

Innovations in the Balancing Incentive Program: New Jersey

The logo for the Balancing Incentive Program features a yellow arch above the word "BALANCING" in a large, black, sans-serif font. Below "BALANCING" is a dark blue horizontal bar containing the words "INCENTIVE PROGRAM" in white, all-caps, sans-serif font.

BALANCING INCENTIVE PROGRAM



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States are continuously updating their balancing efforts. This case study presents state information as of September 2016.

The Balancing Incentive Program, authorized by Section 10202 of the 2010 Affordable Care Act, sought to improve access to community-based long-term services and supports (LTSS). Through September 30, 2015, participating states received enhanced Federal Medical Assistance Percentage (FMAP) on eligible services. States that spent less than half of their total LTSS dollars on community LTSS in 2009 received 2% enhanced FMAP; states that spent less than 25% received 5% enhanced FMAP. As part of the Program, participating states were required to undertake three structural changes: 1) the No Wrong Door (NWD) system, 2) a Core Standardized Assessment (CSA), and 3) conflict-free case management. States were also required to spend Program funds on activities that enhance community LTSS for the Medicaid population. With Centers for Medicare & Medicaid Services (CMS) approval, states have until September 30, 2017, to spend the funds earned under the Program. Finally, by the end of the Program, states should have met the “balancing benchmark,” i.e., spend a certain percentage of total LTSS dollars on community LTSS (25% or 50% depending on the 2009 starting point).

Introduction

In an effort to learn more about how states are transforming their LTSS systems under the Balancing Incentive Program, CMS and its technical assistance provider, Mission Analytics, selected five Program states that implemented structural changes successfully and used Program funds innovatively to expand access to community LTSS. In the spring of 2016, Mission Analytics conducted site visits to these states, interviewing key state staff and stakeholders, and developed case studies based on findings.

This case study focuses on the launch of New Jersey’s MLTSS program, which was supported by the Balancing Incentive Program. New Jersey spent 70% of the enhanced FMAP earned through the Program on the expanded services offered under MLTSS. These funds were directed to new individuals receiving services, additional services provided to new and existing community LTSS users, and enhanced care management offered through Managed Care Organizations (MCOs). Since the launch of MLTSS in July 2014, almost 6,000 more people have accessed community LTSS. In addition, MCOs offer expanded care management to their enrollees, connecting individuals to providers and coordinating acute and long-term care. The Balancing Incentive Program provided New Jersey with a crucial source of revenue, helping the state fund these expansions during MLTSS’ first two years.

Mission Analytics conducted a site visit to New Jersey in May 2016, holding interviews with state staff and a beneficiary of MLTSS, and visiting an MLTSS enrollment site, the Gloucester County Division of Senior Services known as the Gloucester Aging and Disability Resource Center (ADRC). This case study summarizes findings from the site visit along with information submitted by New Jersey through its quarterly progress reports. Given that more and more states are rolling out managed care for their LTSS populations, they can learn from New Jersey’s experience, especially on the use of ADRCs for enrollment and conflict-free case management.

Program at a Glance

Operating Agency: Division of Aging Services, Department of Human Services (DHS)

Collaborating Agencies: Division of Medical Assistance and Health Services, Division of Developmental Disabilities (DDD), Division of Disability Services, and Division of Mental Health and Addiction Services

Project Director: Nancy Day, Director of the Division of Aging Services

Start Date: April 2013

Award Amount: \$110.1 million

Structural Changes

NWD System: New Jersey's ADRCs serve as the backbone of the NWD system given they screen and refer individuals into MLTSS. ADRC staff, accessible by phone and in-person, conduct the Level I screens, and several ADRCs conduct Level II assessments and facilitate the clinical and financial eligibility processes.

CSA: New Jersey's Level II assessment, NJ Choice, is based on the interRAI, which contains the Program's required domains and topics.

Conflict-free case management: Under MLTSS, New Jersey conducts clinical assessments for new Medicaid beneficiaries. MCOs conduct clinical assessments for their members enrolling in MLTSS as well as re-determinations with state approval. MCOs are required to closely monitor utilization and quality of care and implement conflict-free policies.

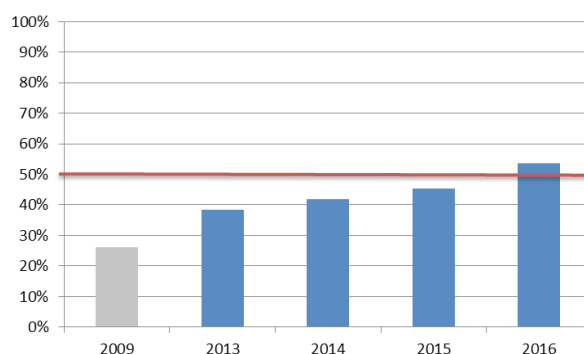
Use of Funds

New Jersey is using program funds to expand services for Medicaid recipients through MLTSS. New Jersey is also supporting mental health transitions by covering supportive services such as outpatient therapy, counseling and case management.

Balancing Benchmark:

The percent of total LTSS dollars spent on community LTSS rose from 26% in 2009 to 45% in 2015. In the first quarter of 2016, the percentage jumped even further to 53.6%. *Because NJ stopped participating in the Program after March 2016, the 2016 bar only contains one quarter of data.*

Percent of Total LTSS Spent on Community LTSS



Background on New Jersey's Community LTSS Waivers

In July 2014, New Jersey overhauled its provision of Medicaid-funded LTSS by consolidating four waivers under managed care through the Comprehensive Medicaid Waiver (CMW), which had been approved by CMS in 2012. Individuals enrolled in the Global Options (GO), AIDS Community Care Alternatives Program (ACCAP), Community Resources for People with Disabilities (CRPD), and Traumatic Brain Injury (TBI) waivers were automatically enrolled in one of four MCOs. Care managers within MCOs are responsible for coordinating individuals' comprehensive care needs.

Another DHS initiative operated by DDD under the CMW is the Supports program for individuals with intellectual and developmental disabilities (ID/DD). The Supports program was launched in 2015 and provides a basic level of support services to participants who live with family members or in their own homes. Each beneficiary receives a smaller package of program services than what is available to individuals served in New Jersey's Community Care Waiver (CCW), primarily because individuals do not require residential supports. The CCW is still administered separately by the DDD and, like the Supports program, is operated as fee for service. New Jersey's Medicaid program is known as NJ FamilyCare.

MLTSS: Overhauling the Provision of Community LTSS

Prior to MLTSS, individuals received their acute care, along with adult day care and personal assistant care services, through an MCO and other LTSS in a Medicaid fee for service environment. Through MLTSS, New Jersey aims to provide its beneficiaries with more comprehensive and coordinated care, consolidated under a single MCO. Below we discuss the launch of MLTSS, the enrollment process for new beneficiaries, and the promotion of conflict-free case management through New Jersey's MLTSS structure.

Getting MLTSS off the Ground

In 2011, in preparation for the influx of Balancing Incentive Program funds, the Division of Medicaid and the transition of approximately 12,000 individuals from a fee for service to a managed care environment was no easy feat. While individuals living in nursing facilities remained in fee for service, individuals already receiving services through one of four waivers automatically began to receive MLTSS through their current MCO. New NJ FamilyCare (Medicaid) enrollees (seeking either community-based or institutional services) also were enrolled in MLTSS. The launch of MLTSS required the state to prepare beneficiaries for the transition, connect providers to MCO networks, and train MCOs on LTSS-care plan development and care management.

In April 2014, four months prior to the official launch of MLTSS, New Jersey informed individuals that the MCO responsible for their acute care would also begin managing their LTSS. A comprehensive website with letters, frequently asked questions, and videos

MLTSS Informational Website

The screenshot shows the MLTSS Informational Website. At the top, it displays the Governor's name (Chris Christie) and the Lt. Governor's name (Kim Guadagno). Below that is the NJ Home | Services A to Z | Departments/Agencies | FAQs navigation bar. The main header reads "STATE OF NEW JERSEY DEPARTMENT OF MEDICAL ASSISTANCE & HEALTH SERVICES DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES". The page is titled "MLTSS Training Videos and Presentations" and lists several resources: "Aging Disability Resource Connection (ADRC) Training for MLTSS (Video)", "ADRC MLTSS Training Slides (Presentation)", "Area Agencies on Aging (AAA) Training for MLTSS (Video)", "AAA MLTSS Training Slides (Presentation)", "Chronic Disease Self Management Program (CDSMP) Training for MLTSS (Video)", "Chronic Disease Self Management Program (Presentation)", "Assisted Living in New Jersey (Video)", "Assisted Living MLTSS Training Slides Part 1 (Presentation)", "Assisted Living MLTSS Training Slides Part 2 (Presentation)", and "Managed Long-Term Services and Supports (MLTSS) Consumer Training (Video)". The page also includes a search bar and a "Submit" button.

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provided detailed information on the transition and services provided. While individuals could make a request to switch MCOs by calling a toll free number, New Jersey staff reported that the call volume for the state-run call center and the individual MCO call centers did not increase significantly. Most beneficiaries chose to remain within the same MCO.

To ensure continuity of and access to care for NJ FamilyCare enrollees, New Jersey also worked closely with its LTSS providers, so they would become part of MCO provider networks. While MCOs must include in their networks any willing nursing facility under the state's any willing provider (AWP) policy, they had more discretion with community-based providers. The state required MCOs to enroll at least two providers within each of New Jersey's 21 counties.¹ Providers were trained on MCO provider network requirements and the processes to enroll in a network. After the launch of MLTSS, providers needed to change their billing practices. Therefore, the state held intensive trainings on how providers could verify an individual's participation in an MCO and the universal claims submission process.

Perhaps the greatest challenge with the launch was getting MCOs up to speed with LTSS care planning. Although MCOs had incorporated adult day care and personal care assistant services into their plans in 2011, they had little experience with other areas of LTSS. Specifically, MCOs were tasked with conducting assessments of their enrollees to confirm eligibility and develop community LTSS plans of care, using NJ Choice, a tool based on the interRAI Home Care. After a six-month training process, which included conducting assessments for the medical day care population, the MCOs conducted assessments on the approximately 12,000 enrollees. However, about one third of the MCO assessments could not be authorized by the Office of Community Choice Options (OCCO) within the Division of Aging Services because information may not have been appropriately coded or responses seemed to conflict with other responses. The areas in which the MCOs had a significant learning curve were related to cognition, communication, incontinence, health conditions, formal care, social supports, independent activities of daily living, and activities of daily living. Therefore, state staff conducted a series of intensive webinars, did retraining and field mentoring, and held ongoing discussions and conference calls with MCO assessors and supervisors to help them think more critically about individuals' needs during the assessment process. The MCO supervisors also initiated enhanced quality assurance review of assessments before submission to the state. This rigorous training process has paid off in terms of higher-quality assessments for enrollees. In addition, New Jersey had to ensure that under the MCOs, beneficiaries were receiving the appropriate level and types of services consistent with the care plans previously developed in the fee for service environment. Specifically, beneficiaries were concerned with reductions in hours of personal care assistance or private duty nursing under the MCOs' plans of care.

Therefore, New Jersey developed a personal care assistant (PCA) tool to quantify typical time and assistance needed for various tasks.¹

ADRCs Play a Critical Role in MLTSS

ADRCs are the primary entry point for any individual interested in enrolling in MLTSS. Serving as the NWD system network, the 21 ADRCs are located throughout the state and have specialists accessible by phone and in person.

¹Rutgers Center for State Health Policy, *Initial Stakeholder Feedback on Implementation of the Managed Care Expansion in Long-Term Services and Supports*, July 2015, accessed through: <http://governor.nh.gov/commissions-task-forces/medicaid-care/documents/mm-11-12-2015-initial-stakeholder-feedback.pdf>

Enrollment Process

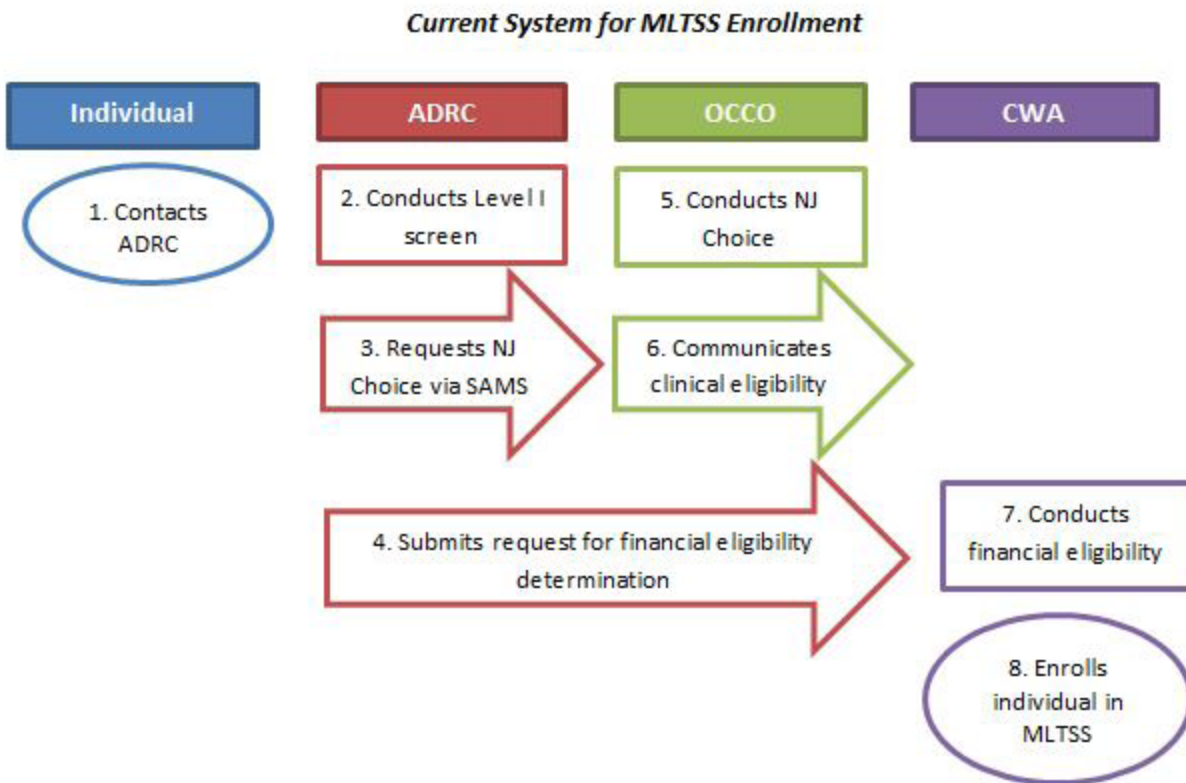
When an ADRC specialist comes into contact with individuals seeking services, the specialist first determine whether the individual may be a good candidate for MLTSS by discussing the home situation and service needs. Some triggers for the second step – a more structured Level I screen – include recent hospital discharge, living alone, and a request for home-delivered meals. The ADRC specialist then administers the Level I screen, which has 29 questions and takes approximately 30 minutes.

ADRC staff reported that the strong collaborative spirit of the agencies responsible for clinical and financial eligibility determination ensures the enrollment process runs smoothly and individuals are provided timely access to services.

The specialist uses financial eligibility questions in the Level I screen as an opportunity to discuss requirements and other service options if the individual does not appear to meet income thresholds. When Level I screen results are input into the ADRC case management system, the individual is assigned a score. Specialists then coordinate the more extensive NJ Choice assessment for individuals with scores above a certain threshold so a final determination of clinical eligibility for MLTSS can be made. While three ADRCs have NJ Choice assessors in-house, most contact OCCO within the Division of Aging Services to arrange the NJ Choice assessment. In these cases, referrals are shared through the ADRC case management system. The OCCO assessor then conducts the NJ Choice assessment in the individual's home. At the same time, the ADRC specialist supports the individual in completing the paper-based application for financial eligibility, which is then mailed to the County Welfare Agency (CWA) to determine financial eligibility. Once OCCO communicates clinical eligibility to the CWA, the CWA enrolls the individual in an auto-assigned MCO. The figure on the next page demonstrates the enrollment process of an individual eligible for MLTSS.

The process relies on various data management systems to capture, store, and share data. ADRC specialists have recently gained access to the NJ FamilyCare eligibility system, so they can determine whether an individual is already enrolled in Medicaid or not. This means ADRC specialists no longer have to check eligibility via personal communications with the CWA. In addition, the ADRC case management system, Social Assistance Management System (SAMS), captures Level I screening results across the 21 ADRCs. Every day, OCCO staff log onto the SAMS system to identify if any screens have triggered the need for the NJ Choice assessment. While OCCO assessors input NJ Choice data into a separate system, Telesys, they enter a summary of individuals' needs into SAMS, so the ADRC specialist is kept in the loop regarding the consumer's clinical eligibility outcome and service needs. OCCO also enters the final clinical eligibility determination into a system accessible by the CWA, so CWA staff can enroll the individual in an MCO once the financial eligibility determinations are also complete. Because the number of systems involved can be daunting, New Jersey developed a Request for Proposal to hire a vendor to reduce the number of systems involved and streamline data management.

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ADRCs: An Important Resource to MCO Staff and Enrollees

So even though they may ask for one thing, if during the course of the conversation, there is a sense that they may have more of a need, we encourage them to let a nurse come out and objectively evaluate the situation and discuss with [them] and the family what kind of support is available.

– ADRC staff member

ADRCs are not just essential components of MLTSS enrollment; they also maintain active relationships with MCOs and individuals after they are enrolled in MLTSS. When MLTSS was launched, some ADRC staff were concerned that the MCOs would not be able to effectively manage the complex needs of the LTSS population. Therefore, they began inviting MCO staff to quarterly meetings to discuss patient care issues and the eligibility determination flow. ADRCs and MCOs also communicate frequently to facilitate annual recertifications. One ADRC specialist reported that an MCO care manager calls her regularly

to help her contact difficult-to-reach participants to ensure they complete their recertification requirements. ADRC staff now see the benefits of having all acute and LTSS services coordinated by a single entity. One ADRC specialist tells participants: “Look at all the help mom’s going to get, and as far as the MCOs, you’re going to have a team, you won’t be out there as a caregiver by yourself trying to understand the diagnosis.”

Of course, the role of the ADRC goes far beyond just supporting MLTSS. Many ADRCs are co-located with other service agencies, facilitating referrals, such as transportation. They also provide meals, organize recreational activities for seniors and individuals with disabilities, connect individuals to Adult Protective Services, and enroll individuals in state-funded programs if they are not eligible for NJ FamilyCare. ADRCs are a crucial partner of NJ FamilyCare because of their commitment to the individuals they serve.

Mitigating Conflict within an MLTSS Environment

Many states struggled with implementing conflict-free case management, one of the Balancing Incentive Program's structural change requirements, in managed care environments because by design, MCOs play a large role in care coordination. Conflict-free case management is an important tenant of New Jersey's MLTSS system. From the onset, the state aimed to develop a system where individuals would receive the appropriate level of services with freedom of provider choice.

As a first component of conflict-free case management, New Jersey developed a complex system for clinical eligibility determination and care plan development. As stated above, a state agency, OCCO, conducts the clinical eligibility assessments for individuals newly enrolling into NJ FamilyChoice and MLTSS. However, MCOs are responsible for conducting assessments for individuals already receiving acute care through their plan who are also in need of LTSS. In addition, MCOs conduct the annual re-assessments for individuals within MLTSS. While assessment findings do not affect MCO capitation rates, they confirm clinical eligibility and inform plans of care.² To ensure that assessments are done correctly and result in the appropriate level of services, New Jersey requires that MCOs use a standardized assessment – NJ Choice – and share assessment findings with the state for approval and quality monitoring. The state's assessment of new beneficiaries, a standardized assessment instrument and data exchange process for MCOs, and the state's careful review and approval of MCO assessments help reduce MCO financial incentives to misrepresent beneficiary service needs.

In addition, given that care management is now embedded within the MCOs, the state requires MCOs to implement conflict-free practices. New Jersey included language in its MCO contracts to ensure that MCO staff responsible for care management are separate from service provision and not related to the individual receiving care. MCOs must also promote self-direction and inform beneficiaries of their rights to appeal decision relates to plans of care.

Excerpt from New Jersey's Contract with MCOs on Conflict-Free Case Management

The foundation of the Contractor's MLTSS Care Management program, and that of any subcontracted or delegated entity performing MLTSS Care Management on behalf of the Contractor, shall be built to ensure a conflict free environment incorporating the following requirements:

- 1. The Contractor shall ensure that its staff responsible for providing Care Management is separate from service provision and that appropriate safeguards exist to mitigate risk of potential conflict of interest.*
- 2. The Contractor shall implement policies and procedures to prohibit Care Managers related by blood or marriage from working with the MLTSS Member; to any of the Member's paid caregivers; or to anyone financially responsible for the Member or empowered to make financial or health-related decisions on the Member's behalf.*
- 3. The Contractor shall ensure that there is a strong oversight and quality management system to promote self-direction and MLTSS Members are clearly informed about their right to appeal decisions about plans of care, eligibility determination and service delivery.*

²There are three main capitation levels: nursing facility level of care (community-based or institutional), high skilled nursing facility, and low skilled nursing facility. These statuses are based on patient medical diagnoses. Within these categories, dual eligibles (i.e., Medicare and Medicaid) and Medicaid-only have different rates because Medicare is the primary payer of medical services for dual eligible (Medicaid being the payer of last resort).

Impact of MLTSS on Community LTSS

Two years after the launch of MLTSS, more people are receiving long-term care in the community. This increase is part of a longer trend in New Jersey to channel more funds to community-based care. In 2009, the year on which Balancing Incentive Program eligibility was based, 26% of New Jersey's LTSS dollars were spent in community-based settings. This percentage has gradually increased over the years, reaching 53.6% in the first quarter of calendar year 2016 and surpassing the "balancing benchmark" of 50%. The change in percentage can be attributed to more individuals receiving community LTSS, fewer individuals receiving care in institutions, and more services provided to those enrolled. The Balancing Incentive Program played a critical role in funding these expansions. These factors and their relationships to MLTSS are described below.

MLTSS and the Use of Balancing Incentive Program Funds

Of the enhanced FMAP earned through the Program, New Jersey spent:

- \$50 million on more people receiving services due to expanded eligibility
- \$14.5 million on enhanced care management
- \$6.7 million on expanded services for increased need for existing enrollees

More Individuals Receiving Community LTSS

Prior to the launch of MLTSS, 29% of New Jersey's LTSS population was receiving community-based care. In April of 2016, that number had reached 38%. The largest increase was from April 2015 to April 2016, when the community LTSS population went from 12,697 to 17,321.

The increased number of individuals receiving community LTSS can be attributed to several factors, including elimination of waiting lists, financial eligibility-related administrative changes, and more individuals learning about the program and taking advantage of its services.

- **Elimination of waitlists:** With the consolidation of four waivers under MLTSS, all waitlists were eliminated. This means that all clinically and financially eligible individuals, including those with behavioral health needs, can access community LTSS. However, this change likely did not lead to the significant increase in the community LTSS population, primarily because the state's largest waiver, the GO waiver, which served almost 11,000 older adults, had no waiting list.
- **Financial eligibility-related administrative changes:** In the beginning of 2015, the state developed a Qualified Income Trust (QIT) program, which allowed individuals to place income above a certain amount in a trust with the state of New Jersey as the beneficiary. Because this income is not counted when determining financial eligibility for MLTSS, QITs allow individuals who would have otherwise been ineligible to access the program. However, once again, the impact of this program on the community LTSS population is small given that most QIT users reside in nursing facilities.
- **Program Expansion:** Perhaps the largest driver of community LTSS usage refers to individuals already enrolled in NJ FamilyCare who transition to MLTSS based on service expansion. Most likely, these individuals' MCOs, which previously only covered acute care, introduced the program to them when they became in need of enhanced services. MCOs have the financial incentives to enroll additional participants in MLTSS as long as their costs remain below the capitation rate. Prior to MLTSS, the referral from an MCO to a waiver program

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may have been more cumbersome and delayed entry.

Fewer Individuals in Nursing Facilities

The percentage of total LTSS funds spent on community LTSS has also been impacted by a decrease in individuals living in institutions. From the start of MLTSS to April 2016, the nursing home population went down by 1,000. This decrease is partly due to the close collaboration between MLTSS and New Jersey's Money Follows the Person (MFP) Program, I Choose Home. One recent MLTSS enrollee, Steve, described his experience in a nursing home and the transition to supportive housing with the support of the program. After suffering from a stroke, Steve landed in a nursing home, where he spent the next four years. Although his physical and cognitive status had improved, he had lost his apartment and was unable to leave the nursing home, where he complained of lack of privacy, freedom and space. After being connected to the I Choose Home program, he and his partner, whom he met in the nursing home, were able to move to supportive housing. He appreciates the close-knit community, garden, ability to use his cooking skills, and most importantly, his independence. As he reported, *"We're our own boss, we pick our destiny, we choose what we're going to do for that day and that's how we live our life."*

New Jersey Gives MCOs Incentives to Provide Community-Based Care

To continue the momentum of increasing community LTSS, while decreasing institutional LTSS, New Jersey is providing incentives for MCOs to divert institutional admissions and transition individuals into the community when appropriate. For every individual who is transitioned from a nursing facility with standards established to define a transition, the MCO receives a \$20,000 incentive. If the individual dies within 120 days, the payment is prorated.

The state has also developed a process to allow high-cost individuals to stay in the community even if their costs exceed the community LTSS capitated rate. The state set up a process for MCOs to counsel high-cost individuals on the most appropriate setting of care for addressing complex needs. When an individual's service costs to remain in the community reaches 85% of the institutional capitation rate, the state developed an interdisciplinary team (IDT) process to ensure that the member is presented with the option of receiving their care in a community or nursing facility setting. The IDT is facilitated by the MCO with state staff involvement to ensure that members are given choice and have the right to receive care in the community even when this service delivery setting is not considered cost effective. Prior to MLTSS, this was not an option for members and they would have been placed in institutional care.

Individuals are Receiving More Community LTSS Services

In addition to more people accessing community LTSS through MLTSS, enrolled individuals are receiving more services. All individuals in MLTSS are eligible for the same set of services whereas they could only receive the services offered in their particular waiver prior to MLTSS.

In addition, the state has been working with MCOs to provide accommodations or services that may not be on the list of MLTSS services, but could keep individuals healthy and in their homes longer. For example, by purchasing an air conditioner for individuals with chronic obstructive pulmonary disease (COPD), MCOs can reduce their costs in the long-run by improving health outcomes.

Care management is a key service now offered by MCOs under MLTSS to support more coordinated acute and long-term care. In addition, each MCO must have an expert on housing, employment, and education to connect individuals to needed services and provide special supports to individuals at risk of homelessness. Previously,

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this service was provided by private vendors contracted by the state. The GO waiver alone relied on 100 separate vendor agencies. When MCOs gained the care management responsibility, many of them hired care managers already working with the vendor agencies to build in-house expertise and knowledge that they had gained through years of working with the LTSS population. One care manager described her work as “being like the putty that stretches to all the different entities to make sure needs don’t fall through the cracks.” Her duties range from assessing participants’ access to nutritious food to accompanying them to doctors’ appointments to connecting them to Adult Protective Services. She says the greatest benefit of MLTSS is having the tools to more easily identify and make referrals to providers and programs under the MCO’s umbrella.

We can be proactive instead of reactive. All of the benefits and services that are available – we pull all of those together as care managers and manage all of those pieces within that continuum of care.
– MCO care manager

MLTSS is not yet old enough to determine whether the new system has led to improvements in care quality or outcomes. New Jersey is calculating 41 measures associated with MLTSS, including hospitalizations, emergency room admission and readmissions, and behavioral health diagnoses. While many of these measures are self-reported by MCOs, New Jersey is working with external organization to conduct quality reviews.

Funding Supportive Housing Services through the Balancing Incentive Program

New Jersey has also used Program funds to help individuals with mental illness reside in the community with the proper supports. With support from the Balancing Incentive Program, the Division of Mental Health and Addiction Services has increased the number of new community-based supportive housing placements. While the state used its own funds to subsidize apartment rental costs, the Program funds have helped to cover supportive services such as outpatient therapy, counseling and case management. The majority of these placements were for individuals discharged from state hospitals, but some of them were “diversions,” or placements for individuals who are at risk of institutionalization.

New Jersey is building the foundation to scale up and sustain these supportive housing services. The state is participating in program support provided by CMS through the Medicaid Innovation Accelerator program to increase housing capacity. The first component focused on providing states an overview of the opportunities available to supportive housing services within the community. The second component focused on fostering partnerships between Medicaid and housing agencies to expand housing development opportunities for Medicaid community-based LTSS beneficiaries. Through this work, New Jersey is develop a strategic plan to incorporate supportive housing into MLTSS. New Jersey has submitted its Medicaid waiver renewal (i.e., MLTSS-related waiver) application to include a supportive housing component.

Conclusion and Next Steps

Two years after the launch of MLTSS, the state can look to potential expansions and issues with sustainability. For one, the state has not entirely removed its “waiver walls;” individuals with ID/DD still receive services under a separate fee for service waiver. The lessons learned through the 2014 launch of MLTSS may pave a smoother way for the ID/DD population should the state and stakeholders decide to pursue managed care for this waiver.

In addition, sustainability is an important issue for the state given the rapid growth in community LTSS utilization. However, New Jersey is not dependent on the Balancing Incentive Program to maintain MLTSS. While the

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Balancing Incentive Program helped fund these expansions, MLTSS was under development in New Jersey before the state was awarded the Balancing Incentive Program funding. With the launch of MLTSS, the state was able to spend the bulk of the money earned through the Program in just three quarters, primarily on the people receiving community LTSS for the first time.

Finally, as MLTSS matures, New Jersey can begin to use the carefully developed monitoring systems to determine the impact of MLTSS on individuals' service arrays and healthcare quality and outcomes. Of course, this oversight and evaluation should inform future policies and programs related to MLTSS.

The state went from having one of the lowest community LTSS percentages in the nation to passing the "balancing benchmark." Other states can look to New Jersey to see how the state managed the rollout, incorporating its ADRC network, working with MCOs to promote accurate care plans, and providing incentives for community LTSS. Through the creativity, commitment and collaboration of the many MLTSS partners – including ADRCs, MCOs, advocates and the various divisions within the Department of Human Services – more and more individuals with long-term care needs are receiving care and living in the communities of their choice, among friends and family, with control over their own lives and futures.