Center for Health Care Strategies

Moving Home- and Community-Based Services to Medicaid Managed Long-Term Services and Supports: Considerations for California and Other Transitioning States

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KEY TAKEAWAYS

- California's transition of select home- and community-based services (HCBS) into Medicaid managed care slated for 2028 aims to enhance coordination for HCBS users and cost predictability for the state, but the change requires careful design to avoid disruptions.
- Lessons from states that have previously transitioned to managed long-term services and supports (MLTSS) programs highlight the importance of continuity-of-care protections, robust provider networks, and active oversight.
- Addressing potential stakeholder concerns upfront — particularly around provider continuity, adequate personal care, and timely provider payment — is critical for California's success.
- This explainer highlights strategies and insights from past state experiences to guide an effective transition of HCBS to Medicaid managed care in California and other transitioning states.

Every Californian deserves the opportunity to live with independence and freedom, whether they are aging or living with disabilities. Long-term services and supports (LTSS) make this possible by providing essential assistance with daily activities, like eating, bathing, housekeeping, and managing medications. While some people receive these services in nursing facilities, many prefer to live in their own homes and communities with the help of home- and community-based services (HCBS).

In 2012, the integration of LTSS into Medi-Cal (Medicaid) managed care began when California launched the Coordinated Care Initiative (CCI) in seven counties. Among other reforms, the CCI shifted administration of some LTSS benefits from fee-for-service (FFS) to Medi-Cal managed care in those counties. Due to cost concerns, in 2017, administration of In-Home Supportive Services (IHSS), California's self-directed personal care services program, was returned to FFS Medi-Cal.

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In 2022, as part of the state's Medi-Cal transformation under CalAIM, California: (1) started transitioning institutional LTSS (including Skilled Nursing Facility benefits) into managed care statewide; (2) began offering some LTSS as Community Supports through Medi-Cal managed care; and (3) communicated intent to carve in select 1915(c) waiver programs — including the Assisted Living Waiver, Home- and Community-Based Alternatives Waiver, Multipurpose Senior Services Program, and Medi-Cal Waiver Program — into managed care in 2028 (timeline and specific waivers subject to change).

In a managed care system, the state contracts with managed care plans (MCPs) and pays them a fixed, risk-adjusted per-member per-month capitation rate in exchange for covering a defined set of services outlined in the contract. This system has the potential to enhance quality of care and coordination across services and providers — for example, by enabling MCPs to set quality standards for providers in their networks and providing care coordination services — while containing costs and shifting some of the financial risk from the state to the MCPs. However, this system may unintentionally introduce new barriers and issues for all parties involved, such as limited access to providers, fewer authorized services for members, and increased administrative burden on providers. These challenges could counteract the system's benefits if not designed properly.

As California and other states prepare for or implement an expanded transition to managed LTSS — or MLTSS — interested stakeholders can learn from the experiences of the 24 states that already moved to MLTSS over the last three decades. This explainer, developed through support from the California Health Care Foundation, offers considerations to help states create systems that best serve members who rely on HCBS. It explores common concerns about the transition to MLTSS from the perspectives of:

HCBS users

Medicaid agencies

HCBS providers

Managed care plans

Stakeholder Concerns About MLTSS and Opportunities to Address Concerns

This section highlights common concerns about the transition of HCBS to MLTSS, organized by core stakeholder groups: **HCBS users**, **HCBS providers**, **Medicaid agencies**, and **MCPs**. It describes common MLTSS program design elements that states have used to address these concerns, as well as new or emerging strategies that transitioning states could implement through contracts or other regulatory or statutory mechanisms to proactively address these issues.

HCBS User Concerns

HCBS User Concern #1: HCBS users risk losing access to their current HCBS providers if they are not already in the MCP's network.

A few ways states have mitigated this concern:

- **"Transition of care"/"continuity of care" contract provision**: This provision requires MCPs to honor new members' existing HCBS care plans and providers during the transition period to MLTSS, regardless of whether the providers are in the MCP's network. For example, **Iowa** required MCPs to honor existing care plans and reimburse existing HCBS providers for 90 days and nursing facility providers for one year following the transition to MLTSS.

  Limitation: Even if an MCP covers an existing HCBS provider for a certain period, a member can still lose access to the provider if a single case agreement is not extended, or the provider does not join the MCP's network. This typically happens when the MCP and provider fail to reach a contractual agreement during the transition, potentially due to disagreements over payment rates and billing requirements, or the provider chooses not to participate in managed care.

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- **"Any willing provider" contract provision**: This provision requires MCPs to contract with any existing fee-for-service (FFS) HCBS provider and include them in their provider network if the provider contracted with Medicaid and is willing to comply with the MCP's policies. States may choose to implement this policy for a defined period following the transition to MLTSS, or indefinitely. For example, **New Jersey** and **Iowa** implemented this provision for HCBS and nursing facilities for two years, whereas **Delaware** and **Tennessee** did not implement this policy for HCBS, but did so indefinitely for nursing facilities. The "any willing provider" provision could especially help HCBS users who are enrolled in both Medicaid and Medicare (dually eligible members) in an exclusively aligned situation based on a Medicare Advantage plan, as there is currently no guarantee that a given Medicare plan's network is 100 percent aligned with the associated Medicaid plan's network and will include their current HCBS providers.

  Limitation: Indefinite "any willing provider" provisions can limit the ability of MCPs to tailor their networks to providers that meet certain quality standards.

Novel approaches transitioning states might consider:

- **Provide flexibility for HCBS users to switch plans to maintain providers**: Transitioning states could allow members who use HCBS to switch MCPs at any time, if the change allows them to maintain their existing HCBS providers.

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- **Establish a network adequacy standard or quality bonus based on retention of members' HCBS providers**: The Centers for Medicare & Medicaid Services' (CMS) MLTSS network adequacy requirements are largely based on the number of HCBS provider types contracted with a health plan in specific geographic areas. Transitioning states could implement an additional network adequacy standard or a quality bonus for MCPs that successfully contract with every provider that a member had prior to the MLTSS transition or joining the MCP.
- **Offer incentives for HCBS providers to contract with MCPs**: To address the issue of providers not wanting to participate in managed care, transitioning states could provide an incentive, financial or otherwise, to those providers that contract with at least one MCP in their coverage area.
- **Proactively educate dually eligible members who use HCBS**: Transitioning states could require HCBS providers to proactively educate dually eligible members about which Medicaid MCPs they contract with and what the aligned dual eligible special needs plan (D-SNP) is, if applicable.

HCBS User Concern #2: MCP practices may lead to HCBS users receiving fewer personal care hours or services overall. Practices might include algorithm-based assessments or restrictive medical necessity criteria, among others.

A few ways states have mitigated this concern:

- **Contract provision related to maintenance of existing HCBS benefits**: This contract provision requires MCPs to maintain the same HCBS benefit determination/authorization (amount, duration, and scope of services) the member had previously for at least a period. **Indiana** requires that health plans honor previous HCBS benefit authorizations for 90 days from enrollment, or the remainder of the prior authorized dates of service, or until the approved units of service are exhausted.

  Limitation: Some states, such as **Pennsylvania**, experienced a significant increase in personal attendant hours just prior to the MLTSS transition.

- **Oversight and enforcement of CMS requirements**: In addition to CMS' guidelines and requirements for person-centered needs assessments and service-planning processes, a 1915(c) HCBS waiver approval from CMS requires a state to attest that it has an "effective system for reviewing the adequacy of participants' service plans," among other requirements. States that have implemented MLTSS typically include language in their health plan contracts expanding compliance with the CMS HCBS waiver assurances to plans.
- **Oversight and enforcement beyond CMS requirements**: Several states — including **Indiana**, **Texas**, **Iowa**, **Virginia**, and **Florida** — require reporting, reviews, and audits of member-level functional assessments and care/service plans, beyond CMS requirements, to ensure MLTSS members receive necessary services. In **Pennsylvania**, plans must provide monthly aggregate reports on changes to services in HCBS care plans and the state has the right to review and request revisions.

States like Indiana, Texas, Iowa, Virginia, and Florida, among others, require reporting, reviews, and audits of functional assessments and care plans, beyond CMS requirements, to ensure members receive necessary services.

- **Member protections**: While MCPs may deny or limit services to ensure appropriate and "medically necessary" care, members also have the right, protected by federal statute and MLTSS contracts, to appeal an MCP decision to reduce, terminate, or deny benefits.
- **Uniform HCBS medical necessity criteria**: Because HCBS are typically provided long-term and are primarily non-medical services, traditional MCP medical necessity or clinical practice guidelines for authorizing and delivering services may not apply. Some states implement uniform definitions of HCBS medical necessity across health plans to prevent unjust service denials or decreases and ensure consistent and equitable access to services. **Pennsylvania's** medical necessity criteria for MLTSS, for example, requires that services: (1) "assist members to achieve or maintain maximum functional capacity in performing daily activities;" and (2) provide the opportunity to "have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of [their] choice."

  Limitation: Even with these member protections in place, few denials are appealed by managed care members nationally, and evidence exists of significant unmet need for services. For example, according to recent results of the HCBS Consumer Assessment of Healthcare Providers and Systems (HCBS-CAHPS) survey, which includes individuals receiving MLTSS, 64 percent of respondents reported that HCBS providers were not available to help with dressing, showering, or bathing.

Novel approaches transitioning states might consider:

- **Ensure automatic review of significant changes to services**: Transitioning states could institute an HCBS quality measure that triggers review (by the state or another entity, such as an external quality review organization) in the event of a cut to or increase in a member's services that is greater than a certain percentage in the period leading up to and during MLTSS implementation.
- **Require documentation of alternatives and member agreement**: Transitioning states could require that MCPs document the following prior to a significant decrease in services: (1) what alternative services will be provided to compensate for the proposed reduction; and/or (2) a clear, written statement signed by the member or their guardian that they no longer wish to receive a service and/or agree with the proposed service reduction/alternative.
- **Collect, report, and act on MLTSS denials and appeals data**: Although not federally required, transitioning states could collect and publicly report on the rate of MCP MLTSS denials or reductions in HCBS and appeals. Where a pattern of significant or population-specific decreases exists, or where a spike in member appeals related to a decrease in services occurs, transitioning states could build in contractual monetary penalties.
- **Limit the use of algorithms and artificial intelligence (AI)**: **California** recently passed a law prohibiting the use of AI as a tool to evaluate and deny health insurance claims. Transitioning states could prohibit MLTSS authorization determinations based solely on analysis results from AI or algorithms.

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- **Set clear expectations for covered services**: In contracts with MCPs, transitioning states could provide an explicit list of all services that MCPs are expected to provide to MLTSS members to minimize the risk of siphoning off services to FFS Medicaid or out-of-pocket payments.

HCBS Provider Concerns

HCBS Provider Concern #1: Providers may experience delays in MCP payment compared to FFS Medicaid payments.

A few ways states have mitigated this concern:

- **Quality withholds**: During the first year of implementation, some MLTSS states withheld a portion of a health plan's total capitation payments. Withholds could be earned back if a plan exceeded minimum performance standards on key operational measures, such as timely claims processing. **Kansas** had a three percent withhold that included claims processing in the first year of its MLTSS program.
- **Clearly defined claims processing requirements and oversight mechanisms**: **Indiana** requires plans to adhere to strict timelines for claims processing (e.g., clean HCBS claims must be paid within seven days of receipt), pay providers interest if claims are paid late, have an internal claims audit function, submit claims processing data to the state, and undergo random sample audits of claims by the state. Health plans in **New Mexico** must report to the state on provider payment timelines, and plans in **Hawaii** must work with an external quality review organization to assess provider satisfaction with MCP reimbursement and responsiveness to identify potential problems relating to claims processing.
- **Sanctions for delayed payment**: In several states, MCPs that fail to reimburse providers within a certain timeframe after clean claims submission are subject to significant monetary penalties. Sanctions in **Pennsylvania's** MLTSS contract range from $2,000 to $30,000, and one plan in **Florida** was sanctioned $9 million in liquidated damages in 2022 for delayed HCBS provider payments.

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- **Default risk reserves**: Some states require that MCPs set up default risk reserves, such as an escrow account, for providers to draw from if their payments are delayed. For example, **New York** requires plans to deposit five percent of projected medical expenses into the account each year. This ensures providers receive payment in a timely manner, even if their claims require further review or corrections.
- **Standardized contract language**: Some MLTSS states, like **Indiana**, require all plans to use the same standardized contract language for all HCBS providers brought into network. This enables providers to better manage the contracting process and navigate billing requirements across multiple MCPs, and allows for more aligned service delivery for members across plans and providers.

Limitation: The above five design elements incentivize plans to pay claims on time, but they do not address the root cause of most payment delays under managed care, which is typically the lack of alignment between data systems and operational processes of providers and plans. To pay a provider, plans must receive a "clean claim," that is without mistakes and includes all required information. However, providers often submit claims they believe are clean, but are not accepted. Efforts have been made by states, MCPs, and provider organizations to educate HCBS providers on managed care billing (e.g., checking member eligibility, ensuring accurate service codes). HCBS provider education, however, is only a partial solution to a larger challenge to timely reimbursement, which has multiple causes.

Novel approaches transitioning states might consider:

- **Leverage community care hubs**: HCBS providers are not unique in their challenges in billing MCPs. Other health-related social needs providers, such as housing or nutrition service providers, are also largely small, non-clinical, community-based organizations (CBOs) that struggle with MCP contracting and billing. To address this gap in capacity for CBOs, entities have emerged across the country called community care hubs. These hubs centralize administrative functions to ease the burden on providers and enable CBO/MCP partnerships. Some states, like **California**, **New York**, and **North Carolina**, have networks of community care hubs that act as administrative intermediaries between some CBOs and MCPs, handling billing and payments. Transitioning states could incentivize HCBS providers and MCPs to use community care hubs, particularly hubs with HCBS experience.

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- **Use a single rate, contract, and billing process**: Requiring one rate, contract template, and billing mechanism for all providers within the same provider type is a practice **Washington State** uses under one of its Medicare managed care models. This reduces the need for providers to learn different billing and payment systems and helps providers manage their cash flow when working with multiple MCPs.

- **Expand self-direction with budget authority so HCBS users can pay for their own services at the time of service**: Self-direction is an LTSS delivery model that allows HCBS users to have decision-making authority and direct responsibility for managing some or all of their Medicaid-funded HCBS. That responsibility can sometimes include authority to decide — with support of a financial management service (FMS) or "supports broker" — how to spend money allocated for HCBS. This approach gives HCBS users control over payment for services within their care plan. FMS entities can help streamline payment, which can lead to timelier HCBS provider payment. For example, one national FMS entity, GT Independence, offers an online portal and smartphone app that allow HCBS users, caregivers, and providers to input timesheets, budgets, claims, and other billing information to speed up payment. Transitioning states could explore use of self-direction with budget authority for all HCBS services being integrated into MLTSS, and allow FMS entities to offer point-of-service payment to HCBS providers, rather than MCP claims-based reimbursement at the end of the month.

- **Strengthen claims-related MLTSS readiness review standards**: Transitioning states could strengthen claims-related MLTSS readiness review standards by adding onsite claims processing system testing, similar to **Tennessee**, that requires MCPs to test improvements to the efficiency and timeliness of the claims adjudication processes prior to MLTSS launch.

HCBS Provider Concern #2: Current providers, particularly those offering care coordination, could be displaced by MCP staff or vendors with little to no experience serving people with LTSS needs.

A few ways states have mitigated this concern:

- **Required delegation of HCBS assessment, care coordination, and/or care management functions**: MLTSS capitation rates are made up of several components required by federal regulations, including the projected cost of care coordination and care management. This tends to be the most profitable part of the MLTSS capitation rate since nearly all states require every MLTSS member to be assigned to an MLTSS care manager and participate in care management. To capture this higher portion of the capitated rate, some plans bring these activities in-house or delegate them to external for-profit companies that have a direct financial investment relationship with the plan instead of continuing to provide these services through CBOs that performed the activities under FFS. This could result in care managers with inadequate knowledge, experience, and conflicts. Some states, like **Ohio**, **Indiana**, and **Pennsylvania**, require plans to contract some or all HCBS care coordination functions (e.g., assessment, care planning, care coordination) to external organizations, as opposed to conducting the activities in-house, to avoid conflicts of interest.

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- **National Committee for Quality Assurance (NCQA) LTSS case management accreditation**: As of June 2023, nine states require that plans have NCQA LTSS health plan distinction. Others, like **Ohio** and **Alabama**, encourage or require the plan's contracted care management providers have NCQA LTSS case management accreditation. NCQA LTSS accreditation includes an extensive evaluation of an organization's ability to provide person-centered care management in key areas, like comprehensive assessment, care transition management, critical incident response, quality measurement, care coordination, member rights communication, and culturally appropriate care delivery.

- **Consumer experience of care survey**: To monitor concerns about unqualified entities providing care management services, MLTSS states typically require plans to conduct or participate in one of two consumer experience of care surveys: the HCBS-CAHPS survey, as conducted in **Florida**, **Hawaii**, and **Illinois** among others; or the National Core Indicators - Aging and Disabilities (NCI-AD), as conducted in **Michigan**, **Ohio**, and **Texas**, among others. Both surveys include questions that assess HCBS users' perceived quality of, and satisfaction with, their LTSS care manager.

  Limitation: HCBS-CAHPS and NCI-AD questions related to HCBS care managers tend to be general (e.g., "case manager is helpful" or "can you reach your case manager when you need to?"). They do not necessarily indicate an HCBS user's satisfaction with their care manager's level of LTSS expertise, understanding of core independent living principles, or provision of non-clinical/non-medical model care management services. Additionally, the lag between when survey data collection begins and when states and MCPs receive survey results can decrease their usefulness.

Novel approaches transitioning states might consider:

- **Limit potential for care management conflicts**: Transitioning states could prohibit MCPs from delegating HCBS care management functions to any company with which the MCP has a financial interest or investment. The state might also consider establishing other conflict-of-interest guardrails based on perceived negative impacts on care and services.
- **Ensure separation between care management and utilization management**: If MCPs are allowed to keep care management activities in-house or delegate those functions to a company the MCP has a financial interest or investment in, transitioning states could require MCPs to have a firewall between care management and utilization management to avoid conflicts of interest, as **Washington State** did in one of their Medicaid managed care models.

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- **Develop explicit state guidance about how HCBS care coordination should occur under MLTSS**: Although not an MLTSS state, one of the factors that allowed **Washington State** to successfully transition a FFS Medicaid model to a managed care system was to develop explicit, written contract requirements around expectations for care coordination. During the transition, the state required that plans contract with existing CBOs providing care management in the FFS model and prohibited the plans from providing the service directly. The state also dictated what roles FFS care coordinators and MCP care managers should play and how they should interact and communicate during the planning and care management process. Communication requirements also extended to other interdisciplinary care team members, such as behavioral health providers, where applicable. Transitioning states could dictate explicit expectations for HCBS care management within the MLTSS contract or by building on existing plan guidance related to care coordination. This guidance might detail information about what the state expects the MCPs to cover in terms of costs and services to avoid confusion around grey areas, like post-acute rehabilitation.
- **Require LTSS care managers as the primary care manager for dually eligible members**: To ensure that HCBS care management under MLTSS remains non-clinically based, transitioning states could require MLTSS care managers to serve as the single point of contact and coordination for dually eligible enrollees who use LTSS, since Medicare has a very limited role in LTSS. Alternatively, if a D-SNP or other Medicare Advantage care manager assumes the primary role, transitioning states could require that those care managers meet NCQA LTSS case management accreditation standards, complete person-centered training, and undergo "independent living philosophy" training with the state's Centers for Independent Living.
- **Develop an HCBS-CAHPS or NCI-AD state supplement**: This survey supplement could include questions specifically assessing an LTSS member's satisfaction with their HCBS care manager's level of LTSS expertise, understanding of core independent living principles, and provision of non-clinical/non-medical model care management services.

- **Require coordination and data sharing**: Transitioning states could require MCPs to share data with the state's Area Agencies on Aging, Centers for Independent Living, or other aging and disability organizations to coordinate with these entities in identifying opportunities to improve care. Transitioning states could model plan contracts after **Indiana**, which require D-SNPs to coordinate with AAAs, such as by incorporating a member's Medicaid waiver service coordinator into the D-SNP's interdisciplinary care team to the highest degree possible and bi-directional sharing of encounter data and Indiana Health Information Exchange data.

HCBS Provider Concern #3: Providers may face a significant increase in demand for services and/or member acuity without an adjustment to their payment rate and staffing ratios.

A few ways states have mitigated this concern:

- **Regular rate reviews**: States often build rate review periods into their MLTSS contracts and mandate that any necessary updates to capitation rates are made based on data requirements outlined in the annual CMS Medicaid Managed Care Rate Development Guide, such as service utilization and demand, and changes in the beneficiary population. After the U.S. Government Accountability Office flagged an issue in 2017 with states not rebasing their MLTSS rates when newer data were available (as required by the 2016 Medicaid Managed Care final rule), **Arizona** and several other states included provisions in their MLTSS contracts requiring an actuarial review every year to determine if adjustments are needed.

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  Limitation: Waiting a year to rebase MCP rates does not necessarily provide financial relief for small HCBS providers experiencing immediate increased demand or member acuity and related staffing and cash flow management challenges.

- **"Access Rule" provisions**: CMS' Ensuring Access to Medicaid Services final rule (Access Rule) includes provisions that will help support adequate payment rates for some HCBS providers. The rule requires that by February 2028, all states with certain Medicaid HCBS waiver programs report annually on the percentage of Medicaid payments spent on compensation for HCBS direct care workers (DCWs) providing homemaker, home health aide, personal care, and habilitation services; and by February 2030, those states must also spend a minimum of 80 percent of Medicaid payments on compensation for DCW providing these services.

  Limitation: There is no guarantee that the current or future federal administrations will proceed with implementation or enforcement of CMS' Access Rule. The rule's payment-related provisions are also dependent on health plans providing accurate reports of their Medicaid spending, which has shown to not be the case in some other reporting processes.

- **Required member-to-care manager ratios**: MLTSS states set required staffing ratios in their contracts with plans to ensure each HCBS care manager can provide adequate care management and coordination assistance to members even with an overall increased demand in services. **Virginia's** MLTSS caseload ratio is 1:175 for institutional settings and 1:70 for HCBS settings. **Indiana** requires an average weighted service coordinator-to-MLTSS member mixed staffing ratio of no more than 1:100.

Limitation: Most MLTSS care management staffing ratios are based on the setting (HCBS versus institutional) and do not account for fluctuations in demand across settings, such as the larger time investment required during initial assessments and care planning.

Novel approaches transitioning states might consider:

- **Establish provider-level risk adjustment**: Several states, including **Wisconsin** and **New York**, use functionally based risk adjustment to set *a plan's* MLTSS rates, since functional status is one of the most accurate indicators of LTSS beneficiaries' resource use and, therefore, highly predictive of actual LTSS costs. Transitioning states could explore having MCPs calculate *provider reimbursement* using tiered rate structures based on functionally based risk adjustment at the HCBS provider level. This could account for the different levels of risk (predicted needs and costs) in the populations served by each provider.

- **Expand the scope and purview of the "interested parties advisory group" under the CMS Access Rule**: Another provision in CMS' Access Rule that could support adequacy of HCBS provider payment rates is the requirement for states to establish an interested parties advisory group to consult on FFS LTSS rates paid to DCWs providing self- and agency-directed HCBS for personal care, home health aide, homemaker, and habilitation services. Transitioning states could expand the scope and purview of the state's interested parties advisory group to include the review of MLTSS rates paid to these and other HCBS providers, as the final rule explicitly allows for the group to "consult on other HCBS, at the State's discretion."

  Transitioning states could explore requiring smaller or fluctuating member-to-care manager ratios in the initial HCBS assessment and care planning stage.

- **Upfront member-to-care planner ratios**: A significant portion of a member's care management services will be conducted during the initial HCBS assessment and care planning process when a member first joins a plan. Transitioning states could explore requiring smaller or fluctuating member-to-care manager ratios based on how many members a care manager is assigned in the initial HCBS assessment and care planning stage. Doing this could help better coordinate care upfront and ease the burden on HCBS care managers.

Medicaid Agency Concerns

Medicaid Agency Concern #1: Administrative, legislative, and community expectations about MLTSS cost savings and rebalancing may not align with the outcomes of the transition, potentially decreasing support for the program.

A few ways states have mitigated this concern:

- **Strategic use of results from emerging MLTSS evaluation studies**: It has been nearly 40 years since the first MLTSS program was created in **Arizona**, and studies are emerging that analyze the effectiveness of this model in meeting key state goals for MLTSS implementation. A 2022 analysis found that MLTSS costs become less or equal to FFS LTSS costs between years two and six of implementation, and actual financial savings from MLTSS are not typically realized until four to 12 years after implementation. Additionally, a 2020 analysis found that while there is some indication of lower nursing facility use, greater use of some types of HCBS, and fewer hospitalizations in MLTSS states, these changes are not consistent across all states and populations. Reminding stakeholders of these findings could help manage expectations.

- **Consensus regarding specific MLTSS policy goals and clearly defined measures of effectiveness in meeting those goals**: Medicaid agencies that are successful in managing expectations about what MLTSS can realistically achieve: (1) align with legislative and community partners on policy goals for the transition and; (2) implement performance measures that show whether those goals are being met. For example, rebalancing spending on HCBS and institutional care was, and continues to be, a primary goal for MLTSS in **Indiana**. There is widespread consensus around the goal because, at the time of MLTSS implementation in 2023, 19 percent of the state's LTSS funding was spent on HCBS, whereas 81 percent was on institutional care.

  Actual financial savings from MLTSS are not typically realized until four to 12 years after implementation. Reminding stakeholders of these findings could help manage expectations.

  Limitation: A significant potential source of savings in MLTSS comes from rebalancing. Yet, using cost savings and rebalancing as a measure of MLTSS effectiveness can be difficult for states. In **California**, for example, the largest HCBS program in the state by enrollment and spending, IHSS, is not under consideration for MLTSS transition, and the state already ranks first in the nation on rebalancing. Given the IHSS carve out, California's current standing, and factors beyond the control of the California Department of Health Care Services (DHCS) — such as statutory requirements for annual minimum wage increases — achieving savings through MLTSS may be challenging.

Novel approaches transitioning states might consider:

- **Identify alternative cost-saving opportunities**: Non-traditional cost-saving strategies that transitioning states could consider to close some financial gaps in an MLTSS model might include:
  - Requiring MCPs to publicly identify the top drivers of medical spend for MLTSS members and demonstrate how greater integration and coordination between clinical and non-clinical staff and partners reduced those medical costs.

- Providing explicit guidance on the type and number of activities MCPs can count as "quality improvement projects" for medical loss ratio calculations.
- Providing guidance around when it is appropriate to proactively "convert" an enrollee in an aged/blind/disabled (ABD) aid code to an MLTSS rate cell, which comes with a higher capitation rate.
- Controlling the growth of MLTSS capitation rates by implementing incentives or penalties for MCPs that stay under or exceed reasonable growth thresholds. **Arizona** has a projected capitation rate growth of three percent for MLTSS and monitors year-over-year changes in capitation rates.

Medicaid Agency Concern #2: New MCP MLTSS provider networks may exacerbate existing access issues due to the critical shortage of DCWs that provide HCBS.

A few ways states have mitigated this concern:

- **Leverage MCP partnerships to address low wages through workforce data collection efforts**: Low wages are a critical challenge in recruiting and retaining DCWs. The median hourly wage for home health and personal care attendants in the U.S. is $12.98 or $18,100 annually, while average U.S. annual expenditures are $77,280 per person. Many states, including **New York**, have state laws requiring wage increases, sometimes annually, for some — but not all — types of DCWs. Yet, without meaningful workforce data collection infrastructure that can track the true cost of actual care, increasing DCW pay to a living wage can prove difficult. A recent report from the National MLTSS Health Plan Association highlights some ways plans support the development of that data infrastructure. Elevance Health, an MLTSS plan, partnered with the University of **Minnesota** to develop a Direct Support Workforce Solutions Portal that collects and reports on DCW workforce demographics, tenure and vacancy, wages and overtime, and benefits and utilization rates.

  Limitation: A meaningful increase in wages for DCWs without sustainable funding can have significant impacts on a state's Medicaid budget and on independent or small business-run home care agencies that do not receive significant Medicaid funding. State minimum wage laws can also have the unintended consequence of putting an HCBS waiver program over federal cost neutrality limits if adequate preparation and funding is not provided.

- **Contractual development strategies**: Some MLTSS states, such as **Arizona** and **Indiana**, required that plans outline HCBS workforce monitoring and development strategies in their recent MLTSS request for proposal responses and include these strategies in their contracts. Some of those strategies included clear career pathways for current HCBS providers, funding for recruiting and training new providers, dedicated MCP support pathways for current providers, and more. **Indiana's** MLTSS contract also requires plans to participate in the NCI-AD State of the Workforce survey, should the state conduct it.

  Arizona and Indiana required that plans outline workforce monitoring and development strategies in their MLTSS proposals and include these strategies in their contracts.

- **Flexible funding models and innovative training programs**: MCPs are often knowledgeable about how to implement alternative funding arrangements, such as value-based payments, and may have the resources to support training models that could impact the DCW shortage. Molina Healthcare, an MLTSS

plan, offers HCBS providers value-based payment and incentives to recruit, train, and retain DCWs. In 2023, the University of Pittsburgh Medical Center, another MLTSS plan, launched a certified nursing assistant apprenticeship program among 14 skilled nursing and rehabilitation centers in partnership with the **Pennsylvania** Department of Education. **Wisconsin's** WisCaregiver Careers program offers training for certified nursing assistants and is partly funded by Civil Monetary Penalty funds.

- **Use MCP provider networks to share resources for DCWs who are legal immigrants**: One in four DCWs is estimated to have been born outside the U.S., and those working in HCBS settings are more likely to be noncitizens than those in institutional settings. In **California**, 47 percent of DCWs are immigrants. According to the National MLTSS Association, "MCPs can play a role in facilitating connections between their provider networks and existing immigration resources." Inclusa, an MLTSS plan, partnered with International Manpower to provide webinars across the plan's provider network to connect medical providers with its HCBS immigrant worker program. In part due to these efforts, 42 health care providers submitted work orders for about 1,500 DCWs.

  Limitation: The ability of state Medicaid leaders, MCP partners, and other stakeholders to proceed with supports for DCWs who are legal immigrants (e.g., green card holders), is challenging at this time, given the policy climate around immigration.

Novel approaches transitioning states might consider:

- **Support MLTSS training**: Transitioning states could partner across sister agencies, organized labor, HCBS users, and other stakeholders to develop and offer a training module specifically on MLTSS for DCWs before any MLTSS transitions occur. This would help to build a prepared and informed workforce and address questions that DCWs may have about the transition.

> ***Transitioning states could partner across sister agencies, organized labor, HCBS users, and other stakeholders to develop and offer a training module on MLTSS for DCWs before any additional MLTSS transitions occur.***

- **Define DCW core competencies**: With input from stakeholders, the state or MCPs could define a universal set of core competencies for all DCWs — regardless of the provider type or care setting — to make it easier for DCWs to work across various LTSS or settings.
- **Develop a "solutions table"**: Transitioning states could create a state-led solutions table that outlines potential DCW stabilization and growth efforts in the state and list key criteria for evaluating each solution — like cost, effectiveness, feasibility, and limitations.
- **Expand the DCW pipeline**: While the labor force participation rate for Americans with disabilities has increased since 2019, it remains lower (24%) than the rate for Americans without disabilities (68%). State Medicaid agencies need workers and many people with disabilities need work. A state's Department of Rehabilitation could consider a partnership initiative with its sister departments and agencies to encourage qualified residents with disabilities who would like to enter the workforce to consider DCW jobs. It could also outline clear training and retention pathways for these individuals.
- **Define DCWs as "essential workers"**: Transitioning states could work to define DCWs as "essential workers" to afford labor and other protections granted to essential workers and prevent disruption of home-based care during times of national or state crises.

Managed Care Plan Concern

MCP Concern: Some MCPs may receive a disproportionate share of high-acuity/high-cost MLTSS members, which would increase their overall risk exposure.

In MLTSS models, states pay MCPs a fixed, monthly capitation (per person) rate, and in exchange, the MCP provides LTSS to Medicaid members. The plans assume the risk for the cost of covered services, incurring financial losses if the cost of LTSS exceeds the monthly payments or retaining profit if the cost of LTSS is less than the total payments. In MLTSS models, MCPs may be exposed to financially unsustainable risks, such as the losses noted above, particularly during times like now, when most plans are in a downward cycle with greater rate pressure and tighter margins. Some common MLTSS design elements built into state contracts help mitigate these risks:

A few ways states have mitigated this concern:

- **Risk adjustment**: States can adjust capitation rates based on the risk (predicted needs and costs) of each MCP's member population. This can be done only for certain populations or geographic areas based on what factors impact cost the most within their state. This helps plans control for high-cost members without the need to increase payment rates across the board. CMS requires that these adjusted rates be budget-neutral to the state. As previously noted, some states, like **New York** and **Wisconsin**, use functionally based risk assessments when calculating rates for MLTSS plans, as traditional assessments based on health status and service use alone do not capture the whole picture of members with non-medical LTSS needs.

  Limitation: Risk adjustments are only as accurate as the data used to calculate them, and functionally based risk assessment data may be incomplete or inaccurate. Functionally based assessments also do not account for unforeseen or low-probability events that may result in higher-than-expected costs, or for people with lower assessment scores who use a high number of services. Plans could intentionally overcalculate a member's risk to receive higher payments, resulting in unnecessary state spending.

- **Risk sharing**: Many MLTSS states incorporate risk-sharing policies into contracts with MCPs to protect the MCP from excessive underpayment based on the acuity of the plan's population mix. These policies set upper and lower thresholds for MCP savings and losses and require that MCPs pay the state if their costs are lower than anticipated, in exchange for assurance that the state will pay MCPs if their costs are higher than anticipated. Some states, like **Kansas**, offered risk sharing in the first few years of MLTSS implementation and eliminated it once the program was stabilized. One form of risk sharing used in the federal Financial Alignment Initiative was called a "risk corridor" and it allowed the state, CMS, and the MCP (to a defined extent) to share in the costs but also in the savings from the program beyond a certain threshold.

  > ***Some states, like Kansas, offered risk sharing in the first few years of MLTSS implementation and eliminated it once the program was stabilized.***

  Limitation: Plans could deny coverage of certain services or cherry-pick members with lower acuity or anticipated risk to keep costs below the threshold and receive incentive payments, resulting in unnecessary state spending and poorer service delivery for members.

- **Reinsurance and Risk Pools**: Some MLTSS states withhold a certain portion of capitation payments to MCPs in exchange for providing reinsurance protection, meaning the state will reimburse the MCPs for any costs that exceed a predefined amount. For example, **New York** has a stop loss program for its Medicaid MCP's nursing home expenditures. Risk pools are a type of reinsurance in which states withhold a portion of capitation payments from all the MLTSS plans and pool the funds for select groups of high-risk members. The funds are then used to reimburse the plans for costs for these members that exceed a predefined amount. Risk pools can be especially useful during the initial transition to MLTSS. For example, **New Mexico** used risk pools to retroactively adjust mix percentages for the initial transition period to managed care when mix percentages were unpredictable for plans. **New York's** high-cost, high-need risk pool is a two percent withhold for all MLTSS plans that is distributed to the plans that have a disproportionate share of high-need MLTSS members at the end of the rating period.

  Limitation: Medicaid reimbursement rates can already be lower than desired by many plans, so they may not want to see a portion of their rates withheld for reinsurance protection. State Medicaid budgets are also limited, so plans are still at risk for unexpected costs that exceed what the state can reimburse.

Novel approaches transitioning states might consider:

- **Institute a universal HCBS assessment**: Transitioning states could use the MLTSS transition to achieve a universal HCBS assessment instrument so that risk mitigation mechanisms, such as functionally based risk adjustment, can be implemented.

> ***States could use the MLTSS transition to achieve a universal HCBS assessment tool so that risk mitigation mechanisms, such as functionally based risk adjustment, can be implemented.***

- **Informal brainstorming opportunities**: Transitioning states could provide safe spaces where MCPs can have non-regulatory and non-contract monitoring conversations with the state about the challenges they experience, providing an opportunity to problem-solve with the state and MCP peers.

Looking Ahead

As Medicaid agencies plan for or implement the transition of FFS HCBS to MLTSS, these considerations can help policymakers, state agency leaders, and stakeholders identify opportunities to design the program and its related regulations, statutes, and contracts in a way that proactively address common stakeholders' key concerns and ensure a system that best serves Medicaid members who use HCBS.

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