having met their new care manager.
 - Providers were not always contracted with MCOs and had to figure out new administrative issues such as how to bill and how to deal with denied claims. The state required continuity of care for members but some providers told us that they were never paid what they believe they were owed (and what they believe they would have been paid under the prior system).
- Administrative Burdens, Rate Decreases, and Payment Delays for Providers. In the prior system, providers had only one system for credentialing and claims. They reported that the claims system was straightforward, with payments received in about 10 days. With MLTSS, providers have to be credentialed and contracted for each MCO with which they are participating, and there is a separate claims system for each MCO. The state did facilitate standardized billing codes for MLTSS services, which is generally noted as a positive development (one exception is discussed below). The state is also moving forward with a single credentialing standard. Providers reported some barriers with contracting with respect to terms or processes they felt were unfavorable or burdensome,

but most of the comments we heard were about payment delays and rate decreases. While MCOs report to the state an average of 15 days to payment for clean claims, many providers asserted to us that clean claims are rare.

- Standardized Billing Codes Combined with Federal Policy Clarification Led to Coordination of Benefits Questions, Complicated Billing, and Payment Delays. The state and MCOs invested extensive time prior to MLTSS implementation in developing standardized billing codes to be used among all MCOs. Stakeholders agree that this concept was a good one. However, in some cases it meant that the same codes were used for Medicare and Medicaid services. In the *Jimmo v. Sebelius* decision, CMS clarified that services that had not been understood by many to be eligible for reimbursement under Medicare were, in fact, eligible (CMS 2013). In some instances, this affected the codes selected for MLTSS services and meant that providers had to submit a Medicare denial prior to submitting for Medicaid payment to comply with fraud provisions. In some cases this is not possible because the provider is not a Medicare provider, the consumer does not have Medicare or the particular service is not covered by Medicare. Even when the standard code works as intended, it means that providers must bill through a manual process, attaching the Medicare denial each time, which complicates work on both the provider and payer side and delays processing. There is a workgroup comprised of state officials, MCOs, and providers to resolve the issue.
- Service Reductions/More Difficulty Obtaining Equipment or Supplies Under MLTSS. Organizations that provide legal advocacy for people who have had services denied or reduced have seen a surge in demand after MLTSS implementation, stretching their resources. They feel they have been successful in protecting the consumers they represent, but wonder how many cases are not reaching them. Providers report some reductions that concern them as well. We also heard several comments about durable medical equipment being harder to obtain now due to a lack of contracted suppliers or restrictions on what is covered. Advocates criticize use of “medical necessity” language to deny services or equipment that by their nature are not medical. An administrative law judge’s denial in a 2016 fair hearing case reads as follows (Strauss 2016): “I CONCLUDE that petitioner does not qualify for a power wheelchair with a power seat elevation feature. Although petitioner makes a compelling argument as to how his feature would enhance the quality of her life and her independence, those important missions do not meet the standard of medical necessity [emphasis in original] as defined by [MCO policy]. By her own description, she already receives assistance with the tasks she describes.” This consumer and their caregiver are then locked into that personal assistance and, unless they can afford the technology, prevented from accessing something that could allow the consumer to work toward being more independent. One of our interviewees described her family member qualifying for a lift chair under the GO waiver. Under MLTSS, which

has generally gone smoothly for this person, the MCO only pays for the motor for the chair. The interviewee couldn't figure out how to get that reimbursed since the chair is sold as a unit with the motor.

- Less Frequent Required Contact with Care Manager. The frequency of required care manager communication under MLTSS was reduced from a minimum monthly phone call and quarterly face-to-face visit to a minimum quarterly face-to-face visit. Some interviewees felt that this resulted in less contact with care managers than before. However, we do not know to what extent this formal requirement translates into changes in practice—we heard one report from a caregiver to more than one individual under the prior system that they did not actually get a regular phone call before; and another report regarding a caregiver under MLTSS whose MCO care manager contacts her more than once per month (though this was not perceived as a positive, but rather creating more work for the caregiver—see pages 55-56).
- Capitated Rate-Setting. The state and MCOs must arrive at capitated rates sufficient to pay for bundles of care without creating excess profits. This is likely more difficult than coming up with rates for individual services because it requires assumptions about usage of multiple services for a group of individuals.⁵¹

Areas of Question/Concern

There were many issues raised where there wasn't agreement among stakeholders as to whether the issue constituted a clear benefit or drawback of MLTSS, and in some cases it wasn't clear whether the issue was due to MLTSS or, instead, was a problem that carried over from the previous system or may have arisen independently of MLTSS.

Role of State in Oversight/Management. While stakeholders note a high level of appreciation for the responsiveness of state staff with individual issues and also note that the state moves to revise contract language to strengthen management when issues arise, many seem to feel that state should take stronger role in talking with stakeholders outside MCOs, identifying systemic issues and pursuing corrective action against MCOs. As we noted earlier, corrective actions taken by the state are generally not public information. Several types of stakeholders said that they had experiences where they felt state staff were too deferential to the MCOs (see example on pages 38-39).

Transparency. Stakeholders are concerned about at least two aspects of transparency.

- 1) Information on Rates Are Not Shared with Stakeholders. Advocates recall that in past waiver programs people knew what their budgets and service costs were and there was transparency as to whether they were approaching the limit of their budget. Now, MCOs

are required to calculate how close MLTSS members are to their cost threshold and to call an interdisciplinary team meeting to discuss needed services with state personnel, the MCO and the member if members are close to the threshold. Advocates are concerned that MCOs could tell people that they are close to their cost limit to try and get them to reduce their services and there is no way for anyone outside the state or the MCOs to verify this. Advocates are concerned that this puts MCOs in a position to minimize service costs and potentially keep the extra funds. State staff do not want to potentially encourage a mindset they have observed in some past cases where people, knowing their maximum budget, may try to get as many services as they possibly can, rather than what they actually need. Since provider rates may differ by MCO, the cost of services is not as easily calculated as under the fee-for-service system.

- 2) Detailed Quality Data Are Largely Not Shared with Stakeholders. Stakeholders are particularly interested in data on service reductions in the move from fee-for-service to managed care (and thereafter), in the details and resolution of complaints/grievances/fair hearing requests, and on whether MLTSS members are assessed appropriately for services, get services in a timely way, and receive the services they are supposed to get (e.g., if their care plan calls for 20 hours of home care, they should be getting 20 hours).

The state envisioned and tracks a set of about 40 MLTSS quality metrics (DMAHS 2014), reported by a mix of MCO and state agencies and with differing frequencies and lag times (some are monthly; others are annually with a 6 month lag for claims run out plus an additional month to calculate the metric). In some cases, the data in which stakeholders are interested has proven too complicated to gather. Complexity of care plans makes them difficult to standardize and upload in a way that would allow for data-mining. Some states are working on data standards for care plans⁵² and New Jersey is looking into this, but in national discussions some advocates caution against care plan structures that are too oriented toward boxes to be filled in because they believe it detracts from person-centered planning.⁵³ Though not all care plans are reviewed, an external quality review organization audits a sample of care plans to ensure that the plans are consistent with clinical assessment data and appear to be person-centered. However, the planned metric that would measure services delivered against the care plan has thus far proven too complicated for the external review organization to calculate. The external quality review organization is working with all the plans to standardize the data they report as the state is concerned that the MCO reported MLTSS quality metrics are not currently comparable, despite the organization early on of a monthly quality meeting with MCO representatives and state staff to standardize data collection and calculation methods.

Data on service reductions is not part of the set of MLTSS Quality Metrics, but was included as an MCO reporting requirement in the first contract upon MLTSS rollout. However, MCOs argued that they did not have sufficient information to do this. Subsequent efforts to require reporting have been complicated by questions of what constitutes a true reduction—for instance, if a member desires more hours and the MCO refuses, there can be a complaint documented about this disagreement over hours, but this is different than the MCO deciding to reduce hours that they had previously granted.

PCA Tool. The tool was implemented in early 2015, not long before we began our first round of interviews. Stakeholders were pleased with the idea of the tool (many had not yet seen it at the time of the first interview) and the state reported fewer complaints regarding hours awarded after implementation. In late 2016, some advocates report seeing MCOs using the average amounts contained in the tool as maximums rather than a guide that could be raised or lowered with explanation. In addition, some question the validity of the benchmark times provided by the tool, noting a lack of information with respect to tool development or validation. Finally, some note that the tool does not cover all the activities that aides are allowed to do and could lead assessors to forget that some activities are covered (see quotes on page 22).

Current MLTSS Legal/Economic Environment. Stakeholders reported several aspects of the way the MLTSS environment is currently organized that they feel are detrimental to optimal functioning.

1) Lack of Regulatory Clarity.

- Both advocates and providers expressed concern that the MCO contract is the law rather than regulations that are subject to public comment and judicial interpretation. During the first round of interviews, advocates noted that they were not able to view a copy of the contract until November 2015.
- Providers are concerned about duplication of efforts with MCOs or being out of compliance with regulations due to managed care system changes. As of late 2016, we have heard that N.J.A.C. 10:60 on home care is being revised.

2) Financial Incentives Not Properly Aligned.

- Because preventing hospital use mainly saves Medicare funds, some interviewees are concerned that MCOs do not have adequate incentives in this regard. One MCO interviewee with extensive care management experience noted that preventing the kind of acute exacerbations that lead to hospital use are clearly the right thing to do and counts as a quality measure even if all savings are not captured by the plan: *“do we not have a responsibility, to improve the lives of our*

member, whoever is getting paid? Why would we want people to go in the hospital—more hospitalizations lead to institutionalization, and that is on the state bill, so it's pretty short sighted to say that ... it's your mother in this program, do you care who's being paid if we kept her out of the hospital, you'll get the credit—the right thing to do ... it will still be a health grade on your plan.” However, information flow for dual eligibles is not always adequate to allow Medicaid MCOs to manage health effectively.

- There is also some concern that MCOs are not sufficiently at risk for nursing home placement because they basically get a rate pass through; thus, some stakeholders fear their incentives lean too heavily toward minimizing the costs of HCBS enrollees.
- Some interviewees feel that MCO management is fundamentally flawed because the incentive to cut costs is too great, and recommended moving to a system like Connecticut's, where the state moved away from managed care for medical services and instead uses an administrative service organization (McEvoy 2013).

- 3) Lack of Free Market among MCOs. Some stakeholders are concerned that there isn't a truly competitive free market among the MCOs, particularly for providers, because one plan has more than half of enrollees.

Care Management. Stakeholders largely agree that care management, and care managers, are the cornerstone of MLTSS. State staff engage directly with care managers in regularly scheduled sessions, increased in early 2017 from twice per year to once every other month to allow more time for discussion.

It is clear that the organizational location of care managers has changed with MLTSS—instead of being located in county or community-based organizations or health care service firms, they are employed directly by MCOs. Some stakeholders will probably always feel that care management is best placed in community-based organizations with no financial interest in minimizing services. Others feel that there are accountabilities for care provision with managed care that do not exist in a fee-for-service system (see paragraph on “Requirement that MCOs provide care” under “Advantages” on pages 44-45).

It is also the case that the required minimum amount of contact of care managers with enrollees is reduced under MLTSS from a monthly phone call and quarterly face-to-face visit to a quarterly visit. The frequency of documented care manager visits under MLTSS is audited on a sample of files for each MCO by the external quality review organization (DMAHS 2017, Attachment B—Quality and Monitoring Activities, EQRO MLTSS Care Management Audits). An MCO stakeholder

noted that it takes a long time to get the results of these audits as well as the NCI-AD results—they would like to see them sooner to help identify any issues or problems that need attention. We are not aware of similar audits under the prior system. So, we cannot say whether the frequency of actual contact has changed. With respect to quality, we heard anecdotal examples of enrollees whose care management has improved with MLTSS; we also heard examples of enrollees whose care management has suffered. Similarly, we heard stories about care managers who moved from former waiver case management agencies and were unhappy in an MCO environment, and others who were satisfied and stayed.

The following are some common concerns among stakeholders about care management that we heard in our interviews:

- 1) Care Manager Turnover—Some clients who previously had case managers for long periods of time experienced turnover with the move to MLTSS, meaning that they had significant stress and inconvenience of having to explain the details of their health and physical functioning to several new people (see quotes on page 26). It is not clear how widespread turnover is. In our interviews, some MCOs reported low turnover; others reported some turnover during implementation. Turnover is discussed during regular conversations between state officials and the MCOs but is not measured as an official metric or required to be reported by the MCO contract. In addition to measuring turnover, one MCO mentioned measuring care manager engagement to ensure that staff were satisfied and performing well. A caregiver with experience before and after MLTSS reported increased continuity with MLTSS.
- 2) Care Manager Scope of Activity—Some interviewees questioned whether the scope of activities by care managers at MCOs was as broad as the scope of prior waiver care managers. It doesn't appear to be officially less, though some interviewees who remain in organizations that used to do care management now report getting requests from MCO care managers to carry out the kinds of activities that they would have done as a care manager, such as helping MLTSS enrollees with documentation for other benefits. There are anecdotal reports of MCO care managers assisting with these kinds of activities. The MCO contract neither requires nor forbids this type of activity.
- 3) Lack of Person-Centered Care Planning—We heard a number of examples of concerns about care management lacking in thoughtfulness or engagement on the part of the care manager. Examples included people transitioning from nursing facilities to community settings that were not accessible for them to get in and out of, or transitions to units that contained very minimal furnishings. One advocate noted *"We had a client who couldn't*

call the MCO for his services and his doctor because he couldn't see his phone and he needed ... one of those big large-sized phones ... really simple, inexpensive things that could keep a person in their home." This was not universal—there were also examples of very thoughtful care management, but stakeholders who had observed both wondered if there was enough accountability for person-centered planning.

Delivery System Design Issues Remaining with MLTSS. Stakeholders raised a number of design issues with the care delivery system that still need improvement even with MLTSS.

1) Remaining System Fragmentation—Interviewees raised several fragmentation issues that remain:

- Delay for MCO enrollment – Currently MCO enrollment can only start on the first of the month, with a cutoff in the latter part of the previous month (precise timing dependent on holidays). This means a delay for most services even after both clinical and financial eligibility is established. Prior to MLTSS there was no required wait, but there may have been delays in practice if a care manager was not available to pick up the case. While state plan services are theoretically available on a fee-for-service basis during the wait for MCO enrollment, it is questionable how many people know of this.
- Enrollees new to Medicaid – While entry to MLTSS is probably improved for those already on Medicaid and enrolled in an MCO because the MCO is positioned to identify and move them into MLTSS, entry remains fragmented for those new to Medicaid because people are directed to either the Area Agencies on Aging or the Division of Disability Services for a screen for community services,⁵⁴ then to their county welfare agency for a financial eligibility determination, and finally (if financially eligible), to OCCO for a clinical eligibility screening. The state has designed a form for county welfare agencies to use to share contact information with Area Agencies on Aging for situations where potential enrollees go to the welfare agency first, so that people can learn of other non-Medicaid programs from which they could benefit.⁵⁵ Some interviewees (elder care attorneys and special child health case managers who did waiver case management with the former CRPD waiver) seemed to feel that their roles in helping people navigate the system had been reduced and that this might be decreasing system efficiency with respect to the speed with which consumers are able to enroll in MLTSS. While most stakeholders seemed to agree that consumers had the right to request a clinical eligibility assessment irrespective of the result of the screening for community services, there were questions about how widely known that is (see quote on page 10).

- Lack of payer data integration – MCOs have ready access to Medicaid claims and require prior authorization for many services, helping them to manage the care for which they are paying. However, most MLTSS enrollees are dually eligible for both Medicare and Medicaid. Thus, Medicaid MCOs may not hear about Medicare utilization or the private insurance utilization that may happen with younger enrollees who are covered by a parent or guardian’s plan. This hampers the ability of MCOs to manage care.
- Utilizing provider knowledge in care planning and service improvement (including care utilization) – As noted in the quote on page 31, some providers feel that MCOs are not using the knowledge they have about consumers to improve care planning and services. One MCO interviewee, when asked if they reached out to direct care staff or other providers in care planning, said *“We probably need to do more of that ... the PCA tool is fairly subjective ... we want to get more involved with the actual activities [done by the aide] to verify the needed hours.”* We also noted that some of the home care providers who have largely withdrawn from Medicaid believe there may be some overutilization of hours of care. They would like to see rates per hour increase because they believe these rates are unsustainable for quality agencies, but believe that hours could be reduced, so the total cost may remain unchanged (see quote about what one provider believes a quality agency does, pages 34-35).

2) Level of Staff Certification—There is some concern among stakeholders that current MLTSS requirements are leading to the use of staff who have more qualifications than necessary, with no automatic quality gain and an increase in costs and difficulty finding qualified staff. Others disagree with this, feeling that the current level of certification requirements are necessary to ensure quality. We heard this with respect to two areas:

- Care managers – One MCO noted that the requirement that the PCA tool must be applied by registered nurses led them to recruit mostly nurses for care management positions so that members weren’t having to deal with different staff. They noted that salaries for nurses are generally higher than for social workers and that nurses are in short supply, which creates risks for understaffing. Given that the NJ Choice assessment can be completed by a nurse or social worker, they wondered if the requirement for the PCA tool could be relaxed.⁵⁶ Other MCOs seemed to indicate that this was somewhat true for them as well, though some still found ways to utilize social work staff.
- Personal care aides employed by an agency – Under the GO waiver, aides for tasks that were not “hands-on” (e.g., bathing, dressing, eating, positioning, toileting) were not required to be certified homemaker home health aides, nor were the

agencies that employed them required to be certified. There were disagreements among stakeholders about whether this was too slippery a slope and led to aides who may have started out doing things like shopping, laundry, housework and food preparation eventually progressing to hands-on care without getting certified (Kitchenman 2013 & July 2014). Planned changes with MLTSS require all aides to be certified and to be employed by certified agencies. Most stakeholders seem to think that these are good changes that improve quality for enrollees, but one provider who had historically employed both certified and uncertified aides noted that they paid certified aides more due to the extra cost burden on the aide to be certified. This provider did not think it made sense for aides to be certified for tasks they were not doing and noted the difficulty in recruiting certified aides given the delays in certification which predated MLTSS but have continued afterward (Gordon et al. 2014, Stainton 2016). Self-directed aides do not have to be certified by the board of nursing (they do have a background check), but self-direction is not an option for everyone.

Burden of Utilization Management on Consumers, Providers and MCOs. Stakeholders generally agree that some utilization management is necessary to ensure the proper use of resources. However, stakeholders from many groups found some of the repetition in clinical assessments (eligibility, done once per year or upon a significant change and personal care assessment, done every 6 months or upon a change in needed services) to be at times intrusive and disruptive for consumers and families without adding value for consumers or being worthwhile from a payer perspective.

- An advocate on clients' reaction to reassessments: *"very much anxiety provoking for a lot of clients ... many of them also feel, this is so invasive, I just did this, I have a static condition that's not going to change and yet I have to answer these questions every however often."*
- A parent of a child receiving private duty nursing, as reported by another stakeholder who had reached out to a group of caregivers: *"Before MLTSS, it was the case manager of the nursing agency that was providing the nursing care ... that case manager was running it ... now ... those 2 have continued, because of the extensiveness of the case, but on top of that has been added ... the MCO's case manager ... the case manager has quarterly visits, plus the case manager calls twice a month for reports, plus the nursing agency that provides the [private duty] nurse ... calls once a month and visits, like every quarter. And then for the other services, a case manager comes in and evaluates ... she's absolutely wiped out from all these reports she constantly has to fill out ... used to oversight, because she's been doing this ... 'can't I just make one report and send it out to everybody?'"* In addition, the child receives 8 hours of service through the school system, so that is another level of interaction the parent must manage.

- An MCO staff member, on the requirement to do a new NJ Choice assessment when the member has a significant change in condition: *“They’re lengthy ... required to be used at different intervals ... don’t really understand why we would need to use them when someone showed a significant change in condition because ... it doesn’t add more services ... maybe there should be a different tool when someone has a significant change in condition ... not just lengthy for us ... it’s lengthy for the member ... if you have a change in condition and aren’t feeling well, we may be in your house for 1.5 to 2 hours, that’s a long time ... and we tried to minimize it ... but you have to gather data.”*

Concerns about the Position of MLTSS in the Safety Net. In addition to advocates generally, we heard this concern from people who have responsibility for addressing the well-being of one or more demographic groups within a certain geographic area. In the past, this latter group of stakeholders felt that they had more influence over decisions regarding who was accepted into waiver programs and/or the services they received—they feel a loss of this influence with MLTSS, and are afraid that the well-being of people for whom they feel responsible will suffer because the MCOs, the state-based gatekeeping staff who do some of the screening (some screening is still done at the county level) and the two state offices of OCCO are generally outside a sphere of interlinked agencies with local responsibility for residents, perhaps making it easier to deny the unclear cases (with respect to eligibility, or service hours for assistance) without having to consider being faced with the potential outcomes of what is going to happen to the consumer or their family, or personal feelings of accountability if another local agency has to respond to them. One comment on the screening for children under MLTSS: *“I don’t think they’re taking the same holistic view ... is this a child who’s going to get into a crisis ... is this a family that’s going to get into a crisis based on the medical need of the child if there isn’t assistance provided ... it’s our job to really suss that out.”*

An example of a situation that turned into an emergency call—in September of 2015, several media outlets aired a story about a frail woman who had home health aides but no help in the evenings (the woman’s Medicaid status was not mentioned). Her aide had left a frozen meal⁵⁷ in the microwave for her to heat up, but the microwave did not work, so she used her personal emergency response system to request help, and a police officer responded and assisted her (Miller 2015, Napoliello 2015, Yates 2015). The officer had assisted the woman in the past with other tasks (Napoliello 2015). Generally, a police officer faced with this situation would notify local social services (see Schweber and Mueller 2015). If the woman had a local case manager, they would likely hear about the situation. With MLTSS, as noted by our county agency and advocate interviewees, finding the woman’s care manager would probably be more difficult—an example, from an advocacy organization: *“on a couple of occasions ... in trying to resolve some ... more complex issues, like where a person had been dropped for some reason ... trying to reconnect*

services ... just sometimes getting through to the plans and getting the right person to access the right service has been very, very challenging for [our person, with expertise] ... 5 or 6 times in the last year and a half where she was so frustrated.” The county welfare agency could see if they had approved the person for Medicaid and, if so, which MCO they were enrolled in, and they could try to contact the MCO to find the care manager—the fact that several MCOs have been reported to attend county level meetings to get to know these personnel could improve this situation. However, our county interviewees still felt that the level of communication between MCOs and county agencies was not as robust as the past communication with waiver case managers.

On the other hand, having more social distance between consumers/families and assessors could remove biases and ensure more consistency in assessments. One interviewee summarized the uncertainty they had faced with respect to the decision to grant clinical eligibility in the past: *“it is all a judgment call ... we did a lot of things that we said “I don’t know” but one of the parts for adults ... was safety ... going to get worse ... so, there was a lot of stuff that didn’t go by the criteria, so now it seems to me like they’re probably looking at the criteria ... it was very hard to go out ... sometimes you just had to put them on ... maybe they’re just not doing that “in our opinion” anymore ... holding them to those strict criteria.”* We suspect that different stakeholders would have a different reaction to hearing this interviewee—some would probably see it as support for the idea that criteria should be strict and specific in order to be fair and allocate scarce resources appropriately; others would note the level of uncertainty involved in assessment and the importance of judgment. An MCO interviewee who had been involved with the LTSS system prior to MLTSS said *“It is difficult ... remember when we were dealing with the state when it was a waiver program. [state personnel] would always say, it’s not [what’s] nice to have, it’s what will meet their needs ... even as far as equipment is concerned ... and I just feel, we don’t want to skimp, if that’s going to meet the needs of the program, but there has to be some ... oversight, some discerning of what’s appropriate.”*

It is important to not overstate the robustness of the social safety net prior to MLTSS. Funding for social services has been strained for some time. In Figure 1 we show declining staff of Area Agencies on Aging relative to the older adult population over time. In a 2015 news article, a county social services supervisor describes flat funding for social services leading to a decrease in staffing while the at-risk population has increased. She also describes lack of expertise among medical professionals with behavioral consequences of dementia and strict criteria for social service intervention, meaning that people have the right to make bad decisions (Schweber and Mueller 2015).

The reaction of county or regional safety net personnel to the impact of MLTSS on them or their agencies is varied. In some cases they had lost staff and resented the MCOs for taking resources out of a public/nonprofit system. In other cases, despite concerns about the well-being of their clients under MLTSS, they were personally relieved to not have to do the at-times tedious work of administering services and felt that the relationship with their clients improved because they were not seen as a gatekeeper for their services but more as a resource.

Conclusions

This report is designed to describe the viewpoints of stakeholders regarding managed long-term services and supports (MLTSS). It is based on two sets of interviews with a variety of stakeholders as well as review of program-related documents and observation of a number of different kinds of meetings relating to MLTSS over the past two to three years. The team did not observe discussions about the design of MLTSS, although we did interview people who were involved.

A total of 78 individuals participated in either individual or group interviews between the two rounds of interviews. From September 2016 through February 2017, 27 interviews (most by telephone) were conducted with 69 people. From February to June of 2015, 16 interviews were conducted with 34 individuals (reported in Farnham, Chakravarty & Lloyd 2015). We also had shorter informal conversations with a handful of additional individuals.

Interviewees included state staff involved in MLTSS implementation, managed care organizations participating in MLTSS, as well as a variety of other stakeholders. Other stakeholders included advocacy groups for older adults and younger people with disabilities, providers of LTSS and their provider associations, and agencies or associations of agencies that work with MLTSS enrollees in a variety of contexts and in some cases provided case management services under the former §1915(c) waivers (e.g., county welfare agencies, Area Agencies on Aging, Centers for Independent Living and Special Child Health Case Management). Some interviewees are members of the MLTSS 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.

We noted a few improvements in stakeholder perceptions from the first to the second round of interviews, including care management, the time duration of MCO service authorizations, relations between consumers and county welfare agencies, relationships between MCOs and other community resources, and the development of the Supports Plus Private Duty Nursing option. Stakeholders still feel that many of these have ongoing need for improvement.

We found a variety of perspectives that pointed to a number of potential advantages and disadvantages thus far with the implementation of MLTSS when compared with the prior fee-for-service waivers, as well as a number of concerns. All of these are outlined in the summary section (3.0) of our findings.

To some degree, perceptions vary by stakeholder role. For instance, providers seem to have been impacted negatively by MLTSS, with rate reductions, increased administrative burden with contracting, credentialing and filing claims with 5 MCOs instead of a single payer, and longer wait times for payments. This has not helped with recruiting and retaining qualified staff, with most providers reporting that this has become more difficult. Providers and advocates sometimes feel that state staff defer to MCOs on matters where they feel the state should take a more active role. We did hear positive mention of MCOs helping locate specialized acute care providers for members served by specialized long-term service providers.

Advocates generally encounter people who are having problems with MLTSS and detailed many issues with still-fragmented systems, service reductions and gaps, lack of proper care management, lack of data-sharing and transparency, and to some degree the lack of advocate involvement in stakeholder and policy discussions. Advocates were generally pleased with changes that have increased access to services such as a more inclusive waiver design (people with developmental disabilities or severe mental illness were generally excluded from the former waiver for older adults—even if these potential enrollees were older adults), a standard menu of services across the waiver, more knowledge about MLTSS among people in the community who encounter potential members, and the carving in of behavioral health services.

MCOs reported being generally satisfied with their relationships with the state and others. Together with advocates, they think that the fair hearing process is too lengthy. Some find the requirement that a nurse must do the personal care assistance hours assessment limiting in terms of the staff they can hire and would like to see that standardized with the NJ Choice eligibility assessment requirement (which allows some with social work credentials). Some would like faster feedback about quality initiatives like external quality review and the NCI-AD survey to allow them to address any problems in a more timely way.

State staff are determined to make the program work with the resources they have available. Advocates and providers generally seem to feel that problems that they identify to state staff are eventually addressed and usually resolved, but in many cases feel that there was too much effort expended on their part and that the average consumer, particularly the vulnerable populations that tend to be receiving MLTSS, would not be able to mount such efforts on their own. Advocates

and providers seem to feel that state staff are not particularly receptive to listening to issues that stakeholders feel may be a potential or future problem, unless they become actual problems. Regarding comments by providers and advocates that state staff meet more often with MCOs than other stakeholders, MLTSS-related staff note that they are charged with regulating MCOs and thus need more time with them. They feel that they offer avenues for providers and advocates to communicate; however, providers and advocates often seem to feel that these avenues are not sufficient to have thorough discussions. Advocates and providers were generally pleased with a quality subgroup to the MLTSS Steering Committee established in late 2016 and early 2017 to discuss moving beyond the any willing provider arrangement for nursing homes.

All stakeholders feel that data that might provide answers to some advocates' concerns about how quickly people are able to access services, gaps in services, and participants' well-being have been slower in coming than would be desired. The state continues to work with an external quality review organization, the NCI-AD, and planning their own audits and data collection to address such questions. Scholars have noted the difficulty of measuring quality in LTSS, so New Jersey is not unique in experiencing this issue (Thomas and Appelbaum 2015).

Overall, our stakeholder interviews provided anecdotal examples of enrollees who were better off under MLTSS than under the prior waiver system as well as enrollees who were worse off under MLTSS. Interviewees discussed different cultures in different MCOs as well as different experiences within the same MCO depending on the staff involved. It is clear there is a potential for greater flexibility in provider rates with MLTSS than under a fee-for-service system, but concerns about LTSS workforce adequacy have persisted. Some stakeholders are concerned about the incentive that MCOs have to minimize costs and utilization, even with the medical loss ratio requirements in the contract. Though there appears to be more oversight of the MCOs than there was under the previous system, transparent quality data has been difficult to develop (something that affects all states utilizing MLTSS, as noted in Dobson et al. (2017)), which is of concern to many stakeholders.

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Appendix: MLTSS Interview Guide, Round 2 Interviews

(Note: Subquestions 1.1-1.11 were distributed to MCO interviewees only)

1. **First, can I get a sense of how you get information about how MLTSS is going?**
 - 1.1. Enrollment. *How is the process of enrolling consumers going? Are you satisfied with the way consumers are assigned to MCOs or given information to choose an MCO? How often are there switches between plans? How difficult is it to ensure continuity of services during switches?*
 - 1.2. Case Management. *How has your experience been with recruiting/retaining case managers? How is the case management experience going—what are the barriers to effective case management?*
 - 1.3. Quality Measurement. *How do you measure the quality of services (case management and other services) that your members receive? Would you see any overarching role in facilitating measurement of provider quality comparable to what the state has done in developing standard billing codes and credentialing? What do you think of the MLTSS Quality Metrics for which you report data? Are there any that you think are particularly relevant for assessing quality and access to care?*
 - 1.4. Assessment Tools. *How is the process of using the NJ Choice and the PCA tool going (tool itself, communications regarding data in the tool, etc.)?*
 - 1.5. Appeals/Grievances/Complaints/Utilization Reviews/Fair Hearings. *How are things going with disagreements with consumers or providers? Any trends, items of note, or ideas for process improvements in this area?*
 - 1.6. Providers. *How are things going with establishment of provider networks for LTSS and behavioral health? Are there any gaps (service wise, region wise, etc.)? What are the reasons for these gaps? How are self-directed services fitting in with this?*
 - 1.7. Transitions. *How are things going with transitions among settings, particularly out of nursing facilities to community settings? Any barriers encountered to effective transitions?*
 - 1.8. Cost Caps/IDT Process. *Are you seeing many consumers hit the cost caps with community services? How do you monitor costs? Are there barriers to an effective IDT process?*
 - 1.9. Information Technology. *Modern operations depend heavily on IT. Have you had any issues with IT in your MLTSS operation?*
 - 1.10. Consumer Advisory Committee: *Do you have an MLTSS Consumer Advisory Committee? How do you find committee members and develop topics or agenda items for the meetings?*
 - 1.11. Other MCO Issues. *Self-attestation forms of no asset transfers for those who are MCO-enrolled prior to MLTSS eligibility. How is this working? Any other issues specific to the MCO role?*

2. **Have the changes with MLTSS benefitted any population or patient groups? Have they caused difficulty? How?**
 - 2.1. *Has it affected the experiences of consumers in accessing services (initial information and referral, clinical and financial eligibility determinations, time for services to start)? How?*
 - 2.2. *Has it affected the types of services consumers receive? How?*
 - 2.3. *Has it affected the hours of services consumers receive? How?*
 - 2.4. *Has the placement of the care management function in the MCOs affected the consumer experience? How?*
 - 2.5. *Has continuity of care been affected by MLTSS (e.g., availability or turnover among care managers or providers, service authorization policy/procedure, etc.)?*
 - 2.6. *Has there been any change in the opportunity for consumers to direct their own services under MLTSS?*
 - 2.7. *Has the process of transitioning from facilities to community settings changed under MLTSS? How?*
 - 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?*
3. **Since MLTSS was implemented, have you noted any changes 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. **Have you seen MLTSS evolve over the first couple of years? How? 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 See the MLTSS Services Dictionary at

http://www.nj.gov/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf (accessed January 18, 2017).

² See the contract between managed care organizations and the state at

<http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf> (accessed January 18, 2017).

³ For a discussion of the overall evaluation plan, see Chakravarty (2015) at

http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_4_13_15.pdf

(accessed January 30, 2017); for the Special Terms and Conditions, see: 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.

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

⁵ For the endorsement, see

<http://www.qualityforum.org/Qps/MeasureDetails.aspx?standardID=2967&print=0&entityTypeID=1> ; for the

surveys, see <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html> (accessed April 12, 2017).

⁶ See reports and other information at <http://nci-ad.org/resources/reports/> (accessed April 12, 2017).

⁷ See http://www.nj.gov/humanservices/dmahs/home/NJCW_Renewal_App_B_Quality_Activities.pdf , part of the January renewal application, or Attachment B from the February application, available at

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/nj-1115-request-pa3.pdf> (accessed April 12, 2017).

⁸ Calculated from slide 35 of presentation to Medical Assistance Advisory Committee (MAAC) on April 13, 2017.

Accessed June 28, 2017 from

http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_4_13_17.pdf (PACE participants were not included in the calculation since they may be either HCBS or nursing home).

⁹ 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.

¹⁰ See “Aging & Disability Resource Connection/Area Agency on Aging (ADRC/AAA)”

<http://www.state.nj.us/humanservices/doas/home/saaa.html> (accessed January 27, 2017).

¹¹ See “Information and Referral Services” <http://www.state.nj.us/humanservices/dds/oias/info/index.html> (accessed January 27, 2017).

¹² Discussed in DMAHS 2016 & 2015, 1115 Waiver Annual Reports.

¹³ The form is available at http://www.state.nj.us/humanservices/dmahs/clients/medicaid/abd/AAA-Auth-2016_Form.pdf ; the application at <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/abd/> (accessed January 27, 2017).

¹⁴ The site, which has a feedback survey for users, is here: <http://www.adrcnj.org/> (accessed January 27, 2017).

¹⁵ AAAs serve people 60 and over, but the population 65 and over is more likely to need services, so we chose that as our denominator.

¹⁶ See Hogan (2014) for a discussion of the assessment process. Consumers meet nursing facility level of care if they require at least limited assistance (physical guidance without taking weight) with at least three ADLs (eating, bathing, dressing, transfer/toilet use, bed mobility, transfers and locomotion) or cognitive disabilities resulting in problems with memory, decision-making or communication coupled with a need for supervision in at least three ADLs). The most dependent episodes over the past three days are considered.

¹⁷ OCCO approves all clinical eligibility, including requests submitted by Medicaid MCOs. For individuals not yet on Medicaid, OCCO staff perform an in-person assessment. See “Office of Community Choice Options” <http://www.state.nj.us/humanservices/doas/home/directory.html> (accessed January 27, 2017).

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- ¹⁸ See “County Welfare Agencies (Boards of Social Services)” <http://www.state.nj.us/humanservices/dfd/programs/njsnap/cwa/> (accessed January 27, 2017).
- ¹⁹ See http://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2016/16-01_Self_Attestation_Process_for_NJ_FamilyCare_ABD_Eligibility.pdf (accessed March 23, 2017). Prior communications were contained in http://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2013/13-02_Addendum_to_PA-1G_Medicaid_Application.pdf and http://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2012/12-18_self_attestation_med_comm.pdf (accessed March 23, 2017).
- ²⁰ Quote from confidential MCO document on file with authors.
- ²¹ See Diskin (2015) for a press account of enrollments in the first 7 months after the transition.
- ²² See page 15, bullet third from top, in http://www.state.nj.us/humanservices/dmahs/clients/medicaid/abd/ABD_Application.pdf (accessed February 10, 2017).
- ²³ MCO contract July 2016, accessed February 14, 2017 from <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>
- ²⁴ For a list of MLTSS services, see MLTSS Services Dictionary, Appendix B.9.0 in MCO contract (accessed February 14, 2017 from <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>).
- ²⁵ The interviewees quoted here are advocates who have worked with consumers both before and after the transition to MLTSS. They were not involved in case management in the prior system or employed by organizations that provided case management.
- ²⁶ A few states (including NJ, though they are not included the list at this site) are working on developing a standard format for care plans—see <https://www.medicaid.gov/medicaid/ltss/teft-program/index.html> (accessed March 21, 2017).
- ²⁷ See pp.2-3 in <http://www.state.nj.us/humanservices/dmahs/info/decisions/2016/BRvUNITEDHEALTHCARE.pdf>
- ²⁸ See <http://www.state.nj.us/humanservices/dmahs/info/decisions/2016/JONvAMERIGROUP.pdf> (accessed March 22, 2017).
- ²⁹ See Article 9 on MLTSS care management and Article 7 on required utilization analysis, MCO contract July 2016, accessed February 14, 2017 from <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>
- ³⁰ See sample job description for member advocate here: <http://jobs.climber.com/jobs/Clerical-Administrative/-NJ-/MLTSS-Member-Advocate-Part-Time-/113266446> (accessed February 22, 2017).
- ³¹ A description and contact information for the unit can be found here http://www.nj.gov/humanservices/dmahs/information/provider/Provider_Meetings/2015/MLTSS_Info_Summary_Sept10.pdf (accessed February 22, 2017).
- ³² See http://www.nj.gov/dobi/division_insurance/managedcare/ihcap.htm (accessed February 22, 2017).
- ³³ See <http://www.state.nj.us/oal/general.html> (accessed February 22, 2017).
- ³⁴ See DMAHS final agency decisions at <http://www.state.nj.us/humanservices/dmahs/info/fads.html> (accessed February 22, 2017).
- ³⁵ See http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_4_20_16.pdf (accessed February 22, 2017).
- ³⁶ See <https://njlaw.rutgers.edu/collections/oal/> (accessed February 22, 2017).
- ³⁷ Most decisions that are appealed involve financial eligibility for Medicaid.
- ³⁸ These data are based on notes taken by J Farnham at the MAAC meeting on October 19, 2016. The presentation was verbal only by Carol Grant; some of the information is in the minutes at http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_10_19_16.pdf (accessed May 25, 2017).
- ³⁹ See testimony of Dr. T. Lind in the MAAC minutes for April 20, 2016 at http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_4_20_16.pdf (accessed March 22, 2017).
- ⁴⁰ By this we mean staff that oversee MLTSS. Many staff oversee other programs with respect to managed care or other services in addition to MLTSS.

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- ⁴¹ MCO Contract, Section 9.10, (July 2016, accessed February 14, 2017 from <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>)
- ⁴² See examples: Horizon NJ Health <http://www.horizonnjhealth.com/for-providers/mltss-critical-incident-reporting> ; Aetna Better Health of NJ https://www.aetnabetterhealth.com/newjersey/assets/pdf/providers/resources/NJ-Critical_Incident_Reporting_Form.pdf ; WellCare <https://tinyurl.com/n59lyqq> (all accessed April 4, 2017).
- ⁴³ See http://www.nj.gov/humanservices/dmahs/home/mltss_training.html (accessed April 4, 2017).
- ⁴⁴ See http://www.nj.gov/humanservices/dmahs/home/mltss_resources.html (accessed April 4, 2017).
- ⁴⁵ See schedule at <http://www.state.nj.us/humanservices/doas/home/aaaxedirmeetings.html> (accessed April 4, 2017).
- ⁴⁶ The original steering committee had four workgroups. The 2012 recommendations can be found here http://www.nj.gov/humanservices/dmahs/home/NJ_MLTSS_Steering_Comm_Recommendations_Report.pdf (accessed March 28, 2017).
- ⁴⁷ See <http://www.state.nj.us/humanservices/dmahs/boards/maac/> (accessed April 4, 2017).
- ⁴⁸ See initial decision by Gorman B (2013) https://njlaw.rutgers.edu/collections/oal/html/initial/hma06884-13_1.html and final decision by Harr V (2013) https://njlaw.rutgers.edu/collections/oal/final/hma06884-13_1.html (both accessed January 30, 2017).
- ⁴⁹ See slide 74 in of presentation to Medical Assistance Advisory Committee (MAAC) on January 23, 2017 http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_1_23_17.pdf (accessed February 8, 2017).
- ⁵⁰ See “Consumer education and training services” on page 302 of the April 24, 2017 contract, accessed May 11, 2017 from <https://www.dhs.wisconsin.gov/familycare/mcos/2017-generic-final.pdf> ; mentioned in minutes to MAAC meeting on October 19, 2016, accessed May 11, 2017 from http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_10_19_16.pdf
- ⁵¹ See the CHCS Managed Long-Term Services and Supports Rate-Setting Resource Center at <http://www.chcs.org/resource/rate-setting-managed-long-term-services-supports-programs-resource-center/> (accessed May 11, 2017).
- ⁵² See <https://www.medicaid.gov/medicaid/ltss/teft-program/index.html> (accessed March 21, 2017).
- ⁵³ Discussion in webinars held May 4, 2016 and May 11, 2016. Slides can be seen at <https://webinar.cms.hhs.gov/dltss/> and sessions are described at <http://www.nasuad.org/community-opportunities/events/cms-person-centered-planning-systems-part-1> (May 4) and <http://www.nasuad.org/node/67795> (May 11); all accessed April 12, 2017. The point referenced was made in discussion rather than in the slides, mainly on May 4. Recordings are not available.
- ⁵⁴ In addition to screening for MLTSS eligibility, which requires the further assessments discussed here, these screenings may also identify services that don’t require further assessment.
- ⁵⁵ See http://www.state.nj.us/humanservices/dmahs/clients/medicaid/abd/AAA-Auth-2016_Form.pdf (accessed January 27, 2017).
- ⁵⁶ Under the prior waiver system, assessment for PCA services was done by nurses in the agencies that would provide the aide and approved by the Division of Disability Services. Nursing supervision of aides was required for agencies providing PCA services and this was separate from the NJ Choice assessment, so there wasn’t any cause to note the discontinuity in requirements for assessor certification.
- ⁵⁷ In our last report we discussed philosophical differences regarding home delivered meals—we heard that MCOs largely felt that bulk home delivered meals were a better value than a Meals on Wheels model, but other stakeholders felt there were other benefits to more regularly delivered ready-to-eat meals in terms of social interaction, monitoring, and so on (Farnham, Chakravarty & Lloyd 2015, p.13). One home care provider we spoke with in the second round noted that there are often waiting lists for Meals on Wheels, though they have decreased with MLTSS. They believed that MCOs had increased the availability of home delivered meals by offering the frozen options and that there were some potential benefits to that in terms of the difficulty keeping meals the proper temperature and the fact that some clients do not eat ready-to-eat meals when delivered but save them for later. They did question whether the frozen meals were healthier, particularly with regard to sodium content.


The Rutgers logo is rendered in a red, serif font. The letter 'R' is significantly larger than the other letters and features a distinctive, sweeping tail that extends downwards and to the left.

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