



# How States Use Medicaid Managed Care to Deliver Long-Term Services and Supports to Children with Special Health Care Needs

## A 50-State Review of Medicaid Managed Care Contracts

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For years, states have used managed care delivery systems to help control costs and improve health care and outcomes for adult Medicaid beneficiaries with complex health care needs. Now, more than a dozen states are using managed care to provide long-term services and supports (LTSS) to children and youth with special health care needs (CYSHCN).

Using Medicaid managed care to provide LTSS is a trend that is expected to grow as managed care becomes the dominant delivery system for state Medicaid enrollees and services. To date, few national reports have explored how states are redesigning their programs to include children in state Medicaid managed long-term services and supports (MLTSS).



In early 2018, the National Academy for State Health Policy (NASHP) analyzed state Medicaid managed care programs nationwide that provide LTSS for children. NASHP reviewed state contracts to identify which pediatric populations were covered, the structure of the programs, and state approaches to evaluating the quality of LTSS and requiring cross-agency collaboration. This issue brief and the accompanying chart highlight strategies that states have used to implement MLTSS and identify key contract language that helped states establish these programs.

## Background

Nearly all states (47 states and Washington, DC) use some type of Medicaid managed care (MMC) system to serve some or all CYSHCN enrolled in Medicaid. Most states (37) use a risk-based managed care system exclusively, whereby a managed care organization (MCO) assumes financial risk.<sup>1</sup>

Nearly 20 percent of US children ages birth to 18 years (14.6 million children) have a chronic and/or complex health care need (e.g., asthma, diabetes, spina bifida, or autism) that requires physical and behavioral health care services and supports beyond what children require normally.<sup>2</sup> Among CYSHCN, children with medical complexity are the smallest yet most rapidly growing population, comprising approximately 0.4 percent of US children.<sup>3</sup> Many CYSHCN require multiple services and supports, including physical and behavioral health, early intervention, education, home health care, and social services.

Medicaid and the Children's Health Insurance Program (CHIP) play a prominent role in providing coverage for CYSHCN, insuring 44 percent of all CYSHCN.<sup>4</sup> Approximately two-thirds of children with medical complexity are en-

rolled in Medicaid, with many eligible for Medicaid due to their disability or medical condition.<sup>5</sup> CYSHCN are eligible for Medicaid through a variety of coverage pathways, such as meeting income guidelines, receiving Supplemental Security Income (SSI) or adoption assistance, or enrollment in foster care.

Historically, many states exempted CYSHCN from Medicaid managed care (MMC) enrollment, determining instead to serve this population of children in fee-for-service systems, whereby Medicaid reimburses providers directly for services. This decision was oftentimes due to the need for ensuring that health care systems could fully address the complexity of care and the number of providers and services required. Recently, that trend has changed and all states with managed care delivery systems now enroll at least some of their CYSHCN population into some type of MMC program.<sup>6</sup>

CYSHCN in Medicaid managed care include SSI recipients, those enrolled in foster care, and those with 1915(c) Home and Community Based Services (HCBS) waivers. Federal Home and Community-Based Services ([HCBS 1915\(c\) waivers](#)) allow states to serve children and adults with long-term services and supports (LTSS) in their homes or communities, rather than in institutional settings.

As states enroll more CYSHCN in MMC, some states are including child-specific provisions in their MMC contracts, including quality measures, network adequacy requirements, and requirements that MCOs communicate with other programs and providers to improve care coordination across systems.<sup>7</sup> States are also including services in managed care contracts, such as behavioral health<sup>8</sup> and LTSS, which historically were provided in fee-for-service systems.

Medicaid managed care programs that include LTSS, called MLTSS, have grown rapidly in recent years. In 2004, eight states operated MLTSS programs that served 105,000 beneficiaries.<sup>9</sup> By 2017, the number of states with MLTSS programs had tripled, with 24 states offering MLTSS to 1.8 million beneficiaries.<sup>10</sup> About half of MLTSS program enrollees are over age 65,<sup>11</sup> and the populations most commonly served by MLTSS are older adults and adults with disabilities, including intellectual and developmental disabilities (ID/DD).<sup>12</sup> States historically have not enrolled children in MLTSS programs, but that trend is also changing.

LTSS are costly for federal and state governments to deliver. Nationally, public LTSS spending exceeds \$242 billion annually. Medicaid is responsible for about \$145 billion or 60 percent of these expenditures<sup>13</sup> and LTSS currently accounts for approximately 30 percent of all Medicaid spending.<sup>14</sup> Annual Med-

## Methodology

In July 2018, NASHP analyzed state Medicaid managed care programs nationwide that provided LTSS for children. For states that provide LTSS to children through Medicaid managed care (MLTSS), NASHP reviewed the most current Medicaid managed care contracts and federal waiver documents that were publically available or provided by state agencies. When contracts were not available, NASHP gathered information from other sources. NASHP used three policy questions to guide its review:

- Which states utilize managed care delivery systems to provide LTSS to CYSHCN enrolled in Medicaid, and which federal Medicaid waiver authorities do states use to provide those services through managed care?
- Of states that enroll CYSHCN in MLTSS programs, which subgroups do states enroll and is enrollment voluntary or mandatory?
- Among states that enroll CYSHCN in their MLTSS programs, what scope of services do states provide? Is the managed care program a LTSS-only plan or a comprehensive plan that provides physical, behavioral, and LTSS?

NASHP also analyzed managed care contracts in MLTSS states for other managed care delivery system attributes, such as including Medicaid quality metrics to determine the quality of LTSS provided to children, network adequacy requirements for LTSS providers, and requirements for cross-agency coordination of LTSS.

Once the contract review was completed, NASHP asked all state Medicaid agency officials for additional information and to review its MLTSS data for accuracy. The findings from this analysis are included in this issue brief and the accompanying state table located in Appendix A.

icaid spending per enrollee is more than 12-times higher for children who use LTSS (\$37,084) compared to those who do not (\$2,863).<sup>15</sup>

There are several factors likely influencing states' decisions to shift eligible Medicaid enrollees into MLTSS. MLTSS programs have been shown to help improve budget predictability and even achieve cost savings.<sup>16</sup> States also report that MLTSS can improve quality of life for Medicaid enrollees by improving health outcomes and their experience with care.<sup>17</sup>

## Long-Term Services and Supports for Individuals Who Are Chronically Ill or Disabled

LTSS encompass a range of medical and non-medical services that are provided to people who are chronically ill or disabled. They typically include services such as nursing facility care, home nursing services, and home- and community-based services (e.g., in-home nursing care). LTSS often provide support with activities of daily living (ADLs), including eating, dressing, and maintaining personal hygiene. LTSS can also support people with what are known as instrumental activities of daily living (IADLS) — assistance with medication management, meal preparation, community mobility, and housekeeping.<sup>18</sup> Many LTSS programs also include care coordination, which can improve care quality, reduce health care costs, and avoid fragmented and duplicative care for CYSHCN and their families.<sup>19,20,21</sup>

LTSS are often provided in institutional settings, such as nursing homes, by a range of health care providers including nurses, home health aides, personal care assistants, and others. Currently, the majority of LTSS are provided by family and friends serving as caregivers.<sup>22</sup> Family caregivers enable people requiring LTSS to stay within their communities and defray some of the high costs of providing LTSS. Depending on the degree of illness or disability, professional assistance may be required in addition to family caregiving. Professional home and community-based services (HCBS) that provide LTSS to people in their communities have become more prevalent in recent years.<sup>23</sup>

Adults who require LTSS often have conditions that fall within the following diagnostic categories: stroke, cancer, injury, dementia, mental illness, diabetes, obesity, and nervous system disorders.<sup>24</sup> While some of these diagnoses require ongoing care, many adults that require LTSS may only need services temporarily to help cover a rehabilitative period after an injury or procedure.

In contrast, CYSHCN can experience a broad range of conditions from various causes and may consequently require a more comprehensive set of services and supports.<sup>25</sup> Furthermore, CYSHCN who receive LTSS are typically children with significant health care conditions and may need LTSS services for the duration of their childhood, and perhaps the rest of their lives.<sup>26</sup> Their LTSS needs may change as they grow and mature. Additionally, changes in size, weight, and maturity may affect what care and support they receive and the types of providers (i.e., pediatric versus adult) they require.<sup>27</sup> Children are often served by numerous systems – distinct from those serving adult LTSS populations – and as a result may require different approaches to care coordination and service integration. Some CYSHCN receive care in a nursing home facility due to their extensive medical and/or behavioral health care needs and limitations in available community-based services.<sup>28</sup>

## How Many States Include Children in MLTSS, and Which Populations?

Over one-quarter of states (14 states)<sup>29</sup> provide MLTSS to children through 17 Medicaid managed care programs. In some cases, states have more than one MMC program to serve specific groups of Medicaid enrollees. In contrast, 24 states provide 39 MLTSS programs to adults.<sup>30</sup>

The populations of CYSHCN that states enroll in their MLTSS programs vary across the country. States predominantly enroll children who receive SSI, are enrolled in Medicaid as the result of their foster care placement, and/or are enrolled in 1915(c) HCBS waivers. There are other eligibility requirements for MLTSS program enrollment in some states. For example, in order to be eligible for the Arizona Long Term Care Services (ALTCS) MLTSS program, children enrolled in Medicaid must require a nursing home or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFs/IID). In Tennessee, CYSHCN must receive nursing home care to qualify for the TennCare CHOICES MLTSS program.

Of the states with MLTSS for children, nearly all mandatorily enroll children who are eligible for the program. On the other hand, some states have chosen to make enrollment in MLTSS voluntary for some populations of children. For example, Arizona's ALTCS program makes enrollment voluntary for children receiving HCBS services; however, children in foster care and receiving SSI are mandatorily enrolled in MLTSS. Similarly, in TennCare ECF CHOICES and TennCare Select, enrollment is voluntary for children in HCBS waiver programs. In Texas STAR Health, which provides MLTSS for children in foster care, enrollment is also voluntary, and in Virginia's Commonwealth Coordinated Care Plus, enrollment is voluntary for all eligible CYSHCN.

## What Type of MLTSS Delivery Systems Do States Use to Serve Children?

States use a variety of MLTSS delivery systems to provide LTSS to children enrolled in Medicaid, and have different programmatic decisions to make in doing so. These include determining the type of managed care system in which to enroll beneficiaries – either a risk-based model that involves contracting with a managed care organization or a prepaid inpatient health plan (PIHP) model. It also entails determining which sets of benefits are provided in MMC versus a fee-for-service system.

PIHP models of managed care typically provide a set type of benefits or services, such as dental care or treatment, for a specific disease. Under this model, states pay health plans on a capitated basis only for services provided by the plan. States must also determine which populations the MLTSS program will be served, the scope of benefits provided, and the federal authority used to implement the program.

Of the 14 states that provide MLTSS services to children, most (11) use a risk-based managed care delivery system. Three states use PIHP programs to deliver a limited set of specialty services, such as behavioral health and LTSS services, but not physical health services. Tennessee has both a PIHP program that provides children and adults LTSS and a risk-based managed care program.

## What Benefits Are Included in MLTSS Programs?

Of states with MLTSS programs, nearly all provide these services as part of a comprehensive set of physical, behavioral, and LTSS benefits (called a comprehensive LTSS benefits program). This approach to benefit design aligns with the overall trend in states to integrate physical and behavioral health services with the goal of better coordinating and managing care.<sup>31</sup>

Three of the 14 states provide LTSS in Medicaid managed care and physical and behavioral health services

through a separate system. Michigan and North Carolina provide LTSS and behavioral health services through PIHPs and provide physical health services on a fee-for-service basis. Delaware's program provides physical health and LTSS in Medicaid managed care, and behavioral health services through a fee-for-service system.

## How Do States Enroll Children in MLTSS Programs?

States include children in MLTSS programs in several different ways. The most common approach is to enroll CYSHCN into a single MLTSS program that serves all or the majority of the state's Medicaid population. A few states have taken a more targeted approach to providing MLTSS, particularly for children. Three states (Arizona, Texas and Virginia) have designed a stand-alone MLTSS programs to specifically serve Medicaid populations with complex health care needs. Arizona and Virginia have MLTSS programs that exclusively serve adults and children with complex needs. Only one state, Texas, has two stand-alone MLTSS programs that exclusively serve children with complex needs. Texas STAR Health provides managed care services, including LTSS, to children in the foster care system, and Texas STAR Kids program provides managed care to children with disabilities.

## Which Medicaid Managed Care Authorities Do States Use for MLTSS?

States implement MMC programs by using one of four federal Medicaid waiver authorities. Several factors determine which federal Medicaid authority is needed, including:

- The population/s a state wishes to cover in the managed care program;
- Whether that coverage is provided on a voluntary or mandatory basis; and
- The types of services and delivery system.<sup>32</sup>

States with MLTSS programs that serve children use several different federal Medicaid authorities for MLTSS, with the most predominant authority being Section 1115 waivers (in 10 states). Section 1115 waivers offer states the most flexibility due to the broad authority provided by the US Secretary of Health and Human Services to waive certain federal Medicaid and CHIP program requirements. States can also use Section 1115 waivers to align changes across their programs in areas such as eligibility, benefits, and provider payments.<sup>33</sup>

### Federal Medicaid Managed Care Waiver Authorities

There are four federal authorities that states can use to operate Medicaid managed care programs. Each authority is different in the populations it covers, whether managed care enrollment is mandatory or voluntary, and what time period and program structure a state wants to pursue. The four authority types are:

- **1932(a) State plan:** States can submit an amendment to their Medicaid state plan to implement and operate a managed care program. Once this amendment is approved by the Centers for Medicare & Medicaid Services (CMS), it becomes part of the state plan and does not have to be renewed on a regular basis as a waiver authority does. Under this authority, states can mandate managed care enrollment except for certain types of enrollees, including children with special health care needs.
- **1915(a) Waiver authority:** States can use this authority to operate a Medicaid managed care program where enrollment is voluntary and implemented by contracting with competitively selected managed care organizations. CMS approval of this waiver allows payments to be made to the contracted MCOs.
- **1915(b) Waiver authority:** States can use this waiver to implement a managed care program with mandatory enrollment for all populations covered under the state plan, including children with special health care needs. Managed care programs operating under this authority must prove they are cost effective and meet the principles of the Medicaid program. States must renew their 1915(b) waivers every two years.
- **1115 Waiver authority:** Section 1115 of the Social Security Act gives the Secretary of Health and Human Services the ability to approve innovative state approaches to deliver services (including through managed care) that meet the objectives of the Medicaid program. In order for an 1115 waiver to be approved, a state must prove it can deliver care that is efficient, cost effective, and high quality. Under this authority, states can mandate enrollment of all populations covered by the state plan.

Source: Medicaid Managed Care Authorities, Centers for Medicare and Medicaid Services, <https://www.medicare.gov/medicaid/managed-care/authorities/index.html>

## How Do States Address Network Adequacy in MLTSS Programs?

Network adequacy is an important aspect of the health care delivery system for children and adults with chronic and complex health conditions. It refers to Medicaid managed care plans having a sufficient number of providers within their plan's network to provide adequate access to covered services for all enrollees.<sup>34</sup> Network adequacy is particularly critical for MLTSS due to the frequency and duration of the services provided.<sup>35</sup>

The Medicaid and CHIP Managed Care Final Rule requires states to approach the provision of LTSS in the same way as other Medicaid covered services. One way that the regulation does this is by specifying standards for states to use when evaluating the adequacy of MLTSS provider networks.<sup>36</sup> As of July 2018, states must establish time and distance standards that apply to LTSS providers -- these standards identify the maximum time and distance that an enrollee should travel to a provider for services. Some states have taken steps to address the adequacy of LTSS provider networks by including other requirements for their MLTSS programs in contracts with MCOs.

Delaware and Tennessee both specify in their MLTSS contracts that MCOs must have LTSS provider capacity to meet the needs of enrollees. Texas and Tennessee stipulate that MCOs should ensure that there are at least two credentialed LTSS providers for each enrollee needing their services. Virginia requires MCOs to enter into contractual agreements with specific types of LTSS providers, including Community Service Boards, which are local offices in the state that link individuals with publicly funded mental health, developmental, and substance abuse services and local behavioral health authorities.

## How Do States Ensure MLTSS Quality?

Quality assurance and measurement in managed care include activities to ensure that MCOs are meeting the requirements specified in their contracts and to determine the quality of enrollee care. Medicaid agencies apply quality assurance and measurement requirements to numerous MMC services, including LTSS. In an effort to ensure MLTSS programs focus on the quality of services provided, under federal law states operating MLTSS programs must meet HCBS quality assurance requirements, but they can delegate monitoring of HCBS service providers to the MCOs. Some states also delegate some quality measurement activities to their Medicaid External Quality Review Organizations.<sup>38</sup>

Many states with MLTSS programs that serve children include

### Medicaid and CHIP Managed Care Final Rule and LTSS

In 2016, CMS released its [Medicaid and CHIP Managed Care Final Rule](#) to align many rules governing MMC with other types of coverage, strengthen payment and accountability, promote quality of care, ensure appropriate beneficiary protections and strengthen service delivery including for MLTSS.<sup>37</sup> The regulation includes provisions that align requirements for how states deliver LTSS in managed care with those for other Medicaid services. Final rule requirements mandate states should:

- Include stakeholders in the oversight of MLTSS programs;
- Follow standards when establishing new managed care programs or transitioning beneficiaries from fee-for-service to managed care such as information provided to beneficiaries and the readiness of MCOs to serve enrollees
- Establish payment models that meet the goals of MLTSS – such as improving overall population health and quality of care, controlling costs, and supporting community integration of enrollees;
- Ensure that managed care programs use person-centered processes that meet enrollee needs – both medical and non-medical -- and that enrollees have the quality of life and level of independence that they desire;
- Coordinate services provided through different programs or delivery systems;
- Meet standards of network adequacy for LTSS providers, and ensure that providers are able to meet the needs of MLTSS enrollees; and
- Implement quality measurement and improvement strategies that include provisions specific to MLTSS

Source: <https://www.medicare.gov/medicaid/managed-care/downloads/strengthening-the-delivery-of-managed-long-term-services-and-supports-fact-sheet.pdf>

specific quality assurance requirements in their contracts with MCOs. Several states, including Delaware<sup>39</sup> and Texas,<sup>40</sup> require MCOs to submit LTSS utilization reports, which detail the amount of LTSS that enrollees receive in order to monitor the amount and scope of these services. Virginia requires MCOs in their MLTSS program develop a customized medical record review process to monitor the assessment for and provision of LTSS.<sup>41</sup>

Few states, however, include quality measures and quality improvement efforts specific to MLTSS in their Medicaid managed care contracts. Some exceptions include Iowa, where MCOs are required to conduct and report the results of the Iowa Participant Experience Survey tool for members receiving HCBS services and data related to CMS-approved HCBS waiver performance measures.<sup>42</sup> New Mexico<sup>43</sup> and Tennessee<sup>44</sup> require MCOs in their MLTSS program to implement a Performance Improvement Project (PIP) focused on long-term services and supports. PIPs are mechanisms for MCOs to focus on a particular clinical or non-clinical aspect of care in order to make improvements in quality.<sup>45</sup>

## How do States Require Coordination between MCOs and State and Local Agencies?

Several state Medicaid agencies require MCOs to collaborate with state and local agencies to coordinate care for Medicaid enrollees in MLTSS. Collaboration can help improve pediatric LTSS provider networks, screening, and assessment of CYSHCN enrolled in MLTSS, care coordination for children enrolled in MLTSS programs, and linkages to other community-based services and sectors. The most common agencies identified for collaboration are those serving individuals with disabilities (ID/DD).

- Hawaii's MLTSS program requires MCOs to partner with state agencies to ensure quality and continuity of LTSS services.<sup>46</sup>
- Tennessee requires MCOs to partner with several agencies, including the Tennessee Department of Intellectual Disabilities Services, to coordinate care for MLTSS enrollees.<sup>47</sup>
- Texas's MLTSS programs require MCOs to coordinate with the state's Department of Aging and Disability Services and providers of LTSS for children who receive LTSS outside of the MCO.<sup>48</sup>

As previously discussed, CYSHCN typically receive services from multiple systems including education, behavioral health, and social services. NASHP's analysis found that few states specify requirements for coordination between MLTSS and child-serving sectors in their contracts with MCOs.

## Key Considerations for Implementing MLTSS for Children

This analysis highlights several strategies that states may want to consider when designing, implementing, and managing an MLTSS program for children.

- **Structure MLTSS to meet the unique needs of CYSHCN.** Most states provide LTSS to children in MMC programs that serve all or the majority of the state's Medicaid population. The states that take this approach may benefit from administrative streamlining in their oversight and management of these programs because they are contracting with fewer MCOs and can potentially leverage existing program elements (e.g., provider networks, quality improvement, and member services) to serve children enrolled in MLTSS. However, some states may opt to serve CYSHCN in a specialized MLTSS program that is specifically designed to serve populations with complex needs. In these cases, the state may be able to identify MCOs that are equipped to serve CYSHCN. Care for CYSHCN may be more easily monitored by instituting reporting and quality requirements for the subset of children being served by a specialized MLTSS program.

- **Require MCOs to coordinate with state and community-based agencies and MLTSS programs.** Requiring MCOs to coordinate with state and local agencies may help improve coordination of services and supports for children enrolled in MLTSS. It can also ensure that their expertise in serving the unique needs of CYSHCN informs service delivery. States may also want to consider requiring MCOs to enter into memorandum of agreements with specific state and community-based agencies that provide or oversee LTSS, which can provide structure and the mechanism to coordinate MLTSS services. Finally, state Medicaid agencies can include relevant state and local agencies, such as state Title V CYSHCN programs, in the planning, design and implementation of MLTSS programs.
- **Identify existing quality measures that might be used or adapted for LTSS.** Child-specific measures that enable states to measure the quality of LTSS services for CYSHCN are very limited. The most widely used measures designed to determine the quality of LTSS services for Medicaid enrollees apply to those 18 years old and older.<sup>49</sup> States interested in implementing more robust quality measurement in their MLTSS programs may identify existing child-specific measures that can be adapted for measuring the quality of LTSS services. These measures might reveal information about a child's access and experience with care, including LTSS. Possible measure sets include the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey,<sup>50</sup> specifically the item set addressing Children with Chronic Conditions, which is a set of survey questions that measure the experience of CYSHCN in health plans and in accessing services.
- **Tailor network adequacy provisions for LTSS providers.** State efforts to ensure access to LTSS within MMC recognize the importance of certain types of LTSS providers, particularly for CYSHCN. LTSS providers critical to CYSHCN include personal care and home nursing providers and nursing facilities. The Medicaid and CHIP Managed Care Final Rule requires time and distance standards for LTSS providers that operate outside of the home. However, it is also critical to ensure that there are a sufficient number of LTSS providers to serve children in a managed care program. States will want to examine provider ratios and engage more LTSS providers in managed care networks to help ensure access to these providers for CYSHCN.
- **Provide support for LTSS providers before and during the transition to managed care.** Some HCBS providers that serve children may be small organizations and lack experience with managed care delivery systems. This can lead to challenges in contracting with and billing multiple MCOs. MCOs may also not be prepared to work with unfamiliar provider types, or may prefer to contract only with larger providers. States will want to support providers during the transition to managed care and help ensure that MCOs understand the unique types of providers that are needed to meet the unique needs of CYSHCN.
- **Engage CYSHCN and their families early and throughout the planning, design, and implementation of a MLTSS program.** Active and ongoing engagement of stakeholders, especially families of CYSHCN, can contribute to the success of MLTSS programs. Families can help Medicaid agencies and MCOs understand the unique needs of their children and provide valuable feedback about programs, policies, and quality measurement. Having family representatives serve on MCO advisory boards is one strategy states can use to make sure that the needs of CYSHCN are being incorporated into MLTSS program oversight.

## Conclusion

The relatively low number of state MLTSS programs serving children -- compared to adult programs -- may result from several factors. Many state MMC programs and MCOs may not have extensive experience providing CYSHCN with LTSS, so the requisite expertise may not be available to fully implement MLTSS for children. State officials may also have concerns that families will perceive a move to MLTSS for their CYSHCN will have a negative impact on their children's services. The desire of families to have continuity of care and access to existing specialty providers is a key concern in the transition to managed care -- one that is not exclusive to LTSS. State leadership and stakeholders may have reservations or anticipate administrative challenges, such as provider training, billing, and ensuring adequate network, that prevent expansion of these programs. States will want to consider these and other challenges and concerns when establishing MLTSS programs for all eligible enrollees, particularly CYSHCN.

However, using MMC to provide LTSS to children is an emerging trend and one that is likely to expand as managed care becomes the dominant delivery system for all Medicaid enrollees and services. Many factors, including states' response to federal rules, may result in more states including children in MLTSS in the coming years. For example, as states change their MLTSS programs to meet the federal Medicaid and CHIP Managed Care Final Rule requirements, they may expand and streamline the categories of Medicaid enrollees they serve, including CYSHCN.

Until this analysis, few national policy studies have addressed the inclusion of children in state Medicaid managed long-term services and supports. NASHP will continue to monitor state strategies for the delivery of MLTSS services to children and identify promising practices in using this delivery system.

## Selected Resources for More Information

- [State Medicaid Managed Care Enrollment and Design for Children and Youth with Special Health Care Needs: A 50-state Review of Medicaid Managed Care Contracts](#)
- [How States Structure Medicaid Managed Care to Meet the Unique Needs of Children and Youth with Special Health Care Needs and an accompanying chart that provides an Overview of Selected State Medicaid Managed Care Programs](#)
- [Structuring Care Coordination Services for Children and Youth with Special Health Care Needs in Medicaid Managed Care: Lessons from Six States](#)
- [State Strategies for Medicaid Quality Improvement for Children and Youth with Special Health Care Needs](#)
- [Standards for Systems of Care for Children and Youth with Special Health Care Needs: Version 2.0](#)
- [Developing Structure and Process Standards for Systems of Care Serving Children and Youth with Special Health Care Needs: A White Paper from the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs Project](#)
- [Identification and Assessment of Children and Youth with Special Health Care Needs in Medicaid Managed Care: Approaches from Three States](#)

## Endnotes

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# 50-State Review of Long-Term Services and Supports for CYSHCN in Medicaid Managed Care

Information as of June 2018

| Key Terms  |  |
|--|--|
| <b>ABD</b> – Aged, blind or disabled<br><b>BH</b> – Behavioral health<br><b>CMS</b> – Centers for Medicare & Medicaid Services<br><b>CYSHCN</b> – Children and youth with special health care needs<br><b>EPSDT</b> – Early and Periodic Screening, Diagnostic and Treatment<br><b>FC</b> – Children placed in foster care<br><b>FFS</b> – Fee for service<br><b>HCBS</b> – Home and community-based services (e.g., skilled nursing care, occupational, speech, and physical therapies, and personal care)<br><b>HH</b> – Home health<br><b>ICF/IID</b> – Intermediate care facilities for individuals with intellectual disabilities | <b>I/DD</b> – Intellectual and/or developmental disabilities<br><b>LTC</b> – Long-term care<br><b>LTSS</b> – Long-term services and supports<br><b>MCO</b> – Managed care organization<br><b>MLTSS</b> – Managed Long-Term Services and Supports<br><b>NCQA</b> – National Committee for Quality Assurance<br><b>NF</b> – Nursing facility<br><b>PCMH</b> – Primary care medical home<br><b>PIHP</b> – Prepaid inpatient health plan<br><b>SED</b> – Serious emotional disturbance<br><b>SSI</b> –Supplemental Security Income |

As health care delivery systems rapidly transform, states are redesigning their long-term services and supports (LTSS) and integrating them into Medicaid managed care programs for children and adults with special needs. These initiatives include efforts to meet the new [federal Medicaid managed care rule](#), develop new payment models, and create specialized managed care plans. This table features states that provide LTSS to children through Medicaid managed care programs and details key elements of their LTSS structures and systems. The information was collected from the most recent publically available contracts between state Medicaid agencies and managed care organizations, Medicaid managed care program websites, and waiver applications approved by the Centers for Medicare & Medicaid Services.

| State | State managed care program for LTSS in Medicaid  |   |  | Categories of CYSHCN receiving LTSS in Medicaid managed care (SSI, FC, HCBS)  | Services provided through managed care: LTSS only (NF, HH, and/or HCBS) or comprehensive (Medical, BH, and LTSS) | MLTSS quality management for children   | Network adequacy provisions for LTSS providers in managed care programs   | Requirements for MCOs to coordinate with other state agencies for LTSS  |
|-------|--|---|--|---|--|---|---|---|
|       | MLTSS program targets children only, or children and adults  | State contracts with more than one MCO (Yes/No) | Federal Medicaid waiver authority used |   |  |   |   |   |
| AZ    | <a href="#">Arizona Long Term Care System (ALTCS)</a><br>Provides MLTSS to older adults, and adults and children with physical and developmental disabilities. | Yes <sup>1</sup>                                | <a href="#">1115 waiver</a>            | SSI (mandatory)<br>FC (mandatory)<br>HCBS (voluntary)<br>Enrollees in these categories are eligible to enroll in ALTCS, but must also require health care services at | Comprehensive  | <b>Long Term Services and Supports:</b> The contractor must have mechanisms to assess the quality and appropriateness of care provided to members receiving LTSS services, including a comparison of the settings of care with the member’s service plan. | The development of home- and community-based services includes provisions for the availability of services on a seven-day-a-week basis and for extended hours, as dictated by member needs. <sup>3</sup><br><b>Durable Medical Equipment (DME) Service Delivery:</b> DME (e.g., wheelchairs, walkers, hospital beds, and oxygen equipment) is critical in optimizing members’ independence and functional level, both physically and mentally, and to support service delivery in the most integrated setting and foster engagement in the community. The contractor is required to provide | <b>Arizona Early Intervention Program (AzEIP):</b> The contractor must pay all AHCCCS-registered AzEIP providers, regardless of their contract status, when Individual Family Service Plans identify and meet the requirement for medically-necessary, EPSDT-covered services. <sup>5</sup> |

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|-------|--|---|---|--|--|---|--|---|
|       | MLTSS program targets children only, or children and adults  | State contracts with more than one MCO (Yes/No) | Federal Medicaid waiver authority used    |  |  |   |  |   |
|       |  |   |   | a nursing facility or ICF/IID level of care.) <sup>2</sup>   |  |   | <p>medically-necessary DME to members in a timely manner consistent with the Arizona Health Care Cost Containment System (AHCCCS) policy. The contractor shall track and report timeliness of DME service delivery.<sup>4</sup></p> <p>In addition to other network adequacy standards or requirements outlined in these contracts, AHCCCS also has requirements outlined in the <a href="#">AHCCCS Contractors Operations Manual</a> (413 and 436).</p>   |   |
| DE    | <a href="#">Diamond State Health Plan – Plus (DSHP)</a><br>Provides MLTSS to older adults, adults with physical disabilities, and children with disabilities residing in nursing facilities. | Yes <sup>6</sup>                                | <a href="#">1115 waiver</a>               | SSI (mandatory)<br><br>Children residing in nursing facilities (mandatory)   | LTSS and Medical<br><br>BH provided through FFS <sup>7</sup>   | The contractor shall monitor DSHP Plus LTSS members' utilization of services in the DSHP Plus LTSS benefit package, identify members who have not received such services within a 30-calendar-day period of time, and notify the state about these members. <sup>8</sup><br><br>The state has developed Quality Care Management and Monitoring Report templates for the DSHP Plus population, which contractors are required to submit on a monthly, quarterly, and annual basis. | The MCO must have HCBS provider capacity to meet the needs of DSHP Plus LTSS members and to provide nursing facility services and HCBS based on the amount, frequency, duration, and scope specified in the member's plan of care.   | Not specific to only LTSS, MCOs are required to coordinate with Delaware's Division of Public Health, Division of Developmental Disability Services, Division of Substance Abuse and Mental Health, Division of Prevention and Behavioral Health Services, and the Department of Education. |
| FL    | <a href="#">Managed Medical Assistance (MMA)</a><br>Provides MLTSS to children up to age 20 with disabilities.   | Yes <sup>9</sup>                                | <a href="#">1115 waiver</a>               | SSI (Voluntary)<br><br>ABD (Voluntary)<br><br>Children receiving services in a prescribed pediatric extended care center (Voluntary) | Comprehensive  | MMA managed care plans and comprehensive LTC plans shall require providers to report adverse incidents to the managed care plan within 48 hours of the incident. <sup>10</sup>  | Certain providers are statewide resources and essential providers for all managed care plans in all regions. The managed care plan shall include these essential providers in its network, even if the provider is located outside of the region served by the managed care plan.<br><br>Statewide essential providers include:<br>- Regional perinatal intensive care centers;<br>- Hospitals licensed as specialty children's; and<br>- Accredited and integrated systems serving medically complex children that comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and prescribed pediatric extended care. | The managed care plan shall make a good faith effort to enter into and maintain agreements with the local Early Intervention Program Office to establish methods of communication and procedures for the timely approval of services covered by Medicaid.                                   |
| HI    | <a href="#">QUEST Integration</a>  | Yes <sup>11</sup>                               | <a href="#">1115 waiver</a> <sup>12</sup> | SSI (mandatory)<br><br>FC (mandatory)  | Comprehensive  | N/A   | N/A  | The MCO is required to coordinate with other state agencies for LTSS to   |

| State | State managed care program for LTSS in Medicaid  |   |   | Categories of CYSHCN receiving LTSS in Medicaid managed care (SSI, FC, HCBS) | Services provided through managed care: LTSS only (NF, HH, and/or HCBS) or comprehensive (Medical, BH, and LTSS) | MLTSS quality management for children   | Network adequacy provisions for LTSS providers in managed care programs  | Requirements for MCOs to coordinate with other state agencies for LTSS  |
|-------|--|---|---|--|--|---|--|---|
|       | MLTSS program targets children only, or children and adults  | State contracts with more than one MCO (Yes/No) | Federal Medicaid waiver authority used                |  |  |   |  |   |
|       | Provides MLTSS to elderly enrollees and/or adults and children with disabilities.  |   |   | HCBS (mandatory)   |  |   |  | ensure a continuum of services for quality outcomes.  |
| IA    | <a href="#">Iowa Health Link</a><br>Provides MLTSS to older adults, adults with I/DD or physical disabilities, and children with disabilities. | Yes <sup>13</sup>                               | <a href="#">1915(b) waiver</a>                        | SSI (mandatory)<br>FC (mandatory)<br>HCBS (mandatory)                        | Comprehensive  | MCOs are required to implement, utilize, and report on the Iowa Participant Experience Survey tool for members receiving HCBS services. <sup>14</sup><br><br>MCOs are also required to provide data related to CMS-approved HCBS waiver performance measures.<br><br>A <a href="#">reporting manual</a> has been developed for MCO reporting. | <b>Long-Term Care Services Access Standards:</b><br><br><b>Network:</b><br><i>Institutional providers:</i> All licensed and Medicaid-certified nursing facilities and ICF/IDs shall be included in the contractor's provider network for two years. Following the minimum period, contractors can evaluate each facility's continued network enrollment based on assessment of quality and performance outcomes and consistent coordination of care, as approved by the state.<br><i>HCBS providers:</i> All certified, accredited, or approved HCBS providers shall be included in the contractor's provider network for two. The contractor shall contract with at least two providers per county for each covered HCBS in the benefit package for each 1915(c) HCBS waiver. In the event a county has an insufficient number of providers licensed, certified, or available, the access standard shall be based on the community standard and shall be justified and documented to the state.<br><br><b>Time and distance:</b> Transport distance to providers shall be the usual and customary, not to exceed 30 minutes or 30 miles for members in urban areas and not to exceed 60 minutes or 60 miles for members in rural areas, except where community standards and documentation shall allow. <sup>15</sup> | Contract requires MCOs to coordinate with state's public health agency, state Department of Education and local community service agencies. <sup>16</sup> |
| KS    | <a href="#">KanCare MLTSS</a><br>Provides MLTSS to older adults, adults with I/DD or physical disabilities, and children with                  | Yes <sup>17</sup>                               | 1915(c) and <a href="#">1115 waiver</a> <sup>18</sup> | SSI (mandatory)<br>FC (mandatory)<br>HCBS (mandatory)                        | Comprehensive  | MCOs are required to measure and report on Increased Integration of Care, which is the rate that integration of physical, behavioral (both mental health and substance use disorder), long-term care, and HCBS waiver services will increase. <sup>19</sup>   | Currently two providers in each county are required. The state is in the process of updating and revising its metrics for MLTSS network adequacy to align with the managed care rule requirements. These changes will be effective in 2019.  | N/A   |

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|-------|---|---|--|--|--|--|---|--|
|       | MLTSS program targets children only, or children and adults   | State contracts with more than one MCO (Yes/No) | Federal Medicaid waiver authority used                                     |  |  |  |   |  |
|       | disabilities and SED.   |   |  |  |  |  |   |  |
| MI    | <b>Managed Specialty Services and Supports</b><br>Provides MLTSS to adults and children with I/DD.  | No, it is a PIHP program <sup>20</sup>          | <a href="#">1915(b) waiver</a>   | SSI (mandatory)<br>FC <sup>21</sup> (mandatory)                              | LTSS and BH  | Because the population in the program is, by definition, the LTSS population, all measures are LTSS-related.   | N/A   | N/A  |
| NM    | <b><a href="#">New Mexico Centennial Care</a></b><br>Provides MLTSS to older adults, adults with I/DD or physical disabilities, and children with disabilities. | Yes <sup>22</sup>                               | 1115 waiver<br>( <a href="#">current</a> )<br>( <a href="#">proposed</a> ) | SSI (mandatory)<br>FC (mandatory)<br>HCBS (mandatory)                        | Comprehensive <sup>23</sup>  | <p>New Mexico Centennial Care provides a range of quality management mechanisms to ensure safe quality services and options to access services that allow the member to remain in the community and Performance Improvement Projects (PIPs) that enhance the system of care.</p> <ul style="list-style-type: none"> <li>MCOs are required to use the most recent version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult and Child Survey Instruments, including the Children with Chronic Conditions (CCC)</li> <li>MCOs are required to participate on the steering committee for the Consumer, Family-Caregiver and Youth Satisfaction Project (C/F/YSP).</li> <li>MCOs are required to develop a comprehensive program for continuous monitoring of the effectiveness of its care coordination processes. The strategies are analyzed for effectiveness and appropriate changes made.</li> <li>MCOs are required to implement the following PIPs: one on LTSS, one on services to children, and two state-directed PIPs as required by the Human Services Department (HSD) and stated in the policy manual, including: one diabetes prevention and management and one screening and management for clinical depression. Other PIPs include community health workers,</li> </ul> | <p>MCOs are required to assure an adequate provider network and demonstrate that its network is sufficient to meet the health care needs of all members, including direct access to a specialist for special health care needs through network adequacy quarterly reports. Geographical access is also monitored for requirements that 90% of members travel less than 30 miles for urban counties, 60 miles for rural counties, and 90 miles for frontier counties.</p> <p>LTSS providers monitored in these reports include personal care agencies, assisted living facilities, and nursing facilities.</p> | <ul style="list-style-type: none"> <li>MCOs are required to coordinate and collaborate with the Children, Youth, and Family Department (CYFD), including children in CYFD custody.</li> <li>MCOs are required to contract with the Department of Health Families First and Children's Medical Services programs for case management-related activities.</li> </ul> |

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|-------|---|---|--|--|--|---|---|--|
|       | MLTSS program targets children only, or children and adults                                   | State contracts with more than one MCO (Yes/No) | Federal Medicaid waiver authority used |  |  |   |   |  |
|       |   |   |  |  |  | <p>telemedicine, patient-centered medical homes and value-based purchasing.</p> <ul style="list-style-type: none"> <li>HSD monitors annually and MCOs are penalized if they do not meet annual targets for improvement for specific performance measures. Performance measures that are related to MLTSS for children include medication management for people with asthma, comprehensive diabetes care, timeliness of prenatal and postpartum care, and follow-up after hospitalization for mental illness.<sup>24</sup></li> </ul>  |   |  |
| NC*   | <b>NC Innovations</b><br>Provides MLTSS to adults and children with I/DD.                     | Yes – PIHP program <sup>25</sup>                | <a href="#">1915(c) waiver</a>         | HCBS <sup>26</sup> (mandatory)   | LTSS and BH  | N/A   | N/A   | N/A  |
| NJ    | <b>NJ FamilyCare</b><br>Provides MLTSS to adults and children with special health care needs. | Yes <sup>27</sup>                               | <a href="#">1115 waiver</a>            | SSI (mandatory)<br>FC (mandatory)<br>HCBS (mandatory)                        | Comprehensive  | <p>The contractor shall develop policies and implement procedures for critical incident reporting and management for incidents that occur in a nursing or special care nursing facility, inpatient behavioral health, or home and community-based, long-term care service delivery setting, including: community alternative residential settings, adult day care centers, other HCBS provider sites, and a member’s home. The contractor’s policy and procedures shall address the process to report potential violations of criminal law to local law enforcement authorities.</p> <p>The MLTSS program shall be integrated into the contractor’s Quality Assessment Performance Improvement program.</p> <p>The state has selected <a href="#">these performance measures</a> for its MLTSS program.</p> | <p><b>MLTSS Network Requirements</b></p> <p>The contractor shall contract with a sufficient number of nursing facilities, special care nursing facilities, assisted living facilities, and community recovery service providers, and in order to have adequate capacity to meet the needs of MLTSS members.</p> <p>The contractor shall have adequate HCBS provider capacity to meet the needs of each MLTSS member receiving HCBS services. At a minimum, the contractor shall contract with at least two providers for each HCBS, other than community-based residential alternatives, to cover each county. For HCBS provided in a member’s place of residence, the provider does not need to be located in the county of the member’s residence but must be willing and able to serve residents of that county.</p> | The contractor shall have methods for coordinating care and creating linkages with external organizations, including but not limited to school districts, child protective service agencies, early intervention agencies, behavioral health, and developmental disabilities service organizations. |
| NY    | <b>Medicaid Managed Care</b><br>Provides MLTSS to CYSHCN and                                  | Yes   | <a href="#">1115 waiver</a>            | SSI (mandatory)<br>FC (mandatory)  | Comprehensive <sup>28</sup>  | N/A   | The contractor’s network must contain all of the provider types necessary to furnish the prepaid benefit package, including but not limited to hospitals, physicians (primary care and specialists), mental health and substance abuse  | <b>Coordination of Services:</b><br>The contractor shall coordinate care for enrollees, as applicable, with specialized providers of long-term   |

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|-------|--|---|--|---|--|---|---|---|
|       | MLTSS program targets children only, or children and adults  | State contracts with more than one MCO (Yes/No) | Federal Medicaid waiver authority used |   |  |   |   |   |
|       | medically fragile children.  |   |  | HCBS (mandatory)  |  |   | disorder providers, allied health professionals, ancillary providers, durable medical equipment (DME) providers, home health providers, and pharmacies, if applicable. <sup>29</sup>  | care for people with developmental disabilities.<br><br>Coordination may involve contracts or linkage agreements (if entities are willing to enter into such an agreement), or other mechanisms to ensure coordinated care for enrollees, such as protocols for reciprocal referral and communication of data and clinical information about MCO enrollees. <sup>30</sup>   |
| TN    | <b>CHOICES</b><br>Provides MLTSS to older adults, adults with I/DD or physical disabilities, and children with disabilities in nursing facilities. | Yes <sup>31</sup>                               | <a href="#">1115 waiver</a>            | Children who receive nursing home care  | Comprehensive <sup>32</sup>  | <b>A.2.15.1 Quality Management/Quality Improvement (QM/QI) Program applies to both CHOICES and ECF CHOICES programs.</b><br>The QM/QI program addresses physical and behavioral health and long-term care services.<br><br>The MCO must establish a QM/QI committee that includes medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers).   | <b>A.2.11.6 Special conditions for long-term services and supports providers (applies to both CHOICES and ECF CHOICES programs)</b><br>- The MCO must contract with any licensed and certified nursing facility willing to contract with the MCO.<br>- The MCO must make a good-faith effort to develop the network capacity to have a travel distance of no more than 60 miles between a member's community-based residential alternative placement and the member's residence before entering the facility.<br>- The MCO must contract with at least two providers for each CHOICES and each ECF CHOICES HCBS enrollee, other than community-based residential alternatives.<br>- The MCO shall maintain a network of CHOICES and ECF CHOICES HCBS providers that is adequate to meet the needs of each and every CHOICES and ECF CHOICES enrollee (per transition policy language in contract).<br>- The MCO contract includes a list of preferred contracting standards for CHOICES and ECF CHOICES HCBS providers, including: <sup>33</sup><br>- Currently participates as a provider in the 1915(c) wavier program and has high quality assurance ratings;<br>- Is actively seeking or has accreditation;<br>- The provider has completed DIDD [Intellectual and Developmental Disabilities] person-centered organization training; | <b>A.2.9.16 Inter-agency coordination (applies to both CHOICES and ECF CHOICES programs)</b><br>The MCO is required to coordinate with other state agencies and local departments for purpose of coordination for enrollees. Specifically, they must coordinate with:<br>- The Tennessee Department of Children's Services (DCS) for the purpose of interfacing with and assuring continuity of care;<br>- The Tennessee Department of Intellectual Disabilities Services (DIDD), for the purpose of coordinating physical and behavioral health services with HCBS available for members who are also enrolled in a Section 1915(c) HCBS waiver for persons with intellectual disabilities, and for purposes of ECF CHOICES, including intake, critical incident reporting and management, and quality monitoring; |
|       | <b>Employment and Community First (ECF) CHOICES</b><br>Provides MLTSS to adults and children with I/DD.  | Yes <sup>35</sup>                               | <a href="#">1115 waiver</a>            | HCBS <sup>36</sup> (mandatory for new waiver enrollees, voluntary, opt-out for existing waiver enrollees) | Comprehensive <sup>37</sup>  | MCOs are required to establish five Performance Improvement Projects (PIPs) – two clinical and three non-clinical. Of the non-clinical PIPs, one must be in the area of long-term care.<br><br>MCOs must be NCQA-accredited and report on all Healthcare Effectiveness Data and Information Set (HEDIS) measures designed by NCQA as relevant to Medicaid (except dental). They are also required to conduct the CAHPS [Consumer Assessment of Healthcare Providers and Systems] adult survey, CAHPS child survey, and the CAHPS children with chronic conditions survey using the most current CAHPS version specified by NCQA.<br><br><b>A.2.24.3 and 4 CHOICES and ECF CHOICES Advisory Groups</b> |   |   |

| State | State managed care program for LTSS in Medicaid  |  |  | Categories of CYSHCN receiving LTSS in Medicaid managed care (SSI, FC, HCBS)  | Services provided through managed care: LTSS only (NF, HH, and/or HCBS) or comprehensive (Medical, BH, and LTSS) | MLTSS quality management for children   | Network adequacy provisions for LTSS providers in managed care programs  | Requirements for MCOs to coordinate with other state agencies for LTSS   |
|-------|--|--|--|---|--|---|--|--|
|       | MLTSS program targets children only, or children and adults  | State contracts with more than one MCO (Yes/No)      | Federal Medicaid waiver authority used |   |  |   |  |  |
|       |  |  |  |   |  | <p>To promote a collaborative effort to enhance the long-term care service delivery system and for individuals with I/DD while maintaining a member-centered focus, a contractor must establish a CHOICES advisory group that is accountable to a contractor’s governing body to provide input and advice regarding a contractor’s CHOICES program and policies. At least 51% of the MCOs CHOICES/ ECF CHOICES advisory groups shall be CHOICES/ECF CHOICES members and/or their representatives (e.g., family members or conservators)</p> | <ul style="list-style-type: none"> <li>- The provider is START-certified, or has completed START training; and</li> <li>- The provider has achieved documented success in helping individuals with I/DD achieve employment opportunities and/or independent living situations.</li> </ul> <p><b>A.2.11.7 Special conditions for persons with intellectual or developmental disabilities (I/DD) including:</b></p> <ul style="list-style-type: none"> <li>- Adequate capacity to deliver covered physical and behavioral health services that meet the needs of persons with I/DD;</li> <li>- Identify and/or recruit and contract with physical and behavioral health care providers, in particular PCPs, who have the qualifications, capabilities, and resources to work with persons with I/DD.</li> <li>- Policies and procedures for assigning members with I/DD to PCPs, and other medical and behavioral health specialists, with I/DD expertise.</li> </ul> <p><b>For primary care providers or physician extenders:</b></p> <ul style="list-style-type: none"> <li>- Transport access suburban/rural/frontier: At or less than 30 miles travel distance and 45 minutes travel time;</li> <li>- Transport access urban: At or less than 20 miles travel distance and 30 minutes travel time;</li> <li>- Member load: 2,500 or less for a physician, and 1,250 or less for a physician extender; and</li> <li>- Appointment/waiting times: Usual and customary practice not to exceed three weeks from date of member’s request for regular appointments and 48 hours for urgent care.</li> </ul> | <ul style="list-style-type: none"> <li>- The Tennessee Department of Mental Health and Substance Abuse Services;</li> <li>- The Tennessee Department of Education and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act and to ensure that school-based services for students with special needs are provided.</li> <li>- The MCO is responsible for the delivery of medically necessary covered services to school-aged children.</li> <li>- MCOs are encouraged to work with school-based providers to manage the care of students with special needs.</li> <li>- See signed Interagency MOUs through this end note.<sup>34</sup></li> </ul> |
|       | TennCare Select Provides MLTSS to children with special health care needs in a PIHP program. <sup>38</sup> | No – one MCO operates the PIHP program <sup>39</sup> | <a href="#">1115 waiver</a>            | SSI (mandatory)<br>FC (mandatory)<br>HCBS (voluntary)<br><br>Children eligible for SSI may opt out of TennCare Select and | Comprehensive  | <p><b>2.15 Quality Management/Quality Improvement (QM/QI) Program</b></p> <p>The QM/QI program shall address physical health, behavioral health, and long-term care services.</p> <p>The MCO must establish a QM/QI committee that includes medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers).</p>   | <p><b>2.11.6 Special conditions for long-term services and supports providers:</b></p> <ul style="list-style-type: none"> <li>- The MCO must contract with any licensed and certified nursing facility willing to contract with the MCO</li> <li>- The MCO must make a good-faith effort to develop the network capacity to have a travel distance of no more than 60 miles between a member’s community-based residential alternative placement and the member’s residence before entering the facility.</li> </ul>   | <p><b>A.2.9.17 Inter-agency coordination</b></p> <ul style="list-style-type: none"> <li>- The MCO is required to coordinate with other state agencies and local departments for various purposes of coordination for enrollees. Specifically, they must coordinate with:</li> <li>- The Tennessee Department of Children’s Services for the</li> </ul>   |

| State | State managed care program for LTSS in Medicaid             |   |  | Categories of CYSHCN receiving LTSS in Medicaid managed care (SSI, FC, HCBS) | Services provided through managed care: LTSS only (NF, HH, and/or HCBS) or comprehensive (Medical, BH, and LTSS) | MLTSS quality management for children  | Network adequacy provisions for LTSS providers in managed care programs   | Requirements for MCOs to coordinate with other state agencies for LTSS   |
|-------|---|---|--|--|--|--|---|--|
|       | MLTSS program targets children only, or children and adults | State contracts with more than one MCO (Yes/No) | Federal Medicaid waiver authority used |  |  |  |   |  |
|       |   |   |  | enroll in another MCO. <sup>40</sup>   |  | <p>MCOs must be NCQA-accredited and report on all HEDIS measures designed by NCQA as relevant to Medicaid (except dental). They are also required to conduct the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey using the most current CAHPS version specified by NCQA.</p> <p><b>A.2.24.3 CHOICES Advisory Groups</b><br/>To promote a collaborative effort to enhance the long-term care service delivery system while maintaining a member-centered focus, the contractor shall establish a CHOICES advisory group that is accountable to the contractor’s governing body to provide input and advice regarding the contractor’s CHOICES program and policies. At least 51% of the MCOs CHOICES advisory groups shall be CHOICES members and/or their representatives (e.g., family members or conservators).</p> | <ul style="list-style-type: none"> <li>- The MCO shall maintain a network of CHOICES HCBS providers that is adequate to meet the needs of each and every CHOICES enrollee (i.e., the ability to initiate services within prescribed timeframes and to provide services in accordance with the person-centered support plan).</li> <li>- The MCO contract includes a list of preferred contracting standards for CHOICES HCBS providers.</li> <li>- Transport access to licensed adult day care providers at or less than 20 miles travel distance and 30 minutes travel time for TennCare enrollees in urban areas; 30 miles travel distance and 45 minutes travel time for enrollees in suburban areas; and 60 miles travel distance and 90 minutes travel time for enrollees in rural/frontier areas, except where community standards and documentation shall apply.</li> </ul> <p><b>For primary care providers or physician extenders:</b></p> <ul style="list-style-type: none"> <li>- The distance/time between the practitioner and member in urban area will be a maximum 20 miles or 30 minutes;</li> <li>- The distance/time between the practitioner and member in suburban/rural/frontier area will be a maximum of 30 miles or 45 minutes.</li> <li>- Transport access for suburban/rural/frontier areas will be a maximum of 30 miles travel distance and 45 minutes travel time;</li> <li>- Transport access for urban areas will be a maximum 20 miles travel distance and 30 minutes travel time;</li> <li>- Member load is 2,500 or less for a physician, and 1,250 or less for a physician extender;</li> <li>- Appointment/wait times: Usual and customary practice not to exceed three weeks from date of a member’s request for regular appointments and 48 hours for urgent care; and</li> <li>- Office wait times should not exceed 45 minutes.</li> </ul> <p><i>Note: Appointments for TennCareSelect members must reflect local practice and be on the same basis as all other patients served by the practitioner.<sup>41</sup></i></p> | <ul style="list-style-type: none"> <li>- purpose of interfacing with and assuring continuity of care;</li> <li>- The Tennessee Department of Intellectual Disabilities Services, for the purposes of coordinating physical and behavioral health services with HCBS available for members who are also enrolled in a Section 1915(c) HCBS waiver for persons with intellectual disabilities;</li> <li>- The Tennessee Department of Mental Health and Substance Abuse Services;</li> <li>- The Tennessee Department of Education and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act and to ensure school-based services for students with special needs are provided. The MCO is responsible for the delivery of medically-necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers to manage the care of students with special needs.</li> </ul> <p>See signed Interagency MOUs through this end note.<sup>42</sup></p> |

| State | State managed care program for LTSS in Medicaid                                   |   |  | Categories of CYSHCN receiving LTSS in Medicaid managed care (SSI, FC, HCBS)  | Services provided through managed care: LTSS only (NF, HH, and/or HCBS) or comprehensive (Medical, BH, and LTSS) | MLTSS quality management for children  | Network adequacy provisions for LTSS providers in managed care programs   | Requirements for MCOs to coordinate with other state agencies for LTSS   |
|-------|---|---|--|---|--|--|---|--|
|       | MLTSS program targets children only, or children and adults                       | State contracts with more than one MCO (Yes/No) | Federal Medicaid waiver authority used   |   |  |  |   |  |
| TX    | <p><a href="#">STAR Health</a><br/>Provides MLTSS to children in foster care.</p> | No – one MCO <sup>43</sup>                      | <p>1915(a) authority to operate managed care for foster care; 1915(c) waiver to operate the Medically Dependent Children's Program</p> | <p>Most children in state conservatorship are mandatorily enrolled in the STAR Health program.</p> <p>Medically Dependent Children Program (MDCP)<sup>44</sup> (Children in STAR Health who receive these waiver services must receive those services through managed care)</p> | Comprehensive <sup>45</sup>  | <p><b>MCO Advisory Group LTSS representation<sup>46</sup></b> – For MCOs offering long-term services and supports, the member advisory group must include a reasonably representative sample of the LTSS member population or advocates. For the LTSS member population the advisory group must include at least three members receiving LTSS through the MCO or their representative.</p> <p><b>Utilization management:</b> The MCO must file quarterly LTSS utilization reports.</p> <p><b>Sources of LTSS measures for the STAR Health program include:</b> The STAR Health caregiver survey, which includes several measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>) survey</p> | <p><b>Network Adequacy and Access to Care<sup>47</sup>:</b></p> <p><b>Community-Based Service Providers:</b> The MCO must ensure that all members have access to at least two providers of each category of community-based services, not including MDCP service providers referenced in this section. If the MCO determines it is unable to provide member access to more than one provider of community-based services, the MCO must submit and receive an exception.</p> <p><b>MDCP STAR Health:</b> The MCO must have a sufficient number of contracts with MDCP service providers so that all members who receive MDCP have access to medically necessary and functionally necessary covered services.</p> <p><b>Access to Care:</b><br/><b>All other Covered Services, except for services provided in the Member's residence:</b> At a minimum, the MCO must ensure that all members have access to at least one network provider for each of the remaining covered services within the contractually prescribed distance or travel time.</p> <p>For each provider type, the MCO must provide access to at least 90% of members within the prescribed distance standard for each state fiscal quarter.</p> | <p><b>Coordination with Child Welfare Agency:</b><br/>The MCO will be responsive to inquiries and requests from the Department of Family and Protective Services (DFPS) staff, members, and caregivers. The service coordinators will provide information to staff, members, and caregivers, and assist these parties with accessing non-clinical services.</p> <p>The MCO, DFPS, and Health and Human Services Commission (HHSC) will meet on a schedule determined by HHSC to address issues and concerns that arise during the Transition and Operations Phases. HHSC may require the MCO to revise processes and procedures, modify trainings or educational materials, or make other program changes as a result of these meetings. The meetings will provide an ongoing opportunity to improve communication and share information between HHSC, DFPS staff, members, providers, caregivers and medical consenters, and the MCO. These meetings may also serve to update STAR Health Program requirements and streamline processes as necessary.<sup>48</sup></p> <p>The MCO must coordinate with other state HHS programs in each Service Area, or each Texas HHS region, regarding the provision of essential public health care services.</p> |
|       | <p><a href="#">STAR Kids</a><br/>Provides MLTSS</p>                               | Yes <sup>49</sup>                               | <a href="#">1115 waiver</a>  | SSI (mandatory)   | Comprehensive <sup>52</sup>  | <b>MCO Advisory LTSS Representation:</b>   | <b>Community-Based Service Providers:</b> The MCO must ensure that all members have access to at least two  | The MCO must coordinate with other state HHS programs in each service  |

| State | State managed care program for LTSS in Medicaid  |   |   | Categories of CYSHCN receiving LTSS in Medicaid managed care (SSI, FC, HCBS)  | Services provided through managed care: LTSS only (NF, HH, and/or HCBS) or comprehensive (Medical, BH, and LTSS) | MLTSS quality management for children  | Network adequacy provisions for LTSS providers in managed care programs  | Requirements for MCOs to coordinate with other state agencies for LTSS   |
|-------|--|---|---|---|--|--|--|--|
|       | MLTSS program targets children only, or children and adults  | State contracts with more than one MCO (Yes/No) | Federal Medicaid waiver authority used  |   |  |  |  |  |
|       | for children with disabilities.  |   | authorizes managed care; 1915(c) authorizes the Medically Dependent Children's Program (MDCP) | <p>HCBS<sup>50</sup> (mandatory)</p> <p>IDD and Youth Empowerment Services (YES) waivers (mandatorily enrolled in managed care for non-waiver services only)</p> <p>MDCP<sup>51</sup> (Children in STAR health who receive MDCP waiver services must receive those services through managed care)</p> |  | <p>For MCOs offering LTSS, the member advisory group must include a reasonably representative sample of the LTSS member population or advocates. For the LTSS member population the advisory group must include at least three members or their representatives receiving LTSS through the MCO or their representative.</p> <p><b>HHSC STAR Kids Managed Care Advisory committee<sup>53</sup>:</b><br/>The legislatively mandated HHSC STAR Kids advisory committee advises HHSC on the establishment and implementation of the STAR Kids Medicaid managed care program. The committee began in October 2013 and will end December 2019.</p> <p><b>Utilization Management:</b><br/>The MCO must file quarterly LTSS Utilization Reports<sup>54</sup></p> <p><b>Sources of LTSS measures for the STAR Kids program include:</b></p> <ul style="list-style-type: none"> <li>- The first biennial STAR Kids caregiver survey, which includes several measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, the National Survey of Children with Special Health Care Needs (NS-CSHCN), and the National Survey of Children's Health (NSCH)</li> <li>- LTSS measures developed by HHSC monitoring timeliness and service coordination</li> </ul> | <p>providers of each category of community-based services, not including MDCP STAR Kids service providers referenced in this section. If the MCO determines it is unable to provide member access to more than one provider of community-based services, the MCO must submit and receive an exception.<sup>55</sup></p> <p><b>MDCP STAR Kids:</b> The MCO must have a sufficient number of contracts with MDCP STAR Kids service Providers so that all members who receive MDCP STAR Kids have access to Medically Necessary and Functionally Necessary Covered Services.</p> <p><b>All other covered services:</b> At a minimum, the MCO must ensure that all members have access to at least one network provider for each of the remaining covered services within 75 miles of the member's residence.</p> <p><b>Access to Care:</b><br/>For each provider type, the MCO must provide access to at least 90 percent of members within the prescribed distance or travel time.</p> | <p>area, or each Texas HHS region, regarding the provision of essential public health care services. The MCO must meet the following requirements:<br/>Coordinate with the Department of Aging and Disability Services and providers of LTSS for members who receive LTSS outside of the MCO.</p>                        |
| VA*   | <p><a href="#">Commonwealth Coordinated Care Plus</a></p> <p>Provides MLTSS for older adults, adults with I/DD or physical disabilities, and children with disabilities.</p> | Yes <sup>56</sup>                               | <a href="#">1915(c) waiver</a>  | <p>Children enrolled in these HCBS 1915(c) waivers:</p> <ul style="list-style-type: none"> <li>- Building Independence</li> <li>- Commonwealth Coordinated Care (CCC) Plus</li> </ul>   | Comprehensive <sup>58</sup>  | <p>Establish internal processes to ensure that the QM activities for primary, specialty, and behavioral health services, and LTSS reflect utilization across the network and include all of the activities in this section of this contract.</p> <p>In collaboration with and as further directed by the Department, develop a customized medical record review process to monitor the assessment for and provision of behavioral health and LTSS.</p>   | <ul style="list-style-type: none"> <li>- The contractor shall include in its network or otherwise arrange care by providers specializing in early childhood, youth and geriatric services, and providers who are specialized in and have demonstrated competency in meeting the unique needs of the CCC Plus program population.</li> <li>- The contractor shall enter into provider contracts for the provision or administration of covered LTSS, including hospice, NF, and CCC Plus Waiver covered services.</li> </ul>  | <ul style="list-style-type: none"> <li>- The contractor shall develop and maintain a network of early intervention providers, certified by DBHDS [Department of Behavioral Health and Developmental Services], with sufficient capacity to serve its CCC Plus Members in need of early intervention services.</li> </ul> |

| State             | State managed care program for LTSS in Medicaid  |   |  | Categories of CYSHCN receiving LTSS in Medicaid managed care (SSI, FC, HCBS)   | Services provided through managed care: LTSS only (NF, HH, and/or HCBS) or comprehensive (Medical, BH, and LTSS)                     | MLTSS quality management for children   | Network adequacy provisions for LTSS providers in managed care programs  | Requirements for MCOs to coordinate with other state agencies for LTSS  |
|-------------------|--|---|--|--|--|---|--|---|
|                   | MLTSS program targets children only, or children and adults                            | State contracts with more than one MCO (Yes/No)   | Federal Medicaid waiver authority used   |  |  |   |  |   |
|                   |  |   |  | <ul style="list-style-type: none"> <li>- Community Living</li> <li>- Family and Individual Supports.<sup>57</sup> (voluntary, opt-out)</li> <li>FC (voluntary, opt-out)</li> </ul> |  | <p>The Contractor's vendor shall perform the CAHPS Adult Version Medicaid survey, CAHPS Child Version, Children with Chronic Conditions Medicaid survey using the most current CAHPS version specified by NCQA.</p> <p>Conduct, as directed by the department, the HCBS Experience survey for members utilizing LTSS. Survey methodology and tools will be jointly developed via a collaborative effort between the department and the CCC Plus program contractors. This shall require that individuals conducting such survey are appropriately and comprehensively trained, culturally competent, and knowledgeable of the population being surveyed.</p> <p>The contractor shall perform at least two clinical and two non-clinical PIPs, beginning in CY2018. One of the two non-clinical PIPs shall be in the area of long-term care and LTSS diversion.<sup>59</sup></p> | <ul style="list-style-type: none"> <li>- Effective Jan. 1, 2018, the contractor shall contract with all Community Service Boards (CSBs) as well as Behavioral Health Authority (e.g., Richmond Behavioral Health Authority) to provide sufficient network access for its CCC Plus members.<sup>60</sup></li> </ul> | <ul style="list-style-type: none"> <li>- The contractor shall work collaboratively with DMAS [Department of Medical Assistance Services – Medicaid] and Department of Social Services in meeting the Federal requirements related to the Virginia Health Care Oversight and Coordination Plan for children in foster care.</li> </ul> |
| <b>Total (14)</b> | <b>Seventeen programs</b><br><br><b>(Some states have more than one MLTSS program)</b> | <b>Contracts with more than one MCO: Fourteen programs</b><br><br><b>No: Three programs</b> | <b>1115: Twelve programs</b><br><br><b>1915(a): One program</b><br><br><b>1915(b): Two programs</b><br><br><b>1915(c): Four programs</b> | <b>SSI: Twelve programs</b><br><br><b>FC: Nine programs</b><br><br><b>HCBS: Twelve programs</b>  | <b>Comprehensive: Fourteen programs</b><br><br><b>LTSS and BH: Two programs</b><br><br><b>LTSS and physical health services: One</b> |   |  |   |

\* This information NASHP compiled was not confirmed by the state's Medicaid agency.

**Endnotes**

<sup>1</sup> Banner-University Family Care, Mercy Care Plan and United Healthcare Community Plan. Arizona Medicaid also contracts with the Arizona Department of Economic Security (DES), Division of Developmental Disabilities (DDD) to provide ALTCs services for children and adults with developmental disabilities.

<sup>2</sup> Centers for Medicare and Medicaid Services. *Arizona Health Care Cost Containment System 1115 Waiver Amendment Approval*. December 29, 2017. p. 33. <https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf>

<sup>3</sup> Arizona Health Care Cost Containment System. *Notice of Request for Proposal for Arizona Long Term Care System (ALTCs) Elderly & Physical Disability (E/PD) Program Contract*. Released November 1, 2016. p. 98.

[https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH18/ReqForProp/ReqForProp\\_Solicitation.pdf](https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH18/ReqForProp/ReqForProp_Solicitation.pdf)

<sup>4</sup> Ibid., p. 100

<sup>5</sup> Ibid., p. 98

<sup>6</sup> United Healthcare Community Plan and Highmark BCBS Health Options – the same MCOs that provide services for the more traditional Managed Care program – Diamond State Health Plan

<sup>7</sup> State of Delaware Department of Health and Social Services. *Model Contract for Health Plans for Diamond State Health Plan*. Released December 2015. p. 50. [http://bidcondocs.delaware.gov/HSS/HSS\\_17028Dshp\\_attA.pdf](http://bidcondocs.delaware.gov/HSS/HSS_17028Dshp_attA.pdf)

<sup>8</sup> State of Delaware Department of Health and Social Services. *Diamond State Health Plan Quality Management Strategy*. Released April 2014. [http://dhss.delaware.gov/dhss/dmma/files/draft\\_qms\\_20140401.pdf](http://dhss.delaware.gov/dhss/dmma/files/draft_qms_20140401.pdf)

<sup>9</sup> Amerigroup, Better Health, Aetna, Humana, Molina, Prestige, Community Care Plan (CCP), Simply, Staywell, Sunshine and United Health (not all plans participating statewide): [https://ahca.myflorida.com/Medicare/statewide\\_mc/pdf/mma/SMMC\\_MMA\\_Snapshot.pdf](https://ahca.myflorida.com/Medicare/statewide_mc/pdf/mma/SMMC_MMA_Snapshot.pdf)

<sup>10</sup> Florida State Agency for Health Care Administration. *Managed Medical Assistance (MMA) Program Contract*. Effective February 1, 2018. [http://www.fdhc.state.fl.us/medicaid/statewide\\_mc/pdf/Contracts/2018-02-01/EXHIBIT\\_II-](http://www.fdhc.state.fl.us/medicaid/statewide_mc/pdf/Contracts/2018-02-01/EXHIBIT_II-)

[A\\_MMA\\_Managed\\_Medical\\_Assistance\\_\(MMA\)\\_Program\\_Feb\\_1\\_2018.pdf](A_MMA_Managed_Medical_Assistance_(MMA)_Program_Feb_1_2018.pdf)

<sup>11</sup> AlohaCare, HMSA, Kaiser Permanente, 'Ohana Health Plan and UnitedHealthCare Community Plan

<sup>12</sup> Hawaii is currently developing their 1115 waiver extension application for another 5 years: <https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/Section-1115-Demonstration-Project-Application.pdf>

<sup>13</sup> Amerigroup Iowa, Inc. and UnitedHealthcare Plan of the River Valley, Inc.

<sup>14</sup> Iowa Department of Human Services. *Managed Care Organization Contract with Amerihealth Caritas Iowa Inc*. Effective January 1, 2016. p. 166. [https://dhs.iowa.gov/sites/default/files/AmeriHealth\\_Iowa\\_Contract.pdf](https://dhs.iowa.gov/sites/default/files/AmeriHealth_Iowa_Contract.pdf)

<sup>15</sup> Iowa Department of Human Services. *Managed Care Organization Contract with Amerigroup Iowa Inc*. Effective January 1, 2016. Exhibit B. [https://dhs.iowa.gov/sites/default/files/AmeriGroup\\_Contract.pdf](https://dhs.iowa.gov/sites/default/files/AmeriGroup_Contract.pdf)

<sup>16</sup> Iowa Department of Human Services. *Managed Care Organization Contract with Amerihealth Caritas Iowa Inc*. Effective January 1, 2016. [https://dhs.iowa.gov/sites/default/files/AmeriHealth\\_Iowa\\_Contract.pdf](https://dhs.iowa.gov/sites/default/files/AmeriHealth_Iowa_Contract.pdf)

<sup>17</sup> Amerigroup, Sunflower State Health Plan and UnitedHealthcare

<sup>18</sup> Kansas incorporates 7 1915c HCBS Waivers within the 1115 Waiver. Kansas applied for a renewal of their existing 1115 waiver in December 2017 which is currently pending with CMS

<sup>19</sup> State of Kansas Department of Administration. *State Quality Strategy for KanCare Medicaid and CHIP Capitated Managed Care*. Released November 1, 2017, RFP Attachment J - <http://admin.ks.gov/offices/procurement-and-contracts/kancare-award>

<sup>20</sup> The Michigan MLTSS program is a PIHP model wherein the state contracts directly with county-based community mental health services programs who are then paid on a capitated basis to provide and manage care.

<sup>21</sup> Individuals enrolled in the Habilitation Supports Waiver and those in the MIChoice Waiver may also be enrolled in this waiver; however, individuals enrolled in Michigan's Children's Waiver Program and Children with Serious Emotional Disturbance Waiver are excluded:

[https://www.michigan.gov/documents/mdhhs/MSSS\\_Waiver\\_Amendment\\_extended\\_09302018\\_617516\\_7.pdf](https://www.michigan.gov/documents/mdhhs/MSSS_Waiver_Amendment_extended_09302018_617516_7.pdf)

<sup>22</sup> Blue Cross Blue Shield of NM, Molina Healthcare, Presbyterian Health Plan, UnitedHealthcare Community Plan

<sup>23</sup> 1915(c) DD waiver enrollees only receive acute care services through Medicaid managed care.

<sup>24</sup> New Mexico Department of Human Services, Centennial Care Letter of Direction #67, March 2017. [http://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/LOD\\_%2362\\_Perf\\_Msr\\_Cal\\_Year\\_2017\\_Targets\\_03.08.2017.pdf](http://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/LOD_%2362_Perf_Msr_Cal_Year_2017_Targets_03.08.2017.pdf)

<sup>25</sup> NC contracts with MCOs or Local Management Entities in their PIHP program: <https://www.ncdhhs.gov/providers/lme-mco-directory>

<sup>26</sup> 1915(c) waiver children with I/DD – children under age 3 on this waiver are excluded from enrollment in the PIHP program.

<sup>27</sup> Amerigroup, Horizon NJ Health, UnitedHealthcare Community Plan, WellCare and Aetna

<sup>28</sup> New York State is currently in the design phase of carving in additional children's services into Medicaid managed care through their 1115 waiver: [https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/index.htm)

<sup>29</sup> New York State Department of Health. *Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract*. Amended October 1, 2015. [https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf)

<sup>30</sup> Ibid.

<sup>31</sup> AmeriChoice, AmeriGroup Community Care, Volunteer State Health Plan (Bluecare)

<sup>32</sup> State of Tennessee, Department of Finance and Administration, Division of TennCare. *Model Managed Care Organization Contract*. Released July 1, 2018. <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>

<sup>33</sup> Entire list of LTSS provider standards can be found here: <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf#page=270>

<sup>34</sup> In addition, the Medicaid Agency has a signed MOU with the Department of Human Services, Division of Vocational Rehabilitation for the coordination of employment supports for children and adults in Employment and Community First CHOICES, and is one of 8 State participating in an Interagency MOU regarding transition services for youth with disabilities and the coordination of transition services (including HCBS) from school to post-secondary education or training.

<sup>35</sup> AmeriGroup and Volunteer State Health Plan (Bluecare)

<sup>36</sup> Mandatory for all new HCBS applicants Voluntary – opt-in for persons with I/DD enrolled in longstanding 1915(c) waivers

<sup>37</sup> Ibid.

<sup>38</sup> BlueCare Tennessee. *Provider Administration Manual*. Revised June 2018. [https://bluecare.bcbst.com/forms/Provider%20Information/BCT\\_PAM.pdf](https://bluecare.bcbst.com/forms/Provider%20Information/BCT_PAM.pdf)

<sup>39</sup> Volunteer State Health Plan – is reimbursed on a non-risk, non-capitated basis for services provided to the coverage groups, and receives fees from the state to offset administrative costs.

<sup>40</sup> State of Tennessee, Department of Finance and Administration, Division of TennCare. *Model Managed Care Organization Contract*. Released July 1, 2018. <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>

<sup>41</sup> BlueCare Tennessee. *Provider Administration Manual*. Revised June 2018. [https://bluecare.bcbst.com/forms/Provider%20Information/BCT\\_PAM.pdf](https://bluecare.bcbst.com/forms/Provider%20Information/BCT_PAM.pdf)

<sup>42</sup> In addition, the Medicaid Agency has a signed MOU with the Department of Human Services, Division of Vocational Rehabilitation for the coordination of employment supports for children and adults in Employment and Community First CHOICES, and is one of 8 State participating in an Interagency MOU regarding transition services for youth with disabilities and the coordination of transition services (including HCBS) from school to post-secondary education or training.

<sup>43</sup> Texas contracts with a single MCO to provide services statewide for this program – Superior HealthPlan

<sup>44</sup> The following 1915(c) waiver: Medically Dependent Children Program (MDCP)

<sup>45</sup> Texas Department of Family and Protective Services. *STAR Health: A Guide to Medical Services at CPS*. [http://www.dfps.state.tx.us/Child\\_Protection/Medical\\_Services/guide-star.asp#services](http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-star.asp#services)

<sup>46</sup> Texas Health and Human Services Commission. *STAR Health Contract Terms*. Effective March 1, 2018. <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/star-health-contract.pdf>

<sup>47</sup> Ibid.

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<sup>48</sup> Ibid.

<sup>49</sup> Aetna Better Health Texas, Amerigroup, Blue Cross Blue Shield of Texas, Children's Medical Center Health Plan, Community First Health Plans, Cook Children's Health Plan, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, UnitedHealthcare Community Plan

<sup>50</sup> The following 1915(c) waivers: Medically Dependent Children Program (MDCP), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), Texas Home Living (TxHML).

<sup>51</sup> The following 1915(c) waiver: Medically Dependent Children Program (MDCP).

<sup>52</sup> Waiver services (with the exception of MDCP services) will still be covered and managed by the waiver program.

<sup>53</sup> Texas Health and Human Services Commission. *STAR Kids Contract Terms*. Effective March 1, 2018 <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/star-kids-contract.pdf>

<sup>54</sup> Ibid.

<sup>55</sup> Ibid.

<sup>56</sup> Aetna Better Health of Virginia, Anthem HealthKeepers Plus, Magellan Complete Care of Virginia, Optima Health, United Healthcare, Virginia Premier Health Plan

<sup>57</sup> Virginia Department of Medical Assistance Services. *Commonwealth Coordinated Care Plus MCO Contract for Managed Long Term Services and Supports*. Effective January 1, 2018.

[http://www.dmas.virginia.gov/Content\\_attachments/mltss/2018%20Final%20Amendment%20Effective%20July%201.docx](http://www.dmas.virginia.gov/Content_attachments/mltss/2018%20Final%20Amendment%20Effective%20July%201.docx)

<sup>58</sup> Carved out services include: Dental, School Health Services, DD Waiver Services, DD case management services, and transportation services to and from DD Waiver Services.

<sup>59</sup> Ibid.

<sup>60</sup> Ibid.