MLTSS INSTITUTE
Where policy and practice meet.

Demonstrating the Value of Medicaid MLTSS Programs

2021 EDITION

ADVANCING STATES

Center for Health Care Strategies

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ADVANCING STATES

Center for Health Care Strategies

The ADvancing States **MLTSS Institute** was established in 2016 in order to drive improvements in key managed long-term services and supports (MLTSS) policy areas, facilitate sharing and learning among states, and provide direct and intensive technical assistance to states and health plans. The work of the Institute will result in expanded agency capacity, greater innovation at the state level, and state/federal engagement on MLTSS policy.

ADvancing States represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support long-term services and supports for older adults and individuals with disabilities.

The **Center for Health Care Strategies (CHCS)** is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.

Acknowledgments

Managed long-term services and supports (MLTSS) is now the Medicaid delivery system for older adults and people with disabilities in half the states. States seeking to modernize and improve their long-term services and supports systems continue to use managed care plans to help them achieve their goals.

Operating an efficient and effective MLTSS program requires thoughtful program design, capable health plan partners, strong state oversight, and appropriate accountability mechanisms. ADvancing States has been deeply engaged in providing technical expertise and assistance to our member states as they plan, design, implement, and evaluate their MLTSS programs through our MLTSS Institute. The Institute, created in 2016, brings together state MLTSS directors with health plan thought leaders to drive improvements in key MLTSS policy areas and facilitate sharing and learning among states.

The Institute has published seven issue briefs in the past five years, and is pleased to present updates to this, the Institute's first issue brief, with new evaluation data on the success of MLTSS programs.

I remain deeply grateful to our visionary Board of Directors, state long-term services and supports leaders, and thought leaders at national health plans who understand that well-run, high-quality MLTSS programs benefit us all, and are willing to invest their time and resources to support the implementation of such programs.

Martha A Roherty

Martha Roherty, Executive Director
ADvancing States

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Executive Summary

Almost half the states are operating Medicaid managed long-term services and supports (MLTSS) programs, but there has historically been limited evidence of their value. To help fill this gap, this report presents updated results from states responding to ADvancing States' survey, as well as new research on states with MLTSS programs. The 12 states responding to the surveys—Arizona, Florida, Iowa, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, Tennessee, Texas, Virginia, and Wisconsin—account for more than half of the states who are operating MLTSS programs. States were asked about their goals in implementing MLTSS programs, what progress they had made in attaining those goals, and if they faced any challenges collecting data to document progress. In addition, new research has documented additional value from MLTSS programs in the following areas:

MLTSS programs may reduce or eliminate waiting lists for waiver services.

- **Rebalancing Medicaid LTSS Spending.** Rebalancing Medicaid long-term services and supports spending toward home- and community-based settings and providing more options for people to live in and receive services in the community was a key goal for all states. Many states have specific rebalancing targets, as well as financial incentives for MLTSS plans to meet them.
- **Improving Member Experience, Quality of Life, and Health Outcomes.** All states wanted to improve consumer health and satisfaction/quality of life. While it can be challenging to attribute improvements in health outcomes solely to MLTSS programs, seven states reported improved consumer health. Eleven states said that they collect data on the quality of life; from those reporting outcomes, MLTSS consumers had improved quality of life and high levels of satisfaction compared to fee-for-service programs. One challenge highlighted by states was that the fielding the surveys used to collect these data is time and labor-intensive.
- **Reducing Waiver Waiting Lists and Increasing Access to Services.** MLTSS programs may reduce or eliminate waiting lists for waiver services. Seven states said they wanted to reduce waiting lists, while others focused on increasing access to services. Some states successfully eliminated waiting lists, while other states addressed waiting lists by prioritizing applicants by level of need. Some states reinvested savings achieved through implementing MLTSS to decrease the number of people on waiting lists.

- **Increasing Budget Predictability and Managing Costs.** MLTSS programs' use of capitated payments can help improve budget predictability. The programs also have the potential to achieve savings by: rebalancing LTSS spending; managing service use; and avoiding unnecessary hospitalizations or institutional placements. While states report they are "bending the cost curve," inadequate data are a barrier to states' ability to demonstrate these outcomes.

The state surveys and recent research provide compelling examples demonstrating that states are meeting their MLTSS program goals. It also underscores the importance of expanding the scope and amount of data collected on program impacts. Health plan contracts with strong data reporting and performance monitoring requirements are important tools for states to build stakeholder support and demonstrate program viability over time.

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Introduction

Since the 1970's, state Medicaid agencies have contracted with managed care organizations (MCOs) to coordinate and manage care for Medicaid consumers. States pay each MCO a fixed—also known as capitated—per-member, per-month (PMPM) payment for each Medicaid consumer enrolled in that MCO's health plan. These arrangements are risk-based, meaning that if the MCO does a poor job of keeping the consumer healthy and incurs expenses above and beyond what the MCO is paid, the MCO does not receive any more funds from the state. Similarly, if the MCO keeps both consumers healthy and manages service utilization appropriately, it may keep some or all savings from the amount paid by the state.

More recently, states have looked to MCOs to provide and coordinate services for more complex populations, such as those requiring long-term services and supports (LTSS). These are a broad array of medical and social services that aid older adults and individuals with chronic illnesses and significant challenges with performing activities of daily living (ADLs)—such as bathing, eating, and toileting—as well as instrumental activities of daily living (IADLs)—such as medication management, budgeting, and transportation. LTSS are delivered in a variety of care settings, which generally fall under two broad categories: institutional (nursing facilities or intermediate care facilities) and community-based (in the home or community settings, such as adult day services).

States have been using comprehensive Medicaid managed long-term services and supports (MLTSS) programs to better manage care for consumers using LTSS, increase access to community-based care, improve member satisfaction and health outcomes, and improve budget predictability. However, no two MLTSS programs are exactly alike. Despite states' increasing adoption of MLTSS, few studies on the value of MLTSS programs have been conducted. States are also mindful of the fact that they will need to carefully monitor the quality of the care provided by the MCOs to these vulnerable consumers.

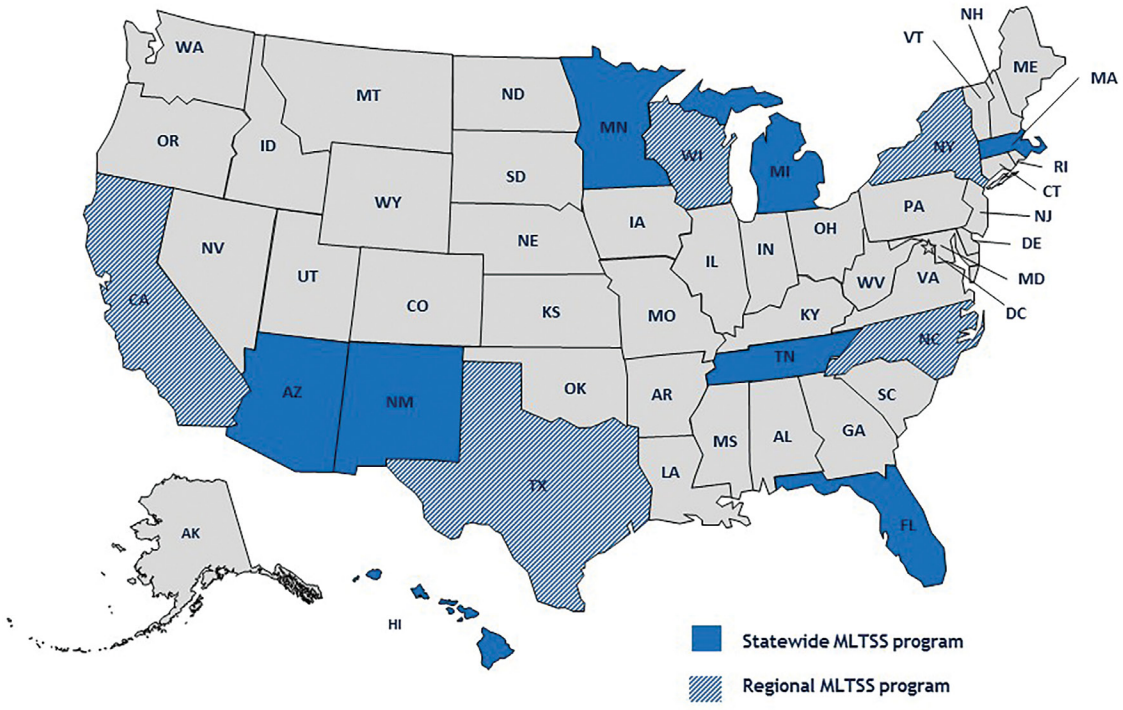
ADvancing States has revised and refreshed this report, originally published in 2017 through a partnership with the Center for Health Care Strategies. The conclusions are based on the prior published research and from new research on MLTSS programs since 2017. The 12 states who responded to ADvancing States' surveys include Arizona, Florida, Iowa, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, Tennessee, Texas, Virginia, and Wisconsin, which account for more than half of the states that have operated MLTSS programs.

Trends in MLTSS Programs

Growth in MLTSS Programs over Time

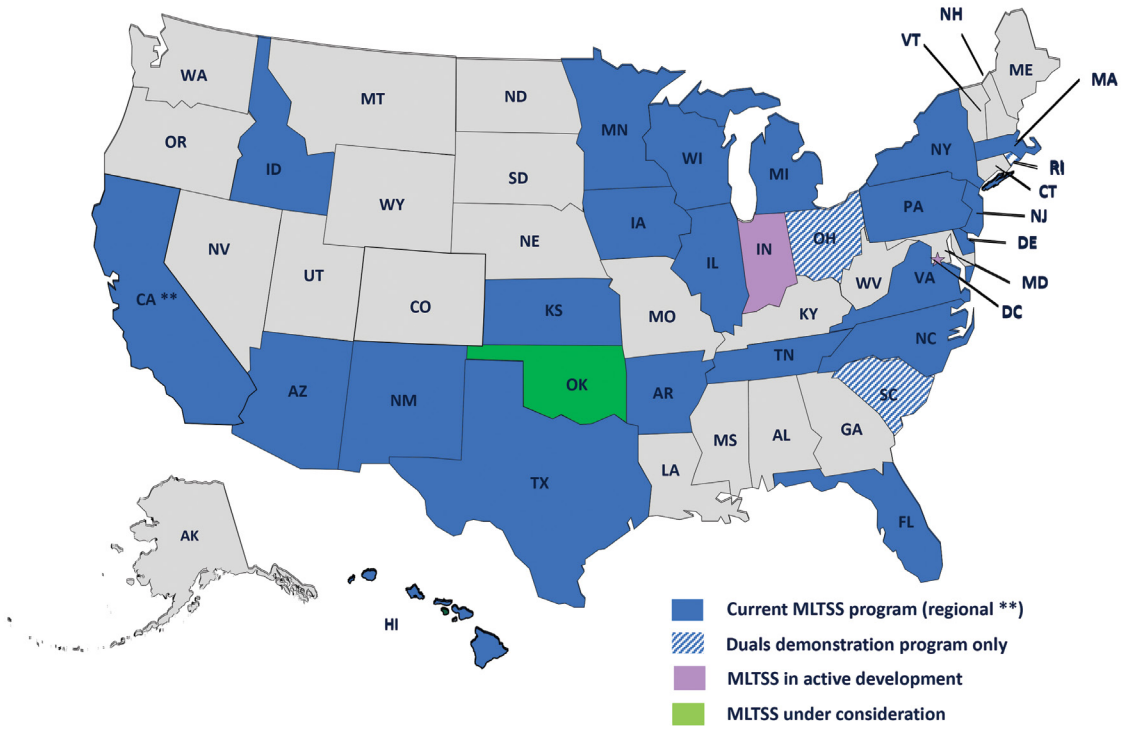
In 1988, Arizona was the first state to have a Section 1115 waiver approved by the Centers for Medicare & Medicaid Services (CMS) to implement MLTSS.[1] Between 2004 and 2010, the number of MLTSS programs increased from eight to 15 (see Figure 1).

Figure 1. MLTSS Programs in 2010



Source: ADvancing States data; Truven Health Analytics

Figure 2. MLTSS Programs in 2021



Source: ADvancing States member survey; CMS data

In 2021, there are 22 states operating MLTSS programs (see Figure 2). Another two states operate MLTSS only within the confines of a Financial Alignment Initiative demonstration, which coordinates care and aligns benefits for individuals eligible for both Medicare and Medicaid (known as dually eligible beneficiaries).[2] Two states (Indiana and Oklahoma) were developing or considering developing new MLTSS programs in late 2021. When this paper was originally published in 2017, 18 states were operating MLTSS programs. Since 2017, MLTSS programs have continued to mature and expand with Arkansas, Idaho, Pennsylvania, and Virginia implementing MLTSS.

States implement MLTSS using various Medicaid waiver authorities, including: Section 1115, 1915(b), 1915(a), and 1932(a) waivers; and Financial Alignment Initiative demonstrations. States combine authority for managed care with MLTSS authorities (such as 1915(c) or 1915(i)) to gain authority for their MLTSS programs. For more information on states' MLTSS program authorities, see the Appendix.

Populations Included in MLTSS Programs

States are increasingly coordinating care for vulnerable populations under their MLTSS programs.[3] Older adults are the most included population, followed by individuals with physical disabilities. Some states also enroll children with disabilities, dually eligible beneficiaries, and individuals with behavioral health conditions, traumatic brain injuries (TBI), and intellectual/developmental disabilities (I/DD). Individuals with I/DD have typically been the last population to be enrolled in MLTSS programs; however, as state

agencies and MCOs gain further experience with effectively coordinating care and gaining stakeholder support, the trend toward integrating this population is expected to continue. States are also increasingly including persons with behavioral health conditions into MLTSS programs.

Benefit Integration

States take different approaches to providing benefits under MLTSS programs. The most common approach is to provide a comprehensive benefit package to the populations enrolled. This type of benefit package permits a consumer to access acute/primary care, LTSS, and behavioral health services from one MCO. Such an approach can allow an MCO to serve the whole person and build provider networks that address all the needs of its consumers. A relatively new trend has states focused on integrating Medicare and Medicaid services more effectively for dually eligible beneficiaries.

Other states provide only LTSS benefits in their MLTSS programs, which means that consumers receive acute/primary care or behavioral health services from another MCO or from the state's traditional fee-for-service program. This program design choice can be driven by:

- The expansion of MLTSS after an established acute care managed care program is in place;
- Legislative or gubernatorial directives for separate programs; and/or
- Interest in contracting with MCOs that specialize in LTSS.

Among the 22 MLTSS programs currently in operation, 85 percent include Medicaid primary and acute care, more than 80 percent include nursing facility services, and 85 percent incorporate Medicaid home-and community-based services (HCBS). Seventy-five percent are available statewide, while the other 25 percent are available in specific regions or less than statewide.[4]

Michigan and North Carolina approach LTSS differently in that they operate long-standing, statewide, county-based, capitated programs that include only behavioral health and I/DD services. Programs can even vary within one state, such as in California, where LTSS is integrated into Medi-Cal (the state's Medicaid program) MCOs in only seven counties. Massachusetts, Minnesota, and Wisconsin have more than one program for their LTSS populations. Furthermore, some states, including Delaware, Hawaii, Minnesota and Tennessee, have used their Section 1115 demonstration authority to provide a more limited set of HCBS to individuals at risk of needing LTSS, including those that have not yet met Medicaid financial eligibility.

Some states have used their Section 1115 demonstrations to provide limited HCBS benefits to 'pre-Medicaid' consumers.

States' MLTSS Goals

States responding to the survey had several goals in implementing their MLTSS programs (see Figure 3). These goals include rebalancing Medicaid spending from institutional settings toward home and community-based care and improving consumer health and satisfaction. Some states also identified reducing Medicaid HCBS waiver waiting lists, increasing budget predictability, and containing costs as program goals.

Figure 3. States' MLTSS Program Goals

- Rebalancing Medicaid LTSS spending
- Improving consumer health and satisfaction
- Reducing Medicaid HCBS waiver waiting lists
- Increasing budget predictability
- Containing costs

Many states see the goals of MLTSS programs as being interconnected. For example, reductions or elimination of waiting lists can help shift Medicaid LTSS spending toward HCBS; and serving more people in the community can improve consumer experience and health outcomes. In turn, improved health outcomes can reduce costs.

Each of the goals for states' MLTSS programs and their reported progress in meeting those goals is examined below. Challenges that states encounter regarding data collection to support these goals are also discussed. Many states have made progress in collecting data, as well as monitoring and evaluating MCO performance in a number of key areas. Since this report was originally published in 2017, several states began using NCI-AD™, a consumer quality of life survey, to assess the performance of their MCOs in meeting consumer needs and helping them achieve their goals. However, challenges remain in measuring the impact of MLTSS programs on consumer's physical health outcomes—as most consumers are receiving medical care from Medicare which is too often not integrated with Medicaid MLTSS programs.

Rebalancing Medicaid LTSS Spending

Goals. Rebalancing Medicaid LTSS spending toward home and community-based care and providing more options for people to live in and receive services in the community—if that is consistent with their needs and desires—is a key goal of MLTSS programs in all the states responding to surveys.

Many of the states surveyed have established specific rebalancing targets, as well as financial incentives for MLTSS plans to meet them. States often structure MLTSS payment rates to encourage MCOs to use HCBS instead of nursing facility services. For example, Florida's goal is to have no more than 35 percent of consumers in its statewide Medicaid Managed Care Long-Term Care program residing in nursing facilities. To that end, the state developed a method to adjust health plan payments annually to provide incentives for meeting rebalancing targets.[5,6] The state pays a blended rate, assuming a specific mix of consumers in nursing facilities and in the community, as well as a 'transition' target. If the MCOs meet or exceed those targets, they benefit financially; if they do not, they will lose money.[7]

States expect that successfully rebalancing LTSS towards HCBS will help to support other MLTSS program goals, including improving quality of life, expanding access to HCBS services, and reducing costs. New Mexico views this shift as supporting the person-centered goals of its Centennial Care program and improving consumers' quality of life.[8] Rebalancing is also a key objective for TennCare CHOICES, which has goals of serving more people using already existing LTSS funds and creating a more sustainable program.[9]

Progress to Date. Eight states (Arizona, Florida, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, and Tennessee) reported that MLTSS has promoted rebalancing the LTSS delivery system, which aligns with national trends in MLTSS rebalancing.[10] Nationally, the percentage of LTSS spending on HCBS increased each year since 1995. Fiscal year 2013 was the first year that HCBS accounted for just over half of LTSS spending in the United States. Between 2013 and 2018, the percentage of Medicaid LTSS funds spent on HCBS increased from 51 percent to 56.1 percent.[11] Beginning in 2016, CMS required states to report the estimated percentage of MLTSS dollars spent on institutional care (e.g., nursing facilities) and HCBS,[12] so specific MLTSS rebalancing expenditure data should become more readily available.

"In Arizona, given our historical perspective, we consider MLTSS to be an important tool to support rebalancing of institutional and HCBS spending, and, in turn, provide greater access to HCBS options."

–Arizona survey respondent

While it would be an overreach to attribute the increase in HCBS spending solely to the increased use of MLTSS, it is reasonable to suggest that MLTSS contributed to this trend. Survey responses provided specific examples of success in states' rebalancing efforts. After 25 years of incrementally adjusting HCBS targets, Arizona reported that 86 percent of its MLTSS consumers are in community settings and 68 percent are living in their own homes. New Jersey has seen a significant shift in its ratio of consumers receiving institutional care versus those receiving community-based care since it started its program in 2014, from a 70/30 ratio (institutional vs. community) to 36/64 ratio in 2021. Moreover, even with an increase in total MLTSS population of 53%, the state has seen a 20% absolute decrease in the number of individuals residing in nursing facilities.[13]

Through comprehensive payment reform, the CHOICES program aims to expand access to HCBS for older adults and adults with disabilities, continue to increase that access over time, and reduce the number of older adults in nursing facilities.[14] A 2020 evaluation of the CHOICES program indicated that each of these objectives has been achieved overall. Most notably, expenditures on nursing facility services remained lower than HCBS services in every evaluation year, from 2011 to 2018.[15] There is, however, an opportunity for the CHOICES program to improve its outcomes related to increasing the average length of stay in HCBS relative to baseline data. Nevertheless, Tennessee's decision to pay a blended capitation payment for LTSS, including nursing facility services and HCBS, has generated numerous positive outcomes. In addition, the Money Follows the Person (MFP) program further incentivized MCOs to rebalance towards HCBS.[16]

Another 2020 study examining nursing facility utilization, HCBS utilization, length of stay for inpatient hospitalization, and potentially avoidable hospital days compared data from Florida, Kansas, New Mexico, New York, and Tennessee.[17] Nursing facility utilization declined among MLTSS enrollees who were dually eligible in Florida and New Mexico, but remained relatively consistent in Kansas, New York, and Tennessee. Among Medicaid-only enrollees, nursing facility utilization declined in all four applicable states (New York has only dually eligible beneficiaries). Regarding HCBS, dually eligible MLTSS enrollees in Tennessee had the lowest utilization, around 30 percent, while enrollees in New York had the highest utilization, around 90 percent. Among Medicaid-only enrollees, HCBS utilization ranged from 42 percent in Florida to 90 percent in New Mexico. In sum, the study found that state expenditures on HCBS were higher than long-term institutional care (i.e., nursing facility services); however, rebalancing trends cannot be generalized.[18]

In a study comparing consumers in Massachusetts' Senior Care Options MLTSS program to a control group of Medicaid consumers who received LTSS through the fee-for-service system, enrollees in Senior Care Options had a 16 percent lower risk of long-stay nursing facility admission, as well as a 23 percent lower rate of nursing facility entry risk at the end-of-life.[19]

Improving Member Experience, Quality of Life, and Health Outcomes

Goals. Most states view MLTSS as an opportunity to create a more seamless experience of care for consumers, which should improve their quality of life. Through care coordination requirements and an enhanced array of services, MLTSS programs can bridge silos that consumers must navigate and improve their health and satisfaction. Improving health outcomes—managing chronic conditions and avoiding potentially preventable hospital admissions or emergency department visits—is a fundamental goal for MLTSS programs. One of the primary drawbacks of traditional fee-for-service programs is the bifurcation of acute care services and long-term services and supports, each of which has an impact on the others. These outcomes may be more likely when a program includes all services—physical health, behavioral health, and LTSS—under one MCO. Accordingly, MCOs are incentivized to provide LTSS in the community as much as possible. Some MCOs are required to adopt processes that facilitate diversion or transition from nursing facility services to consumer-directed HCBS.[20] With the increasing

utilization of HCBS, nursing facilities may be incentivized to use their excess bed availability to make private rooms, which are typically reserved for private-pay residents, available to Medicaid beneficiaries.[21] All of the states surveyed indicated that improving consumer health, as well as consumers' satisfaction and/or quality of life, was a primary goal for MLTSS implementation.

Satisfaction may have a few components reflecting the extent to which consumers feel that their managed care plans—and therefore the MLTSS program as a whole—consider and address their needs and make them feel engaged and supported. For example, many MLTSS programs strive to achieve person-centeredness in service planning and delivery, underscoring the importance of helping consumers live the fullest life possible by meeting their goals and needs. The Quality Improvement in Long-Term Services and Supports (QuILTSS) Initiative in Tennessee is one such program.[22] Many states have sought extensive feedback from consumers, families, and other stakeholders to inform necessary adjustments to program operations and policies and improve quality outcomes to help meet this goal. Early engagement during MLTSS program development and implementation, as well as ongoing engagement during the span of the program, can be an important tool to monitor program success. Moreover, organizations like MACPAC and the National Quality Forum (NQF) report that "access to needed services, experience of care, and quality of life are among the most important measures of program quality".[23]

Many states view care coordination as a key driver of MLTSS programs' ability to improve consumer experience and their quality of life. All MLTSS programs have requirements for care coordinators, often nurses or social workers, to assist consumers with accessing the full array of services offered through the programs. According to an evaluation of California's Cal MediConnect program, "[e]nrollees report that care coordinators are committed to meeting their needs, and have proven helpful in facilitating referrals and authorizations, setting up medical appointments, and educating them about benefits available under [the program]".[24] Additional factors that contributed to enrollees' satisfaction with Cal MediConnect were 1) simplified health insurance; 2) continuity with providers and services; 3) lower out-of-pocket expenses; 4) having a contact person in the program/plan; 5) receiving good quality care; 6) better access to care; 7) improved behavioral health services; and 8) better coordination across providers.[25]

"MLTSS enrollees had consistently better odds of responding more favorably [to NCI-AD quality of life survey questions] than FFS beneficiaries."

–Finding from CMS evaluation of MLTSS programs

Progress to Date. MLTSS program features such as a dedicated care coordinator, better support for family caregivers, higher likelihood of community residence, the ability to live in the setting of one's choice, and improved connection to the community can all have positive effects on consumer health and well-being. However, determining the effects of a particular program feature on consumer outcomes may be difficult to separate from other variables. In addition, it can be challenging to attribute these improvements solely to MLTSS programs in a state where several Medicaid delivery system initiatives may have been implemented at the same time. Nevertheless, several states have made progress in assessing certain outcomes.

Seven states (Arizona, Florida, Kansas, New Jersey, Massachusetts, Minnesota, and Tennessee) reported that their MLTSS programs improved the physical health of consumers enrolled. States have demonstrated improved health outcomes through a variety of tools, including consumer surveys and quality measures derived from managed care encounter data.[26] The U.S. Department of Health and Human Services' Assistant Secretary for Planning and Evaluation released a study in March of 2016 comparing the outcomes of consumers in the Minnesota Senior Health Options (MSHO) program with similar individuals outside of the program, from 2010 to 2012.[27] The study found that consumers in the MSHO program were 48 percent less likely to have a hospital stay; and those who were hospitalized had 26 percent fewer stays overall. MSHO consumers were also 13 percent more likely to receive HCBS and were six percent less likely to have an outpatient emergency department visit, while those who did had 38 percent fewer visits.

Thirteen states (Arizona, Delaware, Florida, Idaho, Iowa, Kansas, Minnesota, New Jersey, Pennsylvania, Tennessee, Texas, Virginia and Wisconsin) use consumer quality of life surveys for those enrolled in their MLTSS programs. Figure 4 below displays the different tools that states are using to assess quality of life and/or satisfaction.

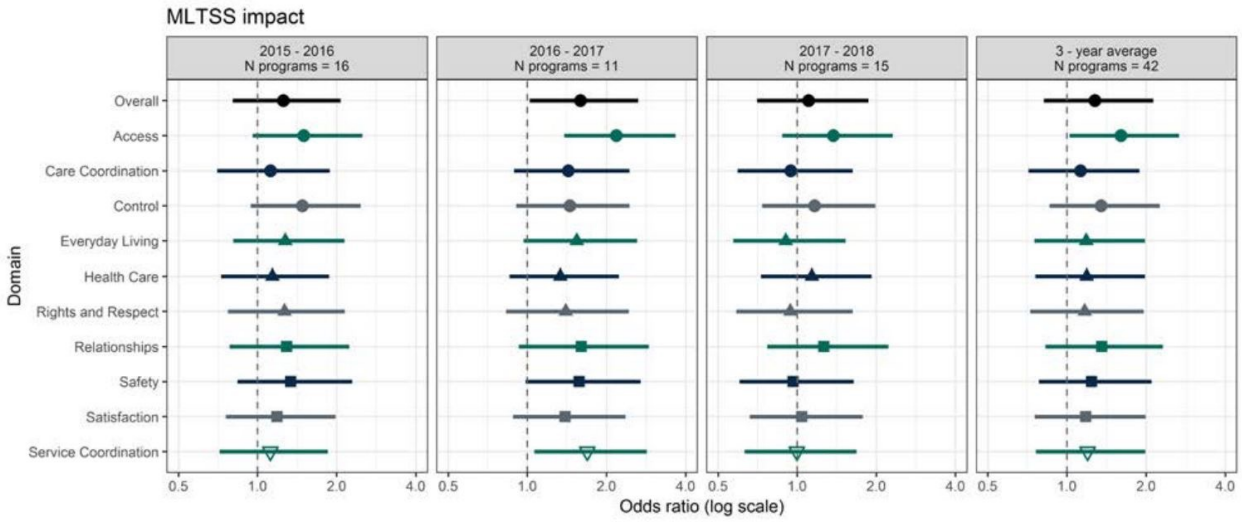
*Figure 4. Tools States with Comprehensive MLTSS Programs Use to Collect Data on MLTSS Consumer Quality of Life and Satisfaction**

State	National Core Indicators – Aging & Disabilities (NCI-AD™)	State-Developed Tools	HCBS CAHPS Survey
Arizona			
Delaware	✓		
Florida			✓
Idaho		✓	
Iowa		✓	
Kansas	✓		✓
Minnesota	✓		
New Jersey	✓		
Pennsylvania			✓
Tennessee	✓		
Texas	✓		
Virginia		✓	
Wisconsin	✓		

** Information not available for Arkansas, California, Hawaii, Illinois, Massachusetts, New Mexico and New York*

The Centers for Medicare & Medicaid Services (CMS) commissioned Mathematica to evaluate the performance of recent MLTSS programs by examining how Medicaid MLTSS beneficiaries enrolled in such programs compare to FFS on their experience of care and quality of life among other things. The final evaluation report, released in November 2020, used consumer responses to 33 items from the National Core Indicators-Aging and Disabilities (NCI-AD™) survey reported in 2016–2018 from both MLTSS and FFS states. A key finding was that, "On average, MLTSS enrollees had 28 percent higher odds of responding favorably to questions related to experience of care and quality of life compared to FFS beneficiaries. All 10 domains examined showed more favorable responses among MLTSS enrollees; however, …in the domains of access, control, relationships, health care, and satisfaction, MLTSS enrollees had consistently better odds of responding more favorably than FFS beneficiaries."[28]

Figure 5 (below) provides a graphic illustration of these evaluation findings:



Source: Medicaid Section 1115 Demonstrations Summative Evaluation Report: Managed Long-Term Services and Support, Mathematica, November 2020.

New Jersey, Tennessee, Texas, and Minnesota and Delaware stratify their NCI-AD sample by MCO so that they can see MCO-specific results for public reporting and quality improvement. Texas recently published a report showing NCI-AD results by MCO in their STAR+PLUS MLTSS program as well as against a national average of MLTSS programs.[29] In Tennessee and Delaware, each MCO is required to analyze their NCI-AD survey results and implement specific quality improvement activities on selected measures.

Reducing Waiver Waiting Lists and Increasing Access to Services

Goals. When there is a greater demand for HCBS services than there are existing 1915(c) waiver slots, some states maintain waiting lists for services.[30] As the United States ages, so has demand for services—in 2018, the waitlist for HCBS service had grown to over 819,000, representing 40 states.[31] MLTSS programs may reduce or eliminate waiting lists, which in turn would result in increased access to LTSS. Seven states (Florida, Iowa, Kansas, New Jersey, New Mexico, Tennessee, and Wisconsin) indicated that a reduction in waiting lists for LTSS was a goal for their MLTSS programs. Tennessee also identified increasing care options and expanding access so that more people can receive care in the community as a related key objective.[32] Other states focused on increasing access to HCBS options, the preferred service setting for most consumers.

Progress to Date. Some states leverage their MLTSS program to eliminate waiting lists, while other states have addressed waiting lists by prioritizing applicants by level of need. Tennessee has eliminated waiting lists for TennCare CHOICES consumers who qualify for a nursing facility level of care; and, through its Section 1115 demonstration, the state also provides individuals needing a lower level of care with a narrower package of services to prevent or delay transitions to nursing facilities.[33,34] Wisconsin also eliminated their two-decade old waitlist for the LTSS program FamilyCare in 2021; Wisconsin now serves over 77,000 adults statewide in their HCBS program array.[35] Other states reported that they reinvested savings from managed care implementation to decrease the number of people on waiting lists. For example, in 2014, Florida invested $12.6 million to enroll wait-listed individuals with the most critical needs into its MLTSS program.[36]

Since Tennessee's elimination of waiting lists for CHOICES consumers, the state has also made significant progress with integrating care under the same MCO for dually eligible beneficiaries.[37] Furthermore, MCOs can receive an incentive payment from the MFP program for each consumer who is transitioned from institutional care to HCBS, with an additional payment upon the consumer's completion of 365 days of MFP participation.[38] Tennessee has also increased access to HCBS by permitting consumers who are transitioning from institutional care and those who are "at risk" of institutional care (Group 2) to be exempt from enrollment targets. This allowance has facilitated more than 500 transitions on average from nursing facility services to HCBS per year.[39]

For some states, in addition to reducing or eliminating wait lists, increasing access can mean expanding the array of services available under an MLTSS program. In certain circumstances, Tennessee also allows its MCOs to provide "Cost-Effective Alternative" services if they provide a less expensive alternative to a Medicaid service and would prevent an individual from developing a condition that would require more costly treatment in the future, such as institutionalization.[40] Examples of Cost-Effective Alternative services include a transition allowance (i.e., up to $2,000 to establish a community residence when transitioning from a nursing facility, including rent/utility deposits, household furnishings, items, etc.) and HCBS (e.g., attendant care) in excess of a defined benefit limit.[41] Budget constraints have made providing a comprehensive dental benefit challenging in Massachusetts' fee-for-service system; but MCOs in its Senior Care Options program have filled this gap by providing dental services when they are not covered by MassHealth.[42]

Increasing Budget Predictability and Managing Costs

Goals. MLTSS programs can improve budget predictability for states simply because MCOs are paid a monthly capitation rate for all covered services. Six states (Florida, Iowa, Kansas, Massachusetts, New Jersey, and Tennessee) identified budget predictability as a goal for MLTSS implementation.

MLTSS programs also have the potential to achieve savings by: rebalancing LTSS spending to provide more HCBS; managing service utilization; and using care coordination to avoid unnecessary inpatient or institutional placements. Tennessee describes managed care as a set of principles that can improve coordination, quality, and cost-effectiveness of care for vulnerable populations, and views quality and cost as "inextricably linked."[43] Florida estimated that without the nursing facility-to-community transitions facilitated by its program, Medicaid LTSS could potentially have cost the state an additional $284 million in 2014-2015, $432 million in 2015-2016, and $200 million per year each year thereafter.[44] Moreover, a study published in the Journal of the American Geriatric Society indicated that the integration of LTSS with home-based primary care (HBPC) delayed long-term hospitalization (i.e., nursing facility services) in "frail, medically complex Medicare beneficiaries without increasing HCBS costs," and produced high patient satisfaction.[45]

"It's important to have realistic expectations for the MLTSS program. The initial focus must be on ensuring that members get high-quality services and providers are paid. Trying to achieve savings too quickly can shift the focus away from these non-negotiables."

–Tennessee survey respondent

Progress to Date. Six states (Florida, Iowa, Massachusetts, New Jersey, New Mexico, and Tennessee) reported collecting data to demonstrate "bending the cost curve" or reducing the rate of growth in Medicaid expenditures. Checking for cost neutrality (e.g., waiver program costs are less than or equal to the cost of institutional programs for the same population enrolled in an HCBS waiver), analyzing Medicaid expenditures, including encounter and enrollment data, and measuring nursing facility diversion rates were the most noted methods to monitor program sustainability and cost-effectiveness.

In an interim evaluation of the TennCare CHOICES program, the Tennessee Department of Finance & Administration reported that expenditures on nursing facility services in 2018 decreased from the baseline rate by 11.32 percent.[46] The yearly data from 2011 to 2018 demonstrates increasing cost-effectiveness, as the expenditure decrease in 2011 was only 1.22 percent.[47] Suggesting further cost-effectiveness, Tennessee's HCBS expenditures in 2018 increased from the baseline rate by 21.07 percent, nearly double the rate increase in 2011 (10.97 percent).[48] Moreover, within the evaluation period, the increase in the number of CHOICES consumers who transitioned from nursing facility services to HCBS ranged from 255.81 percent (2015) to 473.64 percent (2012); and the annual HCBS expenditures remained lower each year than nursing facility expenditures.[49] Expanding on this data, another study comparing the MLTSS programs in Florida, Kansas, New Mexico, New York, and Tennessee found that the five states spent approximately 68.9 percent more on HCBS than other states from 2015 to 2017.[50]

Florida has previously reported that shifting to a capitated, risk-adjusted MLTSS program enhanced the predictability and management of its MLTSS program.[51] In addition, its MLTSS program met five percent savings targets established by the legislature during the first three-month period of statewide implementation in 2013 and 2014.[52] Massachusetts also reported meeting its goal of budget predictability, which would be more challenging in a fee-for-service environment for the "otherwise volatile and high-cost population" served in its Senior Care Options program.[53] In 2019, RTI found that Ohio's MyCare program produced cost savings in the first demonstration period, between 2014 and 2015. The savings were attributed to reduced hospitalizations and hospital readmissions, nursing facility services, and emergency department utilization.[54]

States may also restructure their Medicaid agencies and streamline some responsibilities that are delegated to MCOs, both of which have the potential to decrease the state's administrative burden. Three states (Florida, Massachusetts, and Texas) reported that implementing MLTSS decreased administrative burden in their Medicaid programs. However, implementing MLTSS programs can impact state goals in other areas, too. As Tennessee recognized, it is important to note that successfully implementing managed care and achieving program goals requires a significant investment in monitoring and oversight capabilities, or in the state's infrastructure to "manage" managed care.[55] This includes continuous involvement of state leadership in program management and oversight and having a robust strategy for overseeing MCO performance and accountability.

Challenges in Documenting Financial Outcomes. Ensuring program sustainability and cost-effectiveness are important MLTSS program goals; however, insufficient data have been a barrier to states' ability to demonstrate these outcomes. MLTSS programs generally do not operate independently, but rather are part of a broader Medicaid or integrated care initiative in the state. Therefore, attributing cost-effectiveness solely to the efforts of the MLTSS program can be challenging. In addition, states do not often collect baseline measurements across several cost and quality indicators prior to an MLTSS program launch. Moreover, they do not often have solid cost projections for their fee-for-service programs against which they can compare their MLTSS programs. This makes it almost impossible to reliably make "pre-post" comparisons. Tennessee did monitor relevant targets prior to implementation of CHOICES to establish a baseline and later demonstrate program outcomes. States considering new or expanded MLTSS programs should consider investing resources in establishing baselines from their current program, as it is critical to provide post-implementation comparisons, which are often demanded by stakeholders.

Conclusion

This report reviewed several state goals for implementing MLTSS programs, including: rebalancing Medicaid LTSS spending; improving consumer experience, quality of life, and health outcomes; reducing wait lists and improving access to services; and increasing budget predictability and managing costs. Several states provided compelling examples demonstrating that they are meeting these goals. At the same time, their work underscores the importance of expanding the scope and amount of data collected and continuing to strengthen their efforts to monitor the performance of their contracting MLTSS plans to assure the best outcomes for their consumers.

More data are needed around the impact of MLTSS programs on consumer or family satisfaction, consumers' quality of life and physical health outcomes, and cost effectiveness.

States reported several lessons related to challenges of better demonstrating program value, including the need for standardized quality measures across MLTSS programs to assess person-centeredness and outcomes and better monitoring of managed care performance. Other lessons include:

- Collecting and analyzing encounter data and other programmatic data is challenging;
- Developing an oversight structure for MLTSS programs is complex; and
- Dedicating more staff resources and refining existing staffing strategies for MLTSS implementation and oversight are important to achieving a smooth transition from a fee-for-service system.

One useful step that states can take is to collect baseline measures on consumers' health status and other program variables like cost and service utilization, and then link outcome measures to these benchmarks. This approach may be helpful when:

- State legislatures request information regarding MLTSS program sustainability. States listed a variety of data and reporting measures (e.g., LTSS rebalancing, program sustainability and cost savings, improved health outcomes, and nursing facility diversion) that were helpful in addressing legislative inquiries.

- Stakeholders have concerns about network adequacy and provider payment rates. States noted significant stakeholder pushback when transitioning from fee-for-service models to managed care. A primary concern was MCOs' perceived use of a "medical model" rather than a person-centered approach to the full range of LTSS needed by consumers to lead a meaningful and engaged life. Assessing access and consumer satisfaction pre-and post-implementation could be valuable in addressing stakeholder concerns.
- Stakeholders voice concerns about service reductions or appeals and grievances. Building a track record of strong consumer education and post-enrollment support (e.g., MLTSS ombudsman programs) can mitigate those concerns.

MCO contract requirements could correlate to program goals and facilitate the collection of additional data to demonstrate the value of the program to stakeholders with various concerns and interests. States will find that strong contracting requirements and performance monitoring are important tools for reassuring stakeholders, building their support, and demonstrating program viability over time.

Technical Assistance Available for States

Operating an efficient and effective MLTSS program requires a thoughtful program design, capable health plan partners, strong state oversight, and appropriate accountability mechanisms. A recent study concluded that these factors vary considerably from state to state.[56] ADvancing States created the MLTSS Institute to capitalize on its capacity to deliver solid, reliable technical assistance tailored to each state's program and needs. Furthermore, ADvancing States staff can assist states with any number of activities including stakeholder engagement, quality measurement, value-based purchasing, contract management, and collaboration with health plan partners and other contractors.

ADvancing States created the MLTSS Institute to capitalize on its capacity to deliver solid, reliable technical assistance tailored to each state's program and needs.

Appendix: State MLTSS Programs

State	Managed Care Authority Used	Populations Enrolled					Covered Benefits	
		Seniors	PD	DEB	I/DD	BH	Comprehensive	Other
Arizona[1]	1115	✓	✓	✓	✓		✓	LTSS
Arkansas	1915(b)			✓	✓		✓	LTSS
California	1115; FAI	✓	✓	✓	✓		✓	LTSS
Delaware	1115	✓	✓	✓	✓		✓	LTSS
Florida	1915(b)/(c)	✓	✓					LTSS
Hawaii	1115	✓	✓	✓	✓		✓	LTSS
Idaho	1915(a)/(c)	✓	✓	✓	✓		✓	LTSS
Illinois	1915(b)/(c); FAI	✓	✓	✓			✓	LTSS
Iowa	1915(b)/(c)	✓	✓	✓	✓		✓	LTSS
Kansas	1115/1915(c)	✓	✓	✓	✓		✓	LTSS
Massachusetts	1915(a)/(c); FAI	✓		✓			✓	LTSS
Michigan	1915(a)/(b)/(c); FAI	✓	✓	✓	✓	✓	✓	LTSS; Behavioral Health
Minnesota	1915(a)/(b)/(c)	✓		✓			✓	LTSS
New Jersey	1115	✓	✓	✓	✓		✓	LTSS
New Mexico	1115	✓	✓	✓	✓		✓	LTSS

Continues.

State	Managed Care Authority Used	Populations Enrolled					Covered Benefits	
		Seniors	PD	DEB	I/DD	BH	Comprehensive	Other
New York	1115	✓	✓	✓	✓		✓	LTSS
North Carolina	1915(b)/(c)			✓	✓	✓	✓	LTSS; Behavioral Health
Ohio	1915(b)/(c); FAI	✓	✓	✓			✓	LTSS
Pennsylvania	1915(a)/(b)/(c)	✓	✓	✓	✓		✓	LTSS
South Carolina	FAI			✓			✓	
Tennessee	1115	✓	✓	✓	✓		✓	LTSS
Texas[2]	1115; FAI	✓	✓	✓	✓		✓	LTSS
Virginia	1915(b)/(c)	✓	✓	✓	✓		✓	LTSS
Wisconsin	1915(b)/(c);1932(a)	✓	✓	✓	✓		✓	LTSS

Source: ADvancing States data; CMS Managed Care Profiles (https://www.medicaid.gov/medicaid/managed-care/state-profiles/index.html)

Key

Authority

- 1115 – Section 1115 demonstration
- 1915(a) – Voluntary managed care program
- 1915(b) – 1915(b) managed care waiver
- 1932 – State plan amendment for managed care
- FAI – Financial Alignment Initiative demonstration

Populations

- PD – Persons with physical disabilities
- DEB – Dually eligible beneficiaries
- I/DD – Persons with intellectual/developmental disabilities
- BH – Persons with mental health and/or substance use disorders

Benefits

- Comprehensive – full range of acute/primary/LTSS/behavioral health services
- LTSS – Nursing facility services as well as home- and community-based services only

[i] Arizona enrolls beneficiaries dually eligible for Medicare and Medicaid in its ALTCS program, although "dually eligible" is not one of the program's enrollment categories.

[ii] Texas I/DD population receiving I/DD HCBS 1915(c) waiver services or residing in an ICF/IID receive only acute services through MCOs.

Endnotes

[1] Arizona has always provided LTSS through a managed care delivery system, and so never transitioned from fee-for-service to MLTSS.

[2] States taking part in the Financial Alignment Initiative: CA, CO, IL, MA, MI, NY, OH, RI, SC, TX, VA and WA. For more information see: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

[3] States also use many other strategies to coordinate care—and integrate benefits—for the dually eligible population. Many MLTSS programs include Medicare primary and acute care services for these consumers. States may integrate Medicare and Medicaid services through Financial Alignment Initiative demonstrations, aligned Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) and Medicaid MCOs, and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) among other initiatives

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[9] P. Killingsworth. "State of Tennessee Managed Long Term Services and Supports." Presentation during Wisconsin Managed Care Discussions. November 2015.

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[17] A. Wysocki, Mathematica, op. cit.

[18] Ibid.

[19] Health Management Associates. *Value Assessment of the Senior Care Options (SCO) Program.* July 2015. Available at: http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf.

[20] Tennessee Department of Finance & Administration, Division of TennCare, op. cit.

[21] Ibid.

[22] Ibid.

[23] A. Wysocki, Mathematica, op. cit.

[24] RTI International. *Financial Alignment Initiative California Cal MediConnect: First evaluation report.* Centers for Medicare & Medicaid Services. 2018. Available at: https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf.

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