INSTITUTE FOR MEDICAID INNOVATION

October 2019

Leveraging Opportunities in Medicaid Managed Long-Term Services and Supports (MLTSS)

Authors:
Kimberly D. Tuck, RN
Jennifer E. Moore, PhD, RN, FAAN

Federal and state policymakers continue to look for opportunities to manage spending growth, improve quality of care, and enhance care coordination for individuals enrolled in Medicaid. One of the common strategies utilized by state Medicaid agencies is to transition their long-term services and supports (LTSS) program from a fee-for-service (FFS) payment model to a managed care model; also referred to as managed long-term services and supports (MLTSS).[1] MLTSS is defined by The Centers for Medicare & Medicaid Services (CMS) as an arrangement between a managed care plan and a state Medicaid program.[2] In these arrangements the participating managed care plan receives a capitated payment to provide LTSS to eligible individuals.

This report provides a comprehensive overview of the MLTSS program and highlights opportunities within policy, clinical practice, and research to address the challenges encountered.

This resource has been developed as a companion resource to the Institute for Medicaid Innovation's introductory report, **Understanding Long-Term Services and Supports in Medicaid.**

As part of the transition from fee-for-service (FFS) to managed long-term services and supports (MLTSS) for individuals receiving long-term services and supports (LTSS), state Medicaid agencies have rapidly increased the use of managed care for Medicaid enrollees. The goals for utilizing this model include expansion of Home and Community-Based Services (HCBS), promotion of community inclusion, ensuring quality, and increasing efficiency in the provision of these services.[2] The delivery of these services is complex, and states are utilizing the expertise of Medicaid managed care organizations to deliver these services to eligible individuals.[2]

The mission of the Institute for Medicaid Innovation is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity and the engagement of patients, families, and communities.

Support for this project is provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

As mandated by The Centers for Medicare & Medicaid Services (CMS), state Medicaid programs must cover services provided in nursing facilities and home health services (typically nursing services) but also may include both Home and Community-Based Services (HCBS) and/or intermediate-care facilities for individuals with Intellectual/Developmental Disabilities (I/DD) services, among others.[1] There are various configurations of covered services, with the most comprehensive payment arrangement including services for primary, acute, and behavioral health care.[3]

Among all Medicaid MLTSS programs, coverage for older adults (age 65 and over) continue to be the most prevalent programs (33 of 41 in 2017), followed closely by adults under age 65 with physical disabilities (30 of 41 in 2017).[4] The number of MLTSS programs serving adults with Intellectual/Developmental Disabilities (ID/DD) also increased, from eight states and nine programs in 2012 to 19 states and 24 programs in 2017.[4]

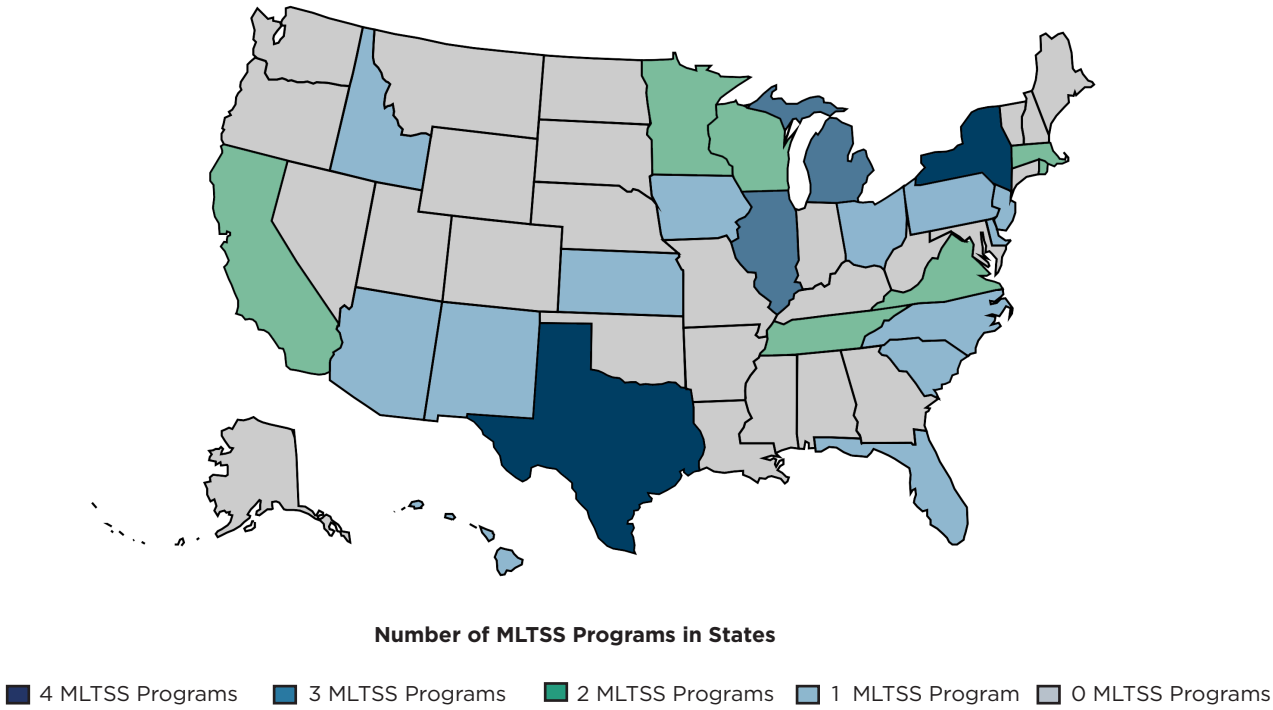
Programs that serve children with disabilities have experienced modest growth, from 8 programs in 8 states in 2012 to 14 programs in 11 states in 2017. Only Texas has a separate children with disabilities program; the remainder of the states cover both adults and children with the same program design.[4]

The CMS has created ten guiding principles utilized during review, approval, and oversight of state MLTSS programs.[3] The principles include:

1. Adequate planning and transition strategies when moving from FFS to managed care.
2. Stakeholder engagement throughout program design and after implementation.
3. Enhanced provision of HCBS with the ability to receive services in the most integrated setting.
4. Alignment of payment structure with MLTSS programmatic goals, including:
    a. improving the health of populations;
    b. improving the beneficiary's experience of care; and
    c. reducing costs through these improvements.
5. Support for individuals receiving care by the ability to use the state as an independent resource to discuss their services.
6. Person-centered processes to ensure that medical and non-medical needs are met, and quality of life and independence are preserved.
7. Comprehensive and integrated service packages of person-centered planning and care across all appropriate settings.
8. Providers who meet the qualifications to provide care that meets members' needs and are sufficient in number.
9. Participant protections through appeal rights and individual welfare safeguards.
10. Quality in service delivery (both for LTSS and MLTSS).

In 2009, six states had some form of an MLTSS program; in 2017 that number had tripled.[4] Some states have developed distinct programs for subsets of their population such as Texas's-distinct children with disabilities program. Figure 1 shows the number of MLTSS programs by state in 2017. This number has grown more than the number of total states with MLTSS programs[4] with several states having up to four MLTSS programs operational in their state.

Figure 1. Number of MLTSS Programs by State, 2017



Source: The Growth of Managed Long-Term Services and Supports Programs: 2017 Update, January 29, 2018. Lewis et al., 2018. https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf

Dual Eligible Special Needs Plans (D-SNPs)

Another category of LTSS recipients are eligible for both Medicare and Medicaid. These dually eligible recipients are generally very poor and have complex health needs.[5] In 2013, this unique population represented 15 percent of Medicaid enrollees, with a cost of 32 percent of all Medicaid spending, and 20 percent of all Medicare enrollees, with a cost of 34 percent of total Medicare spending.[6]

Many of these dually eligible individuals are enrolled in managed care plans known as Dual Eligible Special Needs Plans (D-SNPs).[5,6] D-SNPs were first offered in 2006. In these plans, clinician and hospital services are provided by a Medicare Advantage plan, and Medicaid may pay for the Medicare cost sharing, LTSS, long-term care, and often behavioral health services. These plans enroll individuals who are eligible for both Medical Assistance from a state plan under Title XIX (Medicaid), and Title XVIII (Medicare). These plans offer coordination of both Medicaid and Medicare benefits into a single plan.[5,6] These D-SNPs allow states to encourage or require the plans to integrate Medicare and Medicaid benefits for their members.[6]

As of January 2018, more than 2.1 million individuals were enrolled in D-SNPs in 41 states, Puerto Rico and the District of Columbia.[5]

Historical Timeline

MLTSS programs have been in existence for many years in some states. For example, Arizona's original MLTSS program was started January 1, 1989; Wisconsin began its program in 1996; and Texas, in 1998. Other state MLTSS programs are more recent, with Virginia launching a statewide program for older adults (age 65 and older) and those with physical disabilities on August 1, 2017, and Pennsylvania planning a phased approach, by region as defined by the state, beginning January 1, 2018.[4]

For a complete summary of each state's MLTSS program, visit https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf

Benefits of Managed Long-Term Services and Supports

States acknowledge that there are a variety of benefits when transitioning LTSS from FFS to MLTSS. In a recent report, 12 states were surveyed to ascertain their primary purpose for transitioning from FFS to MLTSS.[7] Their stated reasons included:

- The ability to rebalance LTSS spending by increasing the proportion of funds spent for HCBS while decreasing the proportion of spending for institutional care (n = 12 states);
- Increasing care coordination to improve quality of life and health for individuals (n = 12 states);
- Addressing access gaps by decreasing or eliminating HCBS waiting lists to allow individuals to receive care in the setting of their choice (n = 6 states);
- And, Improving quality efficiencies and potential cost containment through rebalancing where care is received and providing budget predictability (n = 8 states).

In addition to the above goals, these 12 states also stated their desire to provide opportunities for the individuals to have choice and control over the services they receive through self-directed options, person-centered planning, and acknowledgment of the dignity of risk. Dignity of risk is the right of the individual receiving the services to take risks when exercising control and choice over their lives.[1] Care planning with the individual and family also involves considering the contributions and support of the individuals informal caregiver, including respite care and training.[1] Programs may also contain interventions to address social determinants of health (SDoH) such as affordable and accessible housing to support an individual's choice of avoiding residence in an institution.[7]

State Medicaid Agency Goals for MLTSS

In reviewing multiple resource documents (i.e., managed care contract language, §1115(a) approval documents and fact sheets, state websites, and §1915(c) HCBS waiver applications) to identify the goals of state Medicaid agencies in implementing Medicaid MLTSS programs, the following themes were identified.[4] However, not all states focused on the same goals.

- **Coordination of dual-eligibles.** Several states noted that coordinating funding and care coordination for dually eligible individuals will improve MLTSS benefits by reviewing the total cost of an individual's care and the resulting quality outcomes as opposed to one individual having metrics in two coverage and compensation models.

- **Inclusion of I/DD.** Individuals with intellectual and developmental disabilities (I/DD) could benefit from inclusion in MLTSS programs because of the program's coordinated care delivery and access to support services.

- **Standardizing assessments.** The potential of standardized assessments across states to better understand this population was recommended by Medicaid and CHIP Payment and Access Commission (MACPAC) in their June 2014 Report to Congress on Medicaid and CHIP. The report cautioned that as there is increased standardization, the ability to meet a specific individual's identified needs could decrease. This caution also applied to structured care plans that might not completely capture individual circumstances and fully support the success of the individual receiving the care.[8]

- **Improved participant outcomes and quality of care.** States are striving to improve health outcomes and quality of life for participants. Specific goals include increased monitoring of unusual incidents such as preventable hospital admissions and readmissions, and emergency department visits, and improving health outcomes data and participant satisfaction, which are indicators of health improvement and quality. Improved participant outcomes were the most frequently cited goal for implementing MLTSS programs.

- **Increased access to HCBS.** As mandated by the CMS, states are expected to increase their network of providers or increase the availability of Home and Community-based Services (HCBS).

Core MLTSS Functions by Medicaid MCOs

All MLTSS programs include contract requirements that the individual must undergo an assessment and have an individual care plan created based on their assessment findings. Most states require a functional assessment screening to determine an individual's need to receive services. The assessment may also assist in developing a plan of care for the individual.

The federal government does not mandate a standardized screening tool to conduct assessment. Therefore, the assessment and related tools vary by state, and sometimes within a state, with over 100 different assessments and tools currently in use. [2, 8, 9] Each new member is required to have the assessment conducted within a specified timeframe, as defined by each state, and at a minimum, an annual reassessment. The Medicaid health plan must arrange for all needed services and supports to support the individual.[2]

Recent research from the Institute for Medicaid Innovation[10] found that 67 percent of Medicaid managed care organization respondents indicated being at-risk for managed long-term services and supports (MLTSS). With the growing interest of state Medicaid agencies to provide managed long-term services and supports through health plans, it is anticipated that this number will increase. Currently, 100 percent of large health plans (i.e., greater than 1 million covered lives) are at-risk for MLTSS in at least one of their markets.[10] Table 1 illustrates the percentage of Medicaid MCOs at-risk for MLTSS in at least one of their markets and those that used a different clinical model for their MLTSS program stratified by health plan size.

Table 1. Percentage of Medicaid MCOs At-Risk for MLTSS in at Least One of Their Markets and Those That Used a Different Clinical Model, 2018

	Medicaid MCOs with 250,000 or less covered lives	Medicaid MCOs with 250,001 to one million covered lives	Medicaid MCOs with over one million covered lives	All Medicaid MCO Respondents
Percentage of Medicaid Managed Care Organizations At-Risk for MLTSS	43%	60%	100%	67%
Percentage of Medicaid Managed Care Organizations Utilizing a Different Clinical Model of Care for MLTSS Members by Health Plan Size	34%	100%	100%	84%

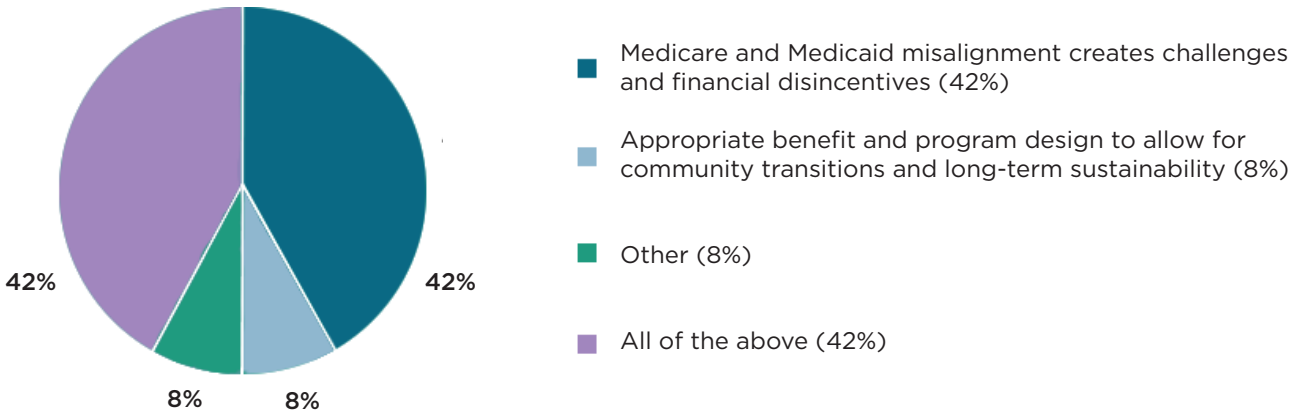
Source: Institute for Medicaid Innovation. (2019). *2019 annual Medicaid MCO survey – MLTSS.* Washington, D.C.

Of the health plans at risk, regardless of size, 100 percent assigned a care coordinator for more than 75 percent of their members.[10] Medicaid MCOs with between 250,001 and one million and more than one million members always (100%) utilized a different model of care for their MLTSS membership. Table 1 also stratifies different clinical models in use by Medicaid MCOs by size of membership.[10]

More than 66 percent of health plans surveyed indicated that a new member was enrolled and received an assessment within 30 days of notification from the state of their eligibility. Almost 100 percent indicated that enrollment and assessment were completed within 90 days of notification to the health plan. All health plans (100%) indicated that for care coordination and transition planning, they utilized a comprehensive list of core functions. Most (92%) indicated utilization of a comprehensive core function list for social needs support. All (100%) used care teams for their MLTSS members.

When considering program design to manage MLTSS, of the health plans surveyed, almost half (42%) cited Medicaid and Medicare misalignment and financial disincentives as part of their process. In addition, 8 percent cited appropriate benefit and program design to allow for community transitions and long-term sustainability as considerations. Almost half (42%) cited both of the above issues as program design considerations. Figure 2 depicts the most commonly cited program design considerations for the surveyed Medicaid health plans.

Figure 2. Most Common Program Design Considerations to Manage LTSS, 2018



Source: Institute for Medicaid Innovation. (2019). *2019 annual Medicaid MCO survey – MLTSS.* Washington, D.C.

All health plans surveyed (100%) conducted risk assessments, coordinated HCBS, coordinated in-home services, developed a plan of care, engaged a care team, supported and connected members to services, supported adherence to the plan of care, and performed transition planning. Other core functions were usually provided (92%) including transportation for appointments, caregiver support, coordination of behavioral health care, coordination with social services, assistance in scheduling provider appointments, guided referrals or hand-offs to needed social services, and serving as a single point of contact for the individuals. Other core functions were utilized less frequently (between 82% and 17%). Table 2 indicates the percentage of Medicaid MCOs that provided discreet core functions.

Table 2. Most Common Core Functions Performed by Medicaid Managed Care Organizations for MLTSS Care Coordination Models, 2018

Core Functions	Percentage of Medicaid MCO's
Conducted risk assessments	100%
Coordinated home and community-based services (e.g., day care, employment, rehab, durable medical equipment, home modifications, personal emergency response systems, residential)	100%
Coordinated in-home services	100%
Developed a comprehensive plan of care	100%
Engaged a care team of professionals to address the needs of the member	100%
In addition to supplying the provider directory, supported the member in identifying and connecting with providers	100%
Supported and encouraged adherence to care plan	100%
Transition planning (e.g., acute care to residential care; residential care to the community)	100%
Arranged transportation for appointments	92%
Caregiver support	92%
Coordinated behavioral health services	92%
Coordinated with social services (i.e. housing providers, nutrition programs) as part of care plan development and adherence	92%
Helped in making appointments with providers	92%
Provided guided referrals or "hand-offs" to other needed social services (e.g., faith-based, non-profit, or other government programs)	92%
Provided information on other needed social services (e.g., faith based, nonprofit, other government programs)	92%
Served as a single point of contact for the member	92%
Shared data with social services	84%
Supported the member preparedness for appointments	84%
Screened for social isolation	75%
Other	17%

Source: Institute for Medicaid Innovation. (2019). *2019 annual Medicaid MCO survey – MLTSS.* Washington, D.C.

The Institute for Medicaid Innovation[10] also assessed the standard MLTSS care team composition. All MCOs (100%) reported the inclusion of a care coordinator, a family member, and the individual receiving care. Inclusion of other individuals as part of the care team ranged from guardian at 92 percent to peer support specialist at 34 percent. Table 3 identifies the percentage of time that care team individuals are included.

Table 3. Most Common Care Team Composition for MLTSS, 2018

Individuals	Percentage of Medicaid MCO's
Care coordinator within the health plan	100%
Family member	100%
Individual member	100%
Guardian	92%
Behavioral health specialist within the health plan	84%
Member's primary care provider	75%
Community health worker within the health plan	67%
Natural/community supports other than guardian	67%
Other health care professional not employed by the health plan	67%
Representative from primary care clinician office	59%
Pharmacist within the health plan	50%
Peer support specialist within the health plan	34%
Other	34%

Source: Institute for Medicaid Innovation. (2019). *2019 annual Medicaid MCO survey – MLTSS.* Washington, D.C.

All Medicaid MCOs (100%) indicated that their care plan included caregiver information and status, demographic and social needs screening information, personal and care goals, the primary care provider, and an emergency/crisis plan. Most (92%) included end-of-life plan, including medical orders for life-sustaining treatment (MOLST) and durable power of attorney (DPOA)/power of attorney(POA)/ guardianship components. Turning to the medical components included in the care plan, all (100%) included activities of daily lining (ADLs), behavioral health status/condition, a community transition plan, the individual's current health/medical status, durable medical equipment (DME) used, a medication list, recent hospital or emergency department visits, and a safety screening. Table 4 outlines both the included care plan and medical components and frequency of inclusion.

Table 4: Most Common Components Included in MLTSS Care Plans Offered by Medicaid Managed Care Organizations, 2018

Care Plan Components	Percentage of Medicaid MCO's
Caregiver information and status	100%
Demographic and social needs screening information (e.g., housing, financial, insurance, employment history)	100%
Goals – personal and care goals	100%
Primary care provider	100%
Emergency (crisis) plan	100%
End-of-life plan including Medical Orders for Life-Sustaining Treatment (MOLST) and Durable Power of Attorney (DPOA)/Power of Attorney (POA)/guardianship	92%
Other	34%
Medical Components	**Percentage of Medicaid MCO's**
Activities of daily living (i.e., feeding, dressing, toileting, ambulating, sleep)	100%
Behavioral health status/condition (i.e., depression, anxiety, stress, drug, alcohol screening)	100%
Community transition plan	100%
Current health/medical status	100%
Durable medical equipment use, hearing aids and vision impairments	100%
Medication list	100%
Recent hospitalizations or emergency department visits	100%
Safety screening (i.e., feeling safe and secure)	100%
Other	9%

Source: Institute for Medicaid Innovation. (2019). *2019 annual Medicaid MCO survey – MLTSS.* Washington, D.C.

Utilization of HCBS

The CMS also has a stated goal of enhancing the provision of HCBS, which is consistent with the requirements of the Americans with Disabilities Act (ADA) and the Supreme Court's 1999 Olmstead decision, which required that individuals receive services by states in the "least restrictive setting possible." [1, 3] 1915 Waivers are often used for HCBS.[4]

Several states have reported improvement in transitioning members from institutional settings back to their home by utilizing HCBS. New Mexico reported that they reduced their percentage of individuals residing in nursing facilities from 18.7 percent in 2011 to 14.3 percent in 2015.[11] They stated that the monthly cost of a nursing home in the state was 2.8 times the cost of an individual utilizing their community benefit in 2016.[11]

In Florida, MTLSS program inception began in 2014. In the 2014 measurement year, the percentage of individuals receiving Skilled Nursing Facility (SNF) services/HCBS was 56%/44%, respectively, and by June 2018, the percentage of enrollees receiving SNF/HCBS had shifted to 43%/57% respectively.[12] The cost per individual had dropped from $3,750 in 2011 (fee-for-service costs) to $3,400 per individual (MTLSS costs) in 2018-a 10 percent cost decrease per individual.[12]

Medicaid Waiver Authorities

The CMS allows several types of Medicaid plan and waiver programs for MLTSS services.[4] Through the state waiver process, the CMS approves the types of services and populations covered by a state.[4] The CMS only requires states to provide the following mandatory LTSS benefits as part of their Medicaid program: **nursing facility services** (defined as providing 24-hour care for both medical and skilled nursing needs, rehabilitation services, or health-related services that do not require hospital care) and **home health services** (nursing, home health aides, and medical equipment and supplies).[8, 13] Additional home health services may be provided by individual states. These include physical, speech, or occupational therapy and audiology services. States can also design the eligibility criteria for utilization of these additional services.[4, 8]

The design of an MLTSS program provides states with the ability to customize their program design, allowing for the flexibility to target specific populations or programs within a state. This allows for inclusion of initiatives such as participant-directed services and supports (also referred to as consumer-directed, self-direction, and participant-driven supports), where the individual and their families can choose the services they need or want and direct the individuals who provide the services[14] or incorporation of a Balancing Incentive or Money Follows the Person Program, which provided financial incentives to states to increase access to non-institutional LTSS and returning individuals to their home or a community-based setting.[15] The New Affordable Care Act provisions can also be included in the state-specific program design.[2] Specific populations targeted to receive services can also be outlined as part of the program components.[4] States utilize different waiver authorities to implement MLTSS programs. For instance, 1115 (a), 1915 (a), 1915 (b), and 1932 (a) waivers are available for states.

The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, first published in 2016,[16] contained provisions specific to Medicaid. The components of the Final Rule include alignment of key rules with other health insurance coverage programs, provisions to modernize managed care purchasing for states, and provisions including key consumer protections and strengthening of the consumer experience.

Provisions of the Final Rule included:

- Managed care standards and requirements that apply regardless of the authority under which the program is operated;
- Regulation that provides the CMS and states with an enforcement mechanism;
- Key changes that address access to care, beneficiary protections, quality-of-care standards, rate setting, and contract approval requirements.[17]

Select waivers can be combined with HCBS waivers (as with concurrent 1915(b)/1915(c) waivers, for example) to operate an MLTSS program.[2] **Innovation encouraged for program development and objectives includes:**

- Service delivery design
- Alternatives to eligibility and coverage, including expansion populations
- Payment approaches with the intent of pairing program improvement goals with financial incentives[2, 17]

Table 5 compares Medicaid managed care authorities and specifies the individuals enrolled, includes the managed care standards and requirements, outlines the application process, discusses federal budget requirements, and highlights the timeframe for approval and the approval period for some of the waiver authorities:

As of 2017, the 1115 (a) was the most utilized waiver for MTLSS programs (n-19); 1115 (b) waivers were the next most prevalent type (n-11). 1915 (a) (n-6), and 1932 (a) program waivers (n-5) were the least prevalent type of waivers.[4]

Table 5. Comparing Medicaid Managed Care Waivers

	1915 (b)	1115	State Plan
Beneficiaries Enrolled	Any beneficiary	Varies, depending on waiver	Certain populations are exempt from mandatory enrollment
Managed care standards and requirements	Managed care standards and requirements, including oversight, are similar under managed care regulation	Managed care standards and requirements, including oversight, are similar under managed care regulation	Managed care standards and requirements, including oversight, are similar under managed care regulation
Application process	Use of CMS's preprinted form recommended	CMS template	Use of CMS's preprinted form recommended
Federal budget requirements	Cost-effectiveness required	Budget-neutrality required	Fiscal impact (budget-neutrality or cost-effectiveness required)
Timeframe for approval	90-day clock	No required timeframe for approval	90-day clock
Approval period and renewals	Two years (up to five if dually eligible individuals are included)	Up to five years	Indefinite approval, renewal not required

Source: The Role of Section 1915(b) Waivers in Medicaid Managed Care, Medicaid and CHIP Payment and Access Commission, March 3, 2017. Benjamin Finder. https://www.macpac.gov/wp-content/uploads/2017/03/The-Role-of-1915b-in-Medicaid-Managed-Care.pdf

State Variation

Because each state Medicaid program is different, the waivers used to create the program vary. Based on the various Medicaid managed care authorities and waiver types available to states, multiple waiver combinations are in use in current MLTSS programs. As an example, Illinois used a Section 1932 State Plan Authority and a 1915(b) waiver to implement its MLTSS program. In contrast, New Jersey used a Section 1115 waiver.[1]

Only three states provide programs covering all services under the MLTSS capitation rate. (Arizona, Kansas, and Wisconsin)[4] All other states carve out one or more benefits from managed care capitation. Institutional care, HCBS, behavioral health, prescription drugs, and inpatient services were the most frequent services to be carved out in these states.[4]

State Medicaid waivers allow a state to specify certain Medicaid eligibility program requirements, allowing for LTSS coverage for individuals not otherwise eligible for Medicaid coverage.[1]

In 2009, six states had some form of an MLTSS program; in 2017 that number had risen to 24.[4] Arizona was the first state to offer MLTSS under the Arizona Health Care Cost Containment System (AHCCCS), beginning in 1989 with a 1115 Research and Demonstration Waiver.[18] Arizona Long-Term Care System (ALTCS) is a Medicaid managed care system operating a statewide program. The original Arizona waiver covered elderly individuals and those with physical or developmental disabilities in the initial program. Today, ALTCS utilizes two systems of payment: one for dually eligible individuals and one for non-dually eligible individuals.[18]

The range of MLTSS services also varies widely by state. New York has a partially capitated model--providing a capitation payment to Medicaid health plans to coordinate total member care--even for services not reimbursed by the plan, but rather, covered and reimbursed by Medicare or Medicaid Fee-for-Service (FFS). Texas, Virginia, and Tennessee are working to integrate LTSS and physical and behavioral health services into an integrated service offering for the individuals within the Medicaid health plans and providers.[1]

Almost every state MLTSS program (21 of 23 states) includes both institutional and HCBS in the same contractual arrangement, while in two states (Michigan and Tennessee) this varies by MLTSS arrangement.[19] Only one state reported an MLTSS benefit change in Fiscal Year 2017 or Fiscal Year 2018. Michigan added hospice benefits in Fiscal Year 2017.[19]

Of the 41 MLTSS programs, almost 50 percent (21 programs) utilize mandatory enrollment (the individual is enrolled in the plan if eligible for services). Less than 20 percent (eight programs) provide a voluntary opt-out enrollment design (the individual is passively enrolled in the plan if eligible unless he or she elects to leave the program) in 2017.[1, 4] There is no information in the literature that indicates a benefit of one type of enrollment over another. The enrollment requirements are part of the waiver application.

Coverage for Older Adults (age 65 or older) continues to be the most prevalent type of program (33 in 2017), followed closely by coverage for adults under age 65 with physical disabilities.[1, 4]

Network Adequacy Requirements

Beginning July 1, 2018, the CMS added an additional requirement: MLTSS programs were compelled to publish network adequacy requirements.[4, 20, 21] As of 2017, twenty-six of the forty-one MLTSS programs published network adequacy standards specific to MLTSS. The programs utilized one or more network adequacy standards.[4] The network adequacy requirements prescribed by the CMS for MLTSS programs include:

- **Choice Standards:** A minimum of two providers to choose from unless the plan had requested an exception in advance. The types of providers typically covered for exceptions included assistive technology, environmental modification, personal emergency response systems, and durable medical equipment and supplies.

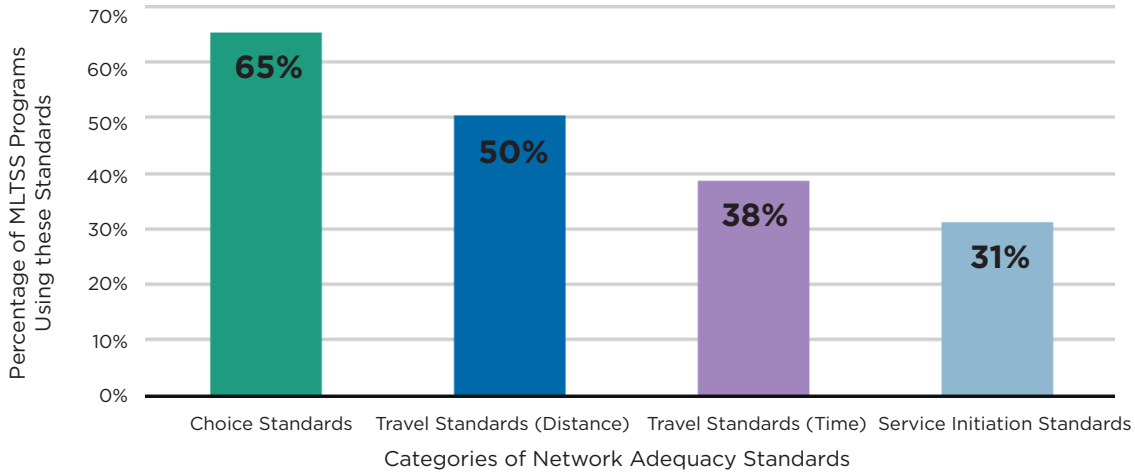
- **Travel standards (distance):** Measurement of travel time in miles from the individual's residence to the provider's location. This standard is typically defined differently for rural versus urban individuals.

- **Travel standards (time):** Measurement in minutes from the individual's residence and the provider's location. Again, this standard is typically defined differently for rural versus urban individuals.

- **Service initiation standards:** The time between a service referral for an individual and the date the requested service was initiated for the individual.[4, 20, 21]

Figure 3 illustrates the network adequacy requirements identified for twenty-six MLTSS programs that published network adequacy requirements and the percentage of Medicaid health plans utilizing each standard that were included as part of their MLTSS program description in 2017.

Figure 3. Network Adequacy Standards Identified for MLTSS Programs, 2017.

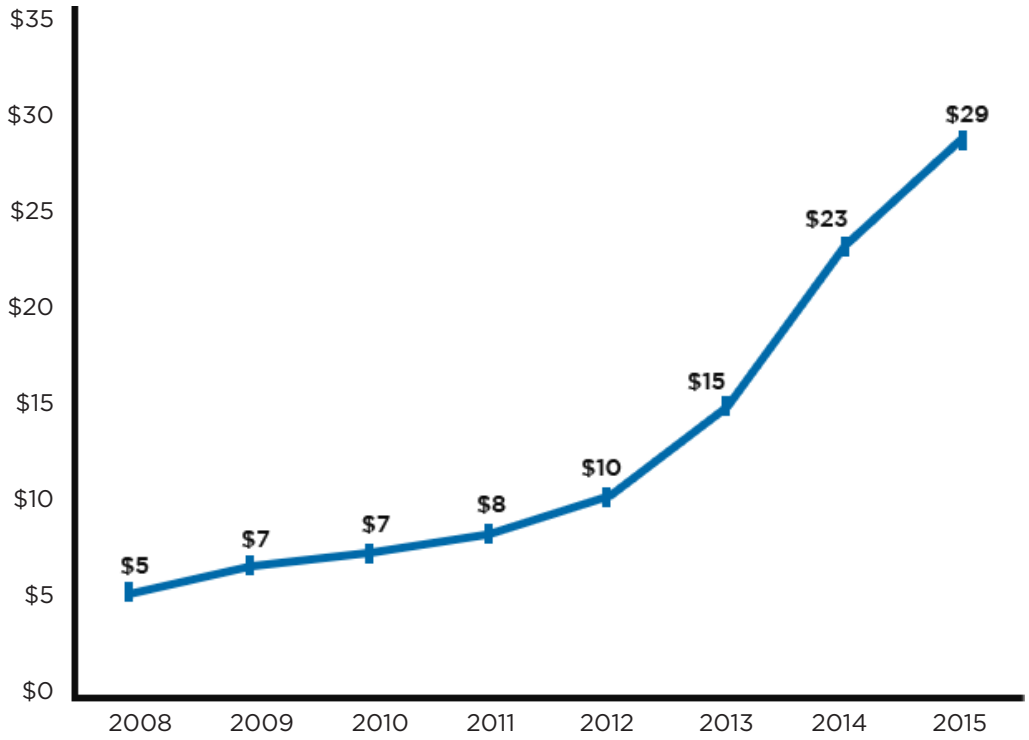


Source: The Growth of Managed Long-Term Services and Supports Programs: 2017 Update, January 29, 2018. Lewis et al., 2018. https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf

Trends and Costs

MLTSS spending is increasing at a rapid rate.[22] As shown in Figure 4, MLTSS spending has increased six-fold since 2008, with the greatest increase between Fiscal Years 2012 and 2018.[22] This rate also includes the program of all-inclusive care for the elderly (PACE), a combined Medicaid and Medicare program that assists individuals with receiving the services and support they need in the community instead of in an institution.[23]

Figure 4. Medicaid Managed LTSS Expenditures, in Billions, FY 2008-2015.



Source: Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf

A few states have conducted evaluations, including financial performance, that focus on their specific state's MLTSS programs. Texas reviewed its Medicaid managed care program outcomes in general, and specifically the STAR+PLUS (the name of its MLTSS program) long-term care component. The results indicated that the long-term care component of Texas's Medicaid program showed an estimated 3.5 percent decrease in costs between 2010 and 2015, compared to expected costs under the previous fee-for-service system.[7]

An evaluation conducted in Minnesota in 2016 demonstrated a 48 percent lower likelihood of a hospital stay and a 6 percent less likely incidence of an emergency department visit for individuals enrolled in the integrated program for dually-eligible individuals than for individuals enrolled in the non-integrated MLTSS program.[24] The analysis controlled for individual and area-level characteristics.

Quality Standards

Title 42 CFR 431.424 outlines general program requirements, and Social Security Administration (SSA) 1115 includes specific requirements for monitoring and evaluating the MLTSS programs.[2, 20] Evaluation components include comparison strategies, hypotheses, and data sources. Each approved state waiver program includes report content expectations, timing of the evaluations, and required monitoring activities.[2]

MLTSS program outcomes are gaining attention. As more states transition from FFS to MLTSS, there is some modest evidence of improvement in quality outcomes, but many questions regarding quality remain. Fairly limited data to form a baseline and historically minimal target quality measures for the MLTSS population make evaluation difficult. Recent efforts include plans to implement new quality measures specific to these covered populations. There are also goals to increase collection of encounter data to assist with monitoring and oversight of MLTSS programs and covered individuals in the future.[1]

The CMS has collaborated with The National Committee for Quality Assurance (NCQA) to develop HEDIS measures specifically for MLTSS programs.[25] Each individual measure is named, and the data collection method is specified. Table 6 identifies the measure owner, the measure name, and the data collection method(s)*.

Table 6. MLTSS Quality Measures

Measure Owner	Measure Name	Data Collection Method(s)
CMS	Long-Term Services and Supports Comprehensive Assessment and Update (CAU) This measure is aligned with HEDIS measure LTSS-CAU; Specifications for LTSS-CAU are available at: http://store.ncqa.org/index.php/catalog/product/view/id/3419/s/hedis-2019-technical-specifications-for-ltss-organizations-epub/	Case Management Record Review
CMS	Long-Term Services and Supports Comprehensive Assessment and Update This measure is aligned with HEDIS measure LTSS-CPU; Specifications for LTSS-CPU are available at: http://store.ncqa.org/index.php/catalog/product/view/id/3419/s/hedis-2019-technical-specifications-for-ltss-organizations-epub/	Case Management Record Review
CMS	Long-Term Services and Supports Comprehensive Assessment and Update This measure is aligned with HEDIS measure LTSS-SCP; Specifications for LTSS-SCP are available at: http://store.ncqa.org/index.php/catalog/product/view/id/3419/s/hedis-2019-technical-specifications-for-ltss-organizations-epub/	Case Management Record Review
CMS	Long-Term Services and Supports Comprehensive Assessment and Update This measure is aligned with HEDIS measure LTSS-RUA; Specifications for LTSS-RAU are available at: http://store.ncqa.org/index.php/catalog/product/view/id/3419/s/hedis-2019-technical-specifications-for-ltss-organizations-epub/	Case Management Record Review
NCQA	Screening, Risk Assessment, and Plan of Care to Prevent Further Falls Falls Part 1 – Screening Falls Part 2 – Assessment and Plan of Care Specifics are available at: http://www.qualityforum.org/QPS/MeasureDetails. .aspx?standardID=445&print=1&entityTypeID=1	Case Management Record Review
CMS	Long-Term Services and Supports Admission to an Institution from the Community Specifics are available at: https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf	Administrative
CMS	Long-Term Services and Supports Minimizing Institutional Length of Stay Specifics are available at: https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf	Administrative
CMS	Long-Term Services and Supports Successful Transition after Long-Term Institutional Stay Specifics are available at: https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf	Administrative

*Measures developed as part of CMS contract: Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees- HHSM-500-2013-13011I, Task Order #HHSM-500-T00004.

Source: Measures for Medicaid Managed Long-Term Services and Supports Plans Technical Specifications and Resource Manual, September 2018, Center for Medicaid and CHIP Services Centers for Medicare & Medicaid Services, https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf

For specific data collection requirements and additional information regarding the HEDIS data set and care plan requirements, visit: https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_asess_care_plan_tech_specs.pdf

Innovations

Section 2602 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) provided for the creation of the Federal Coordinated Health Care Office, often referred to as the Medicare-Medicaid Coordination Office (MMCO).[1] This office is charged with coordinating care and reducing costs for individuals receiving both Medicaid and Medicare services. One of the initiatives is the Financial Alignment Initiative, a demonstration project in which health plans, states, and the CMS design programs. Both capitated and managed FFS (MFFS) models are available for states. There is also a provision that states can design a different approach and seek approval from the CMS. Letters of intent (LOIs) were solicited, and 37 states and the District of Columbia submitted LOIs.[1]

As of February 2017, 12 states were pursuing Financial Alignment Demonstrations to align Medicaid and Medicare revenue streams and integrate acute, primary, and behavioral health care in addition to LTSS. The Financial Alignment Demonstration strives to provide individuals who are enrolled in both Medicaid and Medicare with an alignment of the programs through financial incentives and a better care experience. The CMS partners with states and participates in a collaboration between the CMS Medicare-Medicaid Coordination Office and the CMS Innovation Center.[26]

Ten of these states (California, Illinois, Maryland, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia) created capitated demonstrations, while Colorado and Washington began MFFS models. The initial demonstrations covered more than 450,000 individuals. Minnesota created an arrangement focusing on the alignment of administrative components as an alternative model.[27]

Given the importance of MLTSS delivery of LTSS services in the Medicaid program, there is also a focus on innovation among Medicaid MCOs.[1] Of the health plans surveyed, the majority (83%) indicated that they always included self- advocacy for the individual receiving services. More than half (58%) included care coordination communication tools with caregivers, direct services workers, and other in-home providers or support organizations, partnerships with community-based organizations, caregiver supports and services (outside of administering benefits required by state plan), wellness initiatives, and tools for self-direction; money-follows-the-person or community transition programs were utilized half the time (50%). Other innovations were always utilized by the Medicaid managed care plans between 17 and 25 percent of the time. Table 7 highlights innovations utilized and the percentage of Medicaid managed care organizations that utilized the innovations in the categories of always, sometimes, limited, and not provided.

Table 7. Frequency of Innovations Leveraged by Medicaid Managed Care Organizations for MLTSS, 2018

Innovation	Always Provided (A required part of our approach to MLTSS)	Sometimes (Based on member needs)	Limited or (Small pilot program or case-by-case)	Not Provided
Remote monitoring	17%	17%	41%	25%
Telehealth other than remote monitoring that is specific to the MLTSS population	17%	50%	33%	0%
Care coordination communication tools with care-givers, direct services workers and other in-home providers or support organizations	58%	17%	17%	8%
Partnerships with community based organizations (e.g. AAAs, CILs)	58%	34%	8%	0%
Electronic Visit Verification	25%	17%	17%	41%
Value-based payment arrangements with MLTSS providers	8%	17%	33%	42%
Caregiver supports and services (outside of administering benefits required by state plan)	58%	33%	9%	0%
Wellness initiatives	58%	42%	0%	0%
Healthy eating or nutrition programs outside of administering benefits required by state plan	25%	67%	8%	0%
Unique housing strategies outside of administering benefits required by state plan	8%	75%	17%	0%
Money follows the person or community transition programs	50%	33%	8%	8%
Self-advocacy	83%	17%	0%	0%
Employment initiatives outside of administering benefits required by state plan	25%	33%	33%	9%
Tools for self-direction	58%	33%	9%	0%
Transportation innovations	17%	50%	25%	8%

Source: Institute for Medicaid Innovation. (2019). *2019 annual Medicaid MCO survey – MLTSS.* Washington, D.C.

Looking Ahead: Opportunities for Advancing MLTSS in Medicaid

As outlined in this report, MLTSS continued to grow at a rapid pace during 2012-2017. As the programs and states providing MLTSS continue to increase, programs for adults and adult individuals with disabilities remain the most prevalent. As mentioned, enrollment in programs continues to be split between mandatory inclusion and opt-in/opt-out program design.[4] MLTSS continued to outpace total LTSS spending through the end of fiscal year 2015, with a 24 percent increase from $23 billion to $29 billion, accounting for 18 percent of all LTSS costs.

For the same time period, HCBS spending increased from 53 percent in 2014 to 55 percent in 2015. The spending on HCBS has increased one to three percentage points most years since 1992. Looking again at the 2015 years costs, the number of states (including the District of Columbia) in which more expenditures were for HCBS than for institutional care increased from 25 states in 2014 to 28 in 2015.[1]

Clinical Opportunities

Improve care coordination.

States should provide better care coordination across physical health, LTSS, institutional care, and, in applicable programs, behavioral health services. Today, a fragmented service delivery model remains for many of these services.

Use a person-centered model.

Use a person-centered model when transitioning from FFS to MLTSS instead of a strict medical model to provide individuals with a full range of services to help them lead meaningful and engaged lives.

Research Opportunities

Begin program with baseline data.

States should collect baseline data specifically for their MLTSS program prior to implementation. Today, many program data and outcomes are not separated, because the MLTSS program does not operate independently, but rather as part of an overall Medicaid program. This makes capturing cost-effectiveness solely based on the MLTSS program difficult. Some states also rely on the managed care organization's self-reported data, which affects the data's reliability and the ability to compare data among programs.[7]

Continued increase in HCBS.

As federal and state budgets remain under pressure, there will likely be a continuing shift from institutional settings to increased utilization of HCBS for MLTSS programs. As outlined, the institutional setting is the costliest delivery site for MLTSS services, and beneficiaries prefer a home setting that utilizes HCBS services to maintain independence. As the CMS continues to require utilization of the least-restrictive setting for service provision, we anticipate additional programs to transition individuals back to the community.[1]

Policy Opportunities

Increase consumer choice.

States should seek to offer a broader choice of available services, providers, and settings. Network adequacy standards should illuminate areas of weakness in the availability of providers and settings where care can be accessed.

Improve efficiency.

States should seek to improve the cost-effectiveness of services by making the dollars spent in the program go further. Coordination of services and funding streams (Medicaid and Medicare) are examples of where costs could be lowered.

Standardized Assessments.

Utilization of functional assessments, while mandatory, continue to vary widely in design.

Continued Program Design Changes.

With the new rules regarding network adequacy requirement standards, programs may need to shift to incorporate the new provisions. The new HCBS Setting Rule becomes effective in 2022, again creating opportunity for program design changes to accommodate these rules.[4]

Flexibility from the CMS in program design.

States continue to reform their MLTSS programs. Pennsylvania received approval in 2017 from the CMS for its Community Health Choices program, with a phased implementation starting January 1, 2018. This program utilized both a §1915(b) and §1915(c) waiver. At the end of 2017, Arkansas, Alabama, Louisiana, Nebraska, New Hampshire, Nevada, and Oklahoma were all contemplating MLTSS programs.[4]

References

[1]Medicaid and CHIP Payment and Access Commission. (2018). The Medicaid and CHIP Payment and Access Commission (MACPAC) Report to Congress on Medicaid and CHIP. Retrieved January 16, 2019 from Medicaid and CHIP Payment and Access Commission website: https://www.macpac.gov/wp-content/uploads/2018/03/Report-to-Congress-on-Medicaid-and-CHIP-March-2018.pdf

[2] Medicaid.gov. (2014). Managed long-term services and supports. Retrieved July 16, 2018, from Managed Long-Term Services and Supports website: https://www.medicaid.gov/medicaid/managed-care/ltss/index.html

[3] Department of Health and Human Services and Centers for Medicare & Medicaid Services. (2012). Summary: Essential elements of managed long-term services and supports programs. Retrieved January 16, 2019 from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltss-summary-elements.pdf

[4] Lewis, E., Eiken, S., Amos, A., & Saucier, P. (2018). The growth of managed long-term services and supports programs: 2017 Update. 70. Retrieved May 23, 2019 from https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf

[5] CMS.gov. (2014, April 1). Dual Eligible SNP. Retrieved May 8, 2019, from https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/State-Resource-Center-Frequenly-Asked-Questions-FAQ.pdf

[6] The Centers for Medicare & Medicaid Services. (2014). Medicare managed care manual- Chapter 16b: Special needs plans. Retrieved May 15, 2019 from https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/Chapter-16b.pdf

[7] Dobson, Camille, Gibbs, Stephanie, Mosey, Adam, & Smith, Leah. (2017). Demonstrating the value of Medicaid MLTSS programs. Retrieved June 25, 2019 from NASUAD MLTSS Institute website: http://www.advancingstates.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf

[8] MACPAC. (2014). MACPAC Report to Congress on Medicaid and CHIP. Retrieved January 16, 2019 from Medicaid and CHIP Payment and Access Commission website: https://www.macpac.gov/wp-content/uploads/2015/01/2014-06-13_MACPAC_Report.pdf

[9] MACPAC. (2016). Functional assessments for long-term services and supports: MACPAC. Retrieved January 16, 2019 from https://www.macpac.gov/publication/functional-assessments-for-long-term-services-and-supports/

[10] Institute for Medicaid Innovation. (2019). 2018 annual Medicaid MCO survey – MLTSS

[11] New Mexico Human Services Division. (2016). Centennial care next phase: 1115 Waiver Renewal Subcommittee. Retrieved April 26, 2019 from http://www.hsd.state.nm.us/uploads/files/Presentation%20-%20Dec%2016%202016%20Waiver%20Renewal%20Committee.pdf

[12] Florida Agency for Health Care Administration. (2018, November). AHCA: Recent Medicaid presentations and reports. Retrieved April 26, 2019, from http://ahca.myflorida.com/Medicaid/recent_presentations/index.shtml

[13] Social Security Administration. (n.d.). Title XX–Block grants to States for social services and elder justice. Retrieved April 23, 2019, from Findlaw web site: https://fas.org/sgp/crs/misc/94-953.pdf

[14] U.S. Department of Health and Human Services. Chapter 7. Participant-directed services and supports. (2016, June 14). Retrieved June 27, 2019, from ASPE website: https://aspe.hhs.gov/report/understanding-medicaid-home-and-community-services-primer-2010-edition/chapter-7-participant-directed-services-and-supports

[15] Balancing incentive program. (n.d.). Retrieved June 27, 2019, from https://www.medicaid.gov/medicaid/ltss/balancing/incentive/index.html

[16] Medicaid.gov. (2016). Medicaid and CHIP managed care final rule. Retrieved June 24, 2019, from https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html

[17] Finder, B. (2017). The role of section 1915(b) waivers in Medicaid managed care. Retrieved May 30, 2019 from https://www.macpac.gov/wp-content/uploads/2017/03/The-Role-of-1915b-in-Medicaid-Managed-Care.pdf

[18] U. S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2015, November 23). Appendix A. Arizona long-term CARE system. Retrieved May 13, 2019, from ASPE website: https://aspe.hhs.gov/report/environmental-scan-mltss-quality-requirements-mco-contracts/appendix-arizona-long-term-care-system

[19] Gifford, K., Ellis, E., Edwards, B. C., Lashbrook, A., Hinton, E., Antonisse, L., & 2018. (2018, October 25). States focus on quality and outcomes amid waiver changes: Results from a 50-state Medicaid budget survey for state fiscal years 2018 and 2019 - long-term services and supports reforms. Retrieved May 1, 2019, from The Henry J. Kaiser Family Foundation website: https://www.kff.org/report-section/states-focus-on-quality-and-outcomes-amid-waiver-changes-long-term-services-and-supports-reforms/

[20] Centers for Medicare & Medicaid Services, Department of Health and Human Services. (2016). 42 CFR § 438.330â: Quality assessment and performance improvement program. Retrieved May 15, 2019, from LII / Legal Information Institute website: https://www.law.cornell.edu/cfr/text/42/438.330

[21] Centers for Medicare & Medicaid Services, Department of Health and Human Services. (n.d.). 42 CFR § 431.424â -Evaluation requirements. Retrieved May 15, 2019, from LII / Legal Information Institute website: https://www.law.cornell.edu/cfr/text/42/431.424

[22] Eiken, S., Sredl, K., Burwell, B., & Woodward, R. (2015). Medicaid expenditures for long-term services and supports (LTSS) in FY 2015. Retrieved February 11, 2019 from https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf

[23] PACE | Medicare. (n.d.). Retrieved June 24, 2019, from https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/pace

[24] Anderson, Wayne L., Feng, Zhanlian, & Long, Sharon. (2016). Minnesota managed care longitudinal data analysis. Retrieved June 25, 2019, from U.S. Department of Health & Human Services, Office of the Assistant Secretary For Planning and Evaluation website: https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis

[25] Center for Medicaid and CHIP Services, and Centers for Medicare & Medicaid Services. (2018). Measures for Medicaid managed long-term services and supports plans technical specifications and resource manual. Retrieved April 25, 2019 from https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf

[26] Medicare, the U. S. C. for, Boulevard, M. S. 7500 S., Baltimore, Baltimore, M. 21244 7500 S. B., & USA, M. 21244. (n.d.). Financial alignment initiative for Medicare-Medicaid enrollees | Center for Medicare & Medicaid Innovation. Retrieved June 18, 2019, from https://innovation.cms.gov/initiatives/Financial-Alignment/

[27] Center for Health Care Strategies, Inc. (2017). Update on Medicare-Medicaid Integration. Retrieved May 30, 2019 from https://www.chcs.org/media/Medicare-Medicaid-Integration-Fact-Sheet-030117