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

Information as of June 2018

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

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AZ	**Arizona Long Term Care System (ALTCS)** Provides MLTSS to older adults, and adults and children with physical and developmental disabilities.	Yes[1]	1115 waiver	SSI (mandatory) FC (mandatory) HCBS (voluntary) Enrollees in these categories are eligible to enroll in ALTCS, but must also require health care services at	Comprehensive	**Long Term Services and Supports:** 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.[3] **Durable Medical Equipment (DME) Service Delivery:** 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	**Arizona Early Intervention Program (AzEIP):** 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.[5]

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				a nursing facility or ICF/IID level of care.)[2]			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.[4] In addition to other network adequacy standards or requirements outlined in these contracts, AHCCCS also has requirements outlined in the AHCCCS Contractors Operations Manual (413 and 436).	
DE	**Diamond State Health Plan – Plus (DSHP)** Provides MLTSS to older adults, adults with physical disabilities, and children with disabilities residing in nursing facilities.	Yes[6]	1115 waiver	SSI (mandatory) Children residing in nursing facilities (mandatory)	LTSS and Medical BH provided through FFS[7]	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.[8] 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	**Managed Medical Assistance (MMA)** Provides MLTSS to children up to age 20 with disabilities.	Yes[9]	1115 waiver	SSI (Voluntary) ABD (Voluntary) 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.[10]	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. Statewide essential providers include: - Regional perinatal intensive care centers; - Hospitals licensed as specialty children's; and - 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	**QUEST Integration**	Yes[11]	1115 waiver[12]	SSI (mandatory) FC (mandatory)	Comprehensive	N/A	N/A	The MCO is required to coordinate with other state agencies for LTSS to

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	Provides MLTSS to elderly enrollees and/or adults and children with disabilities.			HCBS (mandatory)				ensure a continuum of services for quality outcomes.
IA	**Iowa Health Link** Provides MLTSS to older adults, adults with I/DD or physical disabilities, and children with disabilities.	Yes[13]	1915(b) waiver	SSI (mandatory) FC (mandatory) HCBS (mandatory)	Comprehensive	MCOs are required to implement, utilize, and report on the Iowa Participant Experience Survey tool for members receiving HCBS services.[14] MCOs are also required to provide data related to CMS-approved HCBS waiver performance measures. A reporting manual has been developed for MCO reporting.	**Long-Term Care Services Access Standards:** **Network:** *Institutional providers:* 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. *HCBS providers:* 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. **Time and distance:** 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.[15]	Contract requires MCOs to coordinate with state's public health agency, state Department of Education and local community service agencies.[16]
KS	**KanCare MLTSS** Provides MLTSS to older adults, adults with I/DD or physical disabilities, and children with	Yes[17]	1915(c) and 1115 waiver[18]	SSI (mandatory) FC (mandatory) 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.[19]	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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	disabilities and SED.							
MI	**Managed Specialty Services and Supports** Provides MLTSS to adults and children with I/DD.	No, it is a PIHP program[20]	1915(b) waiver	SSI (mandatory) FC[21] (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	**New Mexico Centennial Care** Provides MLTSS to older adults, adults with I/DD or physical disabilities, and children with disabilities.	Yes[22]	1115 waiver (current) (proposed)	SSI (mandatory) FC (mandatory) HCBS (mandatory)	Comprehensive[23]	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. • 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) • MCOs are required to participate on the steering committee for the Consumer, Family-Caregiver and Youth Satisfaction Project (C/F/YSP). • 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. • 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,	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 though 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. LTSS providers monitored in these reports include personal care agencies, assisted living facilities, and nursing facilities.	• MCOs are required to coordinate and collaborate with the Children, Youth, and Family Department (CYFD), including children in CYFD custody. • MCOs are required to contract with the Department of Health Families First and Children's Medical Services programs for case management-related activities.

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						telemedicine, patient-centered medical homes and value-based purchasing. • 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.[24]		
NC*	**NC Innovations** Provides MLTSS to adults and children with I/DD.	Yes – PIHP program[25]	1915(c) waiver	HCBS[26] (mandatory)	LTSS and BH	N/A	N/A	N/A
NJ	**NJ FamilyCare** Provides MLTSS to adults and children with special health care needs.	Yes[27]	1115 waiver	SSI (mandatory) FC (mandatory) HCBS (mandatory)	Comprehensive	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. The MLTSS program shall be integrated into the contractor's Quality Assessment Performance Improvement program. The state has selected these performance measures for its MLTSS program.	**MLTSS Network Requirements** 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. 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.	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	**Medicaid Managed Care** Provides MLTSS to CYSHCN and	Yes	1115 waiver	SSI (mandatory) FC (mandatory)	Comprehensive[28]	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	**Coordination of Services:** The contractor shall coordinate care for enrollees, as applicable, with specialized providers of long-term

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	medically fragile children.			HCBS (mandatory)			disorder providers, allied health professionals, ancillary providers, durable medical equipment (DME) providers, home health providers, and pharmacies, if applicable.[29]	care for people with developmental disabilities. 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.[30]
TN	**CHOICES** Provides MLTSS to older adults, adults with I/DD or physical disabilities, and children with disabilities in nursing facilities.	Yes[31]	1115 waiver	Children who receive nursing home care	Comprehensive[32]	**A.2.15.1 Quality Management/Quality Improvement (QM/QI) Program *applies to both CHOICES and ECF CHOICES programs.*** The QM/QI program addresses physical and behavioral health and long-term care services. 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). 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. 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. **A.2.24.3 and 4 CHOICES and ECF CHOICES Advisory Groups**	**A.2.11.6 Special conditions for long-term services and supports providers *(applies to both CHOICES and ECF CHOICES programs)*** - The MCO must contract with any licensed and certified nursing facility willing to contract with the MCO. - 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. - The MCO must contract with at least two providers for each CHOICES and each ECF CHOICES HCBS enrollee, other than community-based residential alternatives. - 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). - The MCO contract includes a list of preferred contracting standards for CHOICES and ECF CHOICES HCBS providers, including:[33] - Currently participates as a provider in the 1915(c) wavier program and has high quality assurance ratings; - Is actively seeking or has accreditation; - The provider has completed DIDD [Intellectual and Developmental Disabilities] person-centered organization training;	**A.2.9.16 Inter-agency coordination *(applies to both CHOICES and ECF CHOICES programs)*** The MCO is required to coordinate with other state agencies and local departments for purpose of coordination for enrollees. Specifically, they must coordinate with: - The Tennessee Department of Children's Services (DCS) for the purpose of interfacing with and assuring continuity of care; - 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;
	Employment and Community First (ECF) CHOICES Provides MLTSS to adults and children with I/DD.	Yes[35]	1115 waiver	HCBS[36] (mandatory for new waiver enrollees, voluntary, opt-out for existing waiver enrollees)	Comprehensive[37]			

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						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)	- The provider is START-certified, or has completed START training; and - The provider has achieved documented success in helping individuals with I/DD achieve employment opportunities and/or independent living situations. **A.2.11.7 Special conditions for persons with intellectual or developmental disabilities (I/DD) including:** - Adequate capacity to deliver covered physical and behavioral health services that meet the needs of persons with I/DD; - 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. - Policies and procedures for assigning members with I/DD to PCPs, and other medical and behavioral health specialists, with I/DD expertise. **For primary care providers or physician extenders:** - Transport access suburban/rural/frontier: At or less than 30 miles travel distance and 45 minutes travel time; - Transport access urban: At or less than 20 miles travel distance and 30 minutes travel time; - Member load: 2,500 or less for a physician, and 1,250 or less for a physician extender; and - 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.	- The Tennessee Department of Mental Health and Substance Abuse Services; - 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. - 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. - See signed Interagency MOUs through this end note.[34]
	TennCare Select Provides MLTSS to children with special health care needs in a PIHP program.[38]	No – one MCO operates the PIHP program[39]	1115 waiver	SSI (mandatory) FC (mandatory) HCBS (voluntary) Children eligible for SSI may opt out of TennCare Select and	Comprehensive	**2.15 Quality Management/Quality Improvement (QM/QI) Program** The QM/QI program shall address physical health, behavioral health, and long-term care services. 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).	**2.11.6 Special conditions for long-term services and supports providers:** - The MCO must contract with any licensed and certified nursing facility willing to contract with the MCO - 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.	**A.2.9.17 Inter-agency coordination** - 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: - The Tennessee Department of Children's Services for the

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				enroll in another MCO.[40]		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. **A.2.24.3 CHOICES Advisory Groups** 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).	- 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). - The MCO contract includes a list of preferred contracting standards for CHOICES HCBS providers. - 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. **For primary care providers or physician extenders:** - The distance/time between the practitioner and member in urban area will be a maximum 20 miles or 30 minutes; - The distance/time between the practitioner and member in suburban/rural/frontier area will be a maximum of 30 miles or 45 minutes. - Transport access for suburban/rural/frontier areas will be a maximum of 30 miles travel distance and 45 minutes travel time; - Transport access for urban areas will be a maximum 20 miles travel distance and 30 minutes travel time; - Member load is 2,500 or less for a physician, and 1,250 or less for a physician extender; - 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 - Office wait times should not exceed 45 minutes. *Note: Appointments for TennCareSelect members must reflect local practice and be on the same basis as all other patients served by the practitioner.*[41]	purpose of interfacing with and assuring continuity of care; - 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; - The Tennessee Department of Mental Health and Substance Abuse Services; - 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. See signed Interagency MOUs through this end note.[42]

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TX	STAR Health Provides MLTSS to children in foster care.	No – one MCO[43]	1915(a) authority to operate managed care for foster care; 1915(c) waiver to operate the Medically Dependent Children's Program	Most children in state conservatorship are mandatorily enrolled in the STAR Health program. Medically Dependent Children Program (MDCP)[44] (Children in STAR Health who receive these waiver services must receive those services through managed care)	Comprehensive[45]	**MCO Advisory Group LTSS representation**[46] – 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. **Utilization management:** The MCO must file quarterly LTSS utilization reports. **Sources of LTSS measures for the STAR Health program include:** The STAR Health caregiver survey, which includes several measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey	**Network Adequacy and Access to Care**[47]**:** **Community-Based Service Providers:** 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. **MDCP STAR Health:** 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. **Access to Care:** **All other Covered Services, except for services provided in the Member's residence:** 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. 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.	**Coordination with Child Welfare Agency:** 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. 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.[48] 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.
	STAR Kids Provides MLTSS	Yes[49]	1115 waiver	SSI (mandatory)	Comprehensive[52]	**MCO Advisory LTSS Representation:**	**Community-Based Service Providers:** 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

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	for children with disabilities.		authorizes managed care; 1915(c) authorizes the Medically Dependent Children's Program (MDCP)	HCBS[50] (mandatory) IDD and Youth Empowerment Services (YES) waivers (mandatorily enrolled in managed care for non-waiver services only) MDCP[51] (Children in STAR health who receive MDCP waiver services must receive those services through managed care)		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. **HHSC STAR Kids Managed Care Advisory committee[53]:** 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. **Utilization Management:** The MCO must file quarterly LTSS Utilization Reports[54] **Sources of LTSS measures for the STAR Kids program include:** - 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) - LTSS measures developed by HHSC monitoring timeliness and service coordination	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.[55] **MDCP STAR Kids:** 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. **All other covered services:** 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. **Access to Care:** For each provider type, the MCO must provide access to at least 90 percent of members within the prescribed distance or travel time.	area, or each Texas HHS region, regarding the provision of essential public health care services. The MCO must meet the following requirements: Coordinate with the Department of Aging and Disability Services and providers of LTSS for members who receive LTSS outside of the MCO.
VA*	**Commonwealth Coordinated Care Plus** Provides MLTSS for older adults, adults with I/DD or physical disabilities, and children with disabilities.	Yes[56]	1915(c) waiver	Children enrolled in these HCBS 1915(c) waivers: - Building Independence - Commonwealth Coordinated Care (CCC) Plus	Comprehensive[58]	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. 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.	- 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. - The contractor shall enter into provider contracts for the provision or administration of covered LTSS, including hospice, NF, and CCC Plus Waiver covered services.	- 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.

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					
				- Community Living - Family and Individual Supports.[57] (voluntary, opt-out) FC (voluntary, opt-out)		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. 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. 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. [59]	- 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.[60]	- 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.
Total (14)	**Seventeen programs** **(Some states have more than one MLTSS program)**	**Contracts with more than one MCO: Fourteen programs** **No: Three programs**	**1115: Twelve programs** **1915(a): One program** **1915(b): Two programs** **1915(c): Four programs**	**SSI: Twelve programs** **FC: Nine programs** **HCBS: Twelve programs**	**Comprehensive: Fourteen programs** **LTSS and BH: Two programs** **LTSS and physical health services: One**			

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

Endnotes

[1] 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.
[2] Centers for Medicare and Medicaid Services. *Arizona Health Care Cost Containment System 1115 Waiver Amendment Approval*. December 29, 2017. p. 33. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf
[3] 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
[4] Ibid., p. 100
[5] Ibid., p. 98
[6] 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
[7] 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
[8] 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
[9] 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/Medicaid/statewide_mc/pdf/mma/SMMC_MMA_Snapshot.pdf
[10] 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-A_MMA_Managed_Medical_Assistance_(MMA)_Program_Feb_1_2018.pdf
[11] AlohaCare, HMSA, Kaiser Permanente, 'Ohana Health Plan and UnitedHealthCare Community Plan
[12] 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
[13] Amerigroup Iowa, Inc. and UnitedHealthcare Plan of the River Valley, Inc.
[14] 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
[15] 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
[16] 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
[17] Amerigroup, Sunflower State Health Plan and UnitedHealthcare
[18] 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
[19] 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
[20] 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.
[21] 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
[22] Blue Cross Blue Shield of NM, Molina Healthcare, Presbyterian Health Plan, UnitedHealthcare Community Plan
[23] 1915(c) DD waiver enrollees only receive acute care services through Medicaid managed care.
[24] 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
[25] NC contracts with MCOs or Local Management Entities in their PIHP program:: https://www.ncdhhs.gov/providers/lme-mco-directory
[26] 1915(c) waiver children with I/DD – children under age 3 on this waiver are excluded from enrollment in the PIHP program.
[27] Amerigroup, Horizon NJ Health, UnitedHealthcare Community Plan , WellCare and Aetna
[28] 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
[29] 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
[30] Ibid.
[31] AmeriChoice, AmeriGroup Community Care, Volunteer State Health Plan (Bluecare)
[32] 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
[33] Entire list of LTSS provider standards can be found here: https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf#page=270
[34] 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.
[35] AmeriGroup and Volunteer State Health Plan (Bluecare)
[36] Mandatory for all new HCBS applicants Voluntary – opt-in for persons with I/DD enrolled in longstanding 1915(c) waivers
[37] Ibid.
[38] BlueCare Tennessee. *Provider Administration Manual*. Revised June 2018. https://bluecare.bcbst.com/forms/Provider%20Information/BCT_PAM.pdf
[39] 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.
[40] 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
[41] BlueCare Tennessee. *Provider Administration Manual*. Revised June 2018. https://bluecare.bcbst.com/forms/Provider%20Information/BCT_PAM.pdf
[42] 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.
[43] Texas contracts with a single MCO to provide services statewide for this program – Superior HealthPlan
[44] The following 1915(c) waiver: Medically Dependent Children Program (MDCP)
[45] 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
[46] 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
[47] Ibid.

[48] Ibid.
[49] 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
[50] 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).
[51] The following 1915(c) waiver: Medically Dependent Children Program (MDCP).
[52] Waiver services (with the exception of MDCP services) will still be covered and managed by the waiver program.
[53] 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
[54] Ibid.
[55] Ibid.
[56] Aetna Better Health of Virginia, Anthem HealthKeepers Plus, Magellan Complete Care of Virginia, Optima Health, United Healthcare, Virginia Premier Health Plan
[57] 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_atchs/mltss/2018%20Final%20Amendment%20Effective%20July%201.docx
[58] Carved out services include: Dental, School Health Services, DD Waiver Services, DD case management services, and transportation services to and from DD Waiver Services.
[59] Ibid.
[60] Ibid.