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The Emerging Role of Managed Care in Long-Term Services and Supports

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Received: February 13, 2018; Editorial Decision Date: April 17, 2018

Decision Editor: Brian Kaskie, PhD

Keywords: Medicaid, Managed long-term services and supports, Dually-eligible individuals

Introduction

Long-term services and supports (LTSS) help individuals with functional limitations—both older adults and people with disabilities—to meet their personal care needs, live in their own homes, participate in their communities, and have a better quality of life. In 2015, more than 9 million Americans aged 65 and older reported having functional limitations (National Center for Health Statistics). The number of people needing LTSS will almost certainly increase as the population above the age of 65 grows to a projected 84 million nationwide by 2050 (Ortman, Velkoff, & Hogan, 2014).

Although many of these individuals receive informal help from unpaid family members or friends, the majority of paid LTSS is publicly financed, mostly by the Medicaid program. In 2015, Medicaid paid for 48% of the \$331 billion spent on LTSS in the United States (Eiken, Sredl, Burwell, & Woodward, 2017). More than 5 million people, 44% of whom are age 65 or older, currently receive LTSS through state Medicaid programs (Eiken, 2017).

Historically, LTSS systems were designed to predominantly deliver LTSS in institutional settings, but as the number of beneficiaries needing LTSS grows, more attention is being given to opportunities to rebalance Medicaid LTSS toward less-restrictive, lower-cost, community-based care. This focus on rebalancing, along with the challenges inherent in a fragmented system of physical, behavioral, and LTSS care delivery, has led an increasing number of state Medicaid agencies to examine ways to better manage LTSS service

delivery, often through managed care arrangements. In addition to a desire for budget predictability and an interest in potential costs savings that could accrue from rebalancing efforts, states may see managed care as offering several advantages over a fee-for-service delivery system, including (1) improved care management and care coordination; (2) greater accountability for outcomes; and (3) the potential for more systematic measurement and monitoring of performance, access, and quality. Currently, 20 states, most of which have had significant experience with managed care contracting for other aspects of their Medicaid programs, contract with managed care plans to deliver LTSS services (Lewis, Eiken, Amos, & Saucier, 2018; Figure 1). No clear patterns are apparent in the types of states adopting managed long-term services and supports (MLTSS) (e.g., income levels, geography, etc.). These MLTSS programs enroll roughly 1 million people, including older adults, younger people with disabilities, and individuals with intellectual or developmental disabilities (Centers for Medicare & Medicaid Services, 2016).

This article describes states' goals and experiences in implementing Medicaid MLTSS, as well as considerations for further development and evaluation of these programs. It also discusses related efforts to use MLTSS programs as a platform to better integrate and coordinate care for those who are dually eligible for Medicare and Medicaid. Finally, we present some possible future directions for MLTSS program refinement, based on early trends across states.

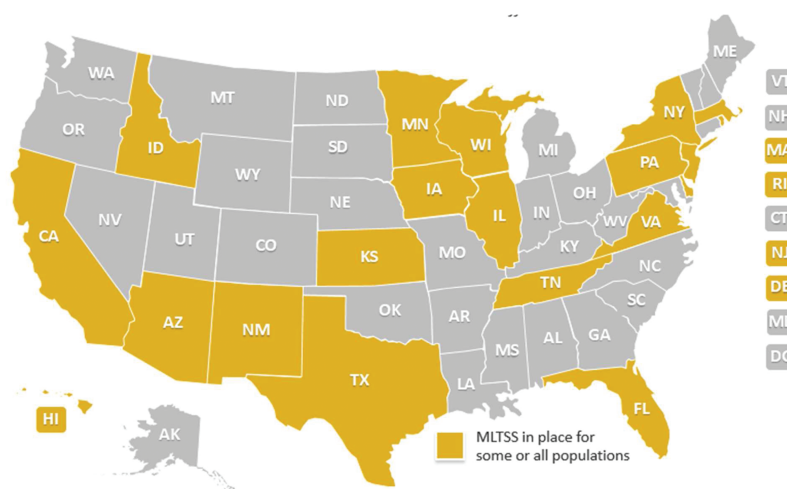


Figure 1. States with MLTSS programs, 2017. Source: [National Association of States United for Aging and Disabilities, 2017](#).

States' Goals for Medicaid MLTSS Programs

States have a variety of goals for their Medicaid MLTSS programs, including (1) rebalancing state spending on LTSS away from higher-cost nursing facility care; (2) increasing access to home- and community-based services (HCBS); (3) improving beneficiary experiences and quality of life; and (4) improving budget predictability and, potentially, better managing costs (Gibbs, Smith, Dobson, & Mosey, 2017). These goals are aligned with those articulated in the Triple Aim: improving the patient experience of care, improving population health, and reducing health care costs (Berwick, Nolan, & Whittington, 2008). They also align with personal preferences, as the majority of people in need of LTSS want to live in their own homes and communities. States' goals for their MLTSS programs are often interconnected. For example, rebalancing LTSS spending toward HCBS and serving more people in the community can improve beneficiary experiences; increase access to community-based care; and shift financial risk, potentially even lowering or controlling costs for these states. While moving to MLTSS may help some states to reduce Medicaid agency staffs' burden in overseeing fee-for-service LTSS, being an effective purchaser of managed care services requires strong performance monitoring and state oversight of MLTSS contacts. Although many states' MLTSS programs are relatively new and outcomes data are limited, there is some

evidence that these programs are making progress toward their goals and that potential benefits of MLTSS are being realized. Following are more detailed descriptions of states' MLTSS program goals and examples of progress to date.

Rebalancing Medicaid LTSS Spending

A common goal of state MLTSS programs is to create incentives for rebalancing spending toward home- and community-based care, while providing more options for people who wish to remain in their homes and receive LTSS in the community. Many states have specific rebalancing targets and insert financial incentives into their contracts to encourage MLTSS plans to work toward HCBS. In Florida, if an MLTSS enrollee is in a nursing facility but transitions to the community at some point during the contract year, her or his plan is paid at a higher nursing facility rate for the full year; conversely, if the enrollee is living in the community, but transitions to institutional care, the plan is paid at the lower community rate for the full year (Kidder, 2017a). This creates strong incentives to support LTSS enrollees in community settings.

Increasing the proportion of individuals in community settings is a goal for states both with and without MLTSS. Mississippi, which does not have MLTSS, increased the HCBS portion of its LTSS spending by 6% between 2011 and 2014 (Reinhard et al., 2017). However, state investments in MLTSS can contribute to rebalancing success. Arizona has had MLTSS since 1989, and 70% of its LTSS spending is for HCBS, one of the highest proportions nationally (Eiken, 2017). Since Florida's statewide MLTSS program was implemented in 2013, 12% fewer Medicaid enrollees receive care in nursing facilities, and the state has seen Medicaid cost savings related to these rebalancing efforts (Kidder, 2017b).

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It should be noted that MLTSS is just one of a number of options that states have to promote rebalancing. States have used and continue to use other tools, such as the Money Follows the Person rebalancing demonstration grants, the Balancing Incentive Program, Section 1915(c) home- and community-based waiver authority, and HCBS state plan options that can be tailored to expand community-based options, all of which may be implemented through or alongside an MLTSS program (Barth, Klebonis, & Archibald, 2011).

Increasing Access to Home- and Community-Based Services

States must provide institutional care to Medicaid beneficiaries who need that level of service, but coverage for HCBS is optional. Nonetheless, most states choose to provide HCBS through either their Medicaid state plans or Section 1915 waiver programs. However, there is often a greater demand for HCBS than there are existing 1915c waiver slots, and many states have waiting lists for services. In 2015, over 600,000 individuals were on HCBS waiver waiting lists in 35 states (Ng, Harrington, Musumeci, & Ubri, 2016). MLTSS programs typically require plans to cover both institutional LTSS and community-based HCBS, which may help reduce or eliminate waiting lists. In parallel with its launch of an MLTSS program, Tennessee created an additional eligibility group of individuals considered at risk of needing nursing home care if they did not receive HCBS. This additional group of lower-acuity LTSS eligible individuals could access a more limited array of HCBS, which helped eliminate HCBS waiting lists for MLTSS enrollees who met nursing home levels of care (Killingsworth, 2015).

Some states are increasing HCBS access by expanding the array of services available under their MLTSS programs. In Tennessee, MLTSS plans can provide “Cost-Effective Alternative” services (e.g., nursing facility transition allowances, adult day services, and nutrition programs) if they are less expensive than another Medicaid service and can possibly prevent the need for more costly care in the future (Tennessee Division of TennCare, Health Care Finance & Administration, 2014).

Improving Beneficiary Experience of Care and Quality of Life

States typically operate MLTSS programs in parallel with managed care programs for Medicaid acute care services, and align an individual’s enrollment in acute care and MLTSS plans operated by the same organization. Having one entity responsible for the full array of Medicaid services may provide a more seamless experience for enrollees and make it easier to coordinate their care. Through care coordination requirements and access to an enhanced array of services, MLTSS plans can help enrollees to bridge gaps in care that Medicaid beneficiaries in fee-for-service delivery systems would typically have to navigate on their

own. In addition, by assessing enrollees’ individual needs, developing a service plan to meet the individual’s goals, improving connections to the community, and supporting family caregivers, these programs may help enrollees feel more engaged and empowered.

As with other potential outcomes, improved experience of care and quality of life may be affected by factors other than enrollees’ participation in MLTSS. However, states are developing surveys to assess enrollee experiences, and some have made progress in this area. Florida found that 76% of respondents to its survey of MLTSS enrollees reported an improved quality of life after joining a plan (Kidder, 2017b). In Texas, MLTSS enrollees reported that receiving HCBS gave them a sense of independence that was important for their quality of life (Institute for Child Health Policy, University of Florida, 2013).

Providing Budget Predictability and Potentially Better Managing Costs

MLTSS programs can improve budget predictability for states, simply because plans are paid a monthly capitation rate for a defined population and all covered services. MLTSS programs also have the potential to achieve savings by (1) creating incentives to rebalance LTSS spending to provide more HCBS; (2) managing service utilization; and (3) using care coordination to avoid unnecessary inpatient hospital stays or institutional placements. A recent assessment of Massachusetts’ MLTSS program found that enrollees had a 16% lower risk of long-stay nursing facility admission and a 23% lower risk of nursing facility entry at the end of life compared to a control group of Medicaid beneficiaries receiving LTSS through the fee-for-service system (Health Management Associates, 2015). Similarly, an evaluation of the Minnesota Senior Health Options program found that enrollees were 48% less likely to have a hospital stay and 6% less likely to have an outpatient emergency department visit than a comparable population of non-enrollees (Anderson, Feng, & Long, 2016).

Lessons and Potential Concerns about MLTSS

As states have moved from providing Medicaid LTSS on a fee-for-service basis to relying on MLTSS programs, they have been cognizant of the impact that this shift might have on beneficiaries and providers. States know that stakeholder engagement of beneficiaries and providers during both the design and implementation phases supports MLTSS programs’ success. In terms of provider engagement goals, states have focused on first helping both nursing facilities and HCBS providers to understand potential MLTSS program benefits and on gathering their input on system design. These states then create opportunities for these providers to interact with managed care plans prior to program launch.

However, beyond the need to gain support of individual LTSS providers, there also are more overarching, structural concerns about MLTSS programs

- **Provider Networks and Continuity of Care**
- In many states, enrollment in MLTSS programs is mandatory for beneficiaries who need LTSS. Policymakers and beneficiary advocates have expressed reservations about the ability of MLTSS plans to create provider networks with sufficient depth and breadth for enrollees with complex care needs. They have similar concerns about MLTSS plans' willingness to incorporate strong continuity of care provisions to help newly-enrolling beneficiaries maintain long-standing relationships with their providers ([National Senior Citizens Law Center, 2012](#)). In response, it is common for states and plans to establish continuity of care requirements for new enrollees so that they may continue to see their providers for a defined period of time, whether or not they stay in the network.
- **Assessed Level of Need**
- Other concerns relate to potential conflicts of interest when MLTSS plans are responsible for assessing an individual's level of service needs and also are at financial risk for providing those services. Beneficiary advocates have reported reductions in service hours after enrollment in MLTSS plans. In response, states and MLTSS plans argue that the use of plans' standardized assessment tools have the potential to allocate resources more equitably and more appropriately between medical care and LTSS, so that more beneficiaries are able to access LTSS ([Lefler, 2013](#)).
- **Program Oversight**
- A recent Government Accountability Office (GAO) study called for better oversight of MLTSS programs by both the Centers for Medicare & Medicaid Services (CMS) and states. The GAO expressed concerns that inadequate oversight prevents CMS and states from knowing whether MLTSS programs are achieving their goals (e.g., rebalancing LTSS, improving quality of life, etc.). In addition, a lack of oversight means that CMS cannot guarantee that MLTSS program rates are appropriate and adequate, which may have implications for quality and access. The GAO concluded that states need to make better use of available information (e.g., data from external quality reviews; beneficiary surveys, grievances, and appeals; and input from stakeholder meetings). In addition, the report recommended that CMS take steps to identify and obtain data to oversee key aspects of states' MLTSS programs ([U.S. Government Accountability Office, 2017](#)). States are aware of these concerns and, as mentioned above, recognize that moving to MLTSS requires them to step up their contracting and performance monitoring capacities.

Using MLTSS Programs to Integrate Care for Dually Eligible Populations

In addition to the goals described above, MLTSS programs also offer the potential to better integrate care for

the 11 million Americans dually eligible for Medicare and Medicaid, approximately 60% of whom are aged 65 or over ([Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission, 2018](#)). Broadly speaking, Medicare covers primary and acute care services (including hospital and post-acute care) and prescription drugs for this population, while Medicaid covers LTSS, Medicare cost-sharing, and most behavioral health services. Because dually-eligible beneficiaries receive services from two programs that were not designed to work together, their care is often fragmented and uncoordinated, leading to reduced access to care, poor care quality, and higher costs ([Medicare Payment Advisory Commission, 2011](#)).

The need to better integrate Medicare and Medicaid (i.e., blend the programs' different care management and administrative processes and policies into unified program elements) or, at a more basic level, to better align them (i.e., make processes and policies work together more seamlessly) has been long recognized, but has been difficult for states until recent opportunities authorized under the Affordable Care Act. Earlier efforts, such as the Program of All-Inclusive Care for the Elderly (PACE), completely integrated Medicare and Medicaid benefits and financing, but PACE enrollment was only at about 40,000 after decades of operation, likely reflecting inherent limitations for the spread of the model ([Gross, Temkin-Greener, Kinitz, & Mukamel, 2004](#)). The ongoing demonstrations under the Financial Alignment Initiative also offer the opportunity for significant integration, but final evaluation results are some time away ([Bipartisan Policy Center, 2017](#)).

In recent years, MLTSS programs have emerged as a potential platform to advance integration between these programs. Just as MLTSS plans can be made to align with Medicaid acute-care managed-care plans, they can also be aligned with a type of Medicare Advantage plan called a Dual Eligible Special Needs Plan (D-SNP). These plans, which enroll only dually-eligible individuals, are required to provide a coordinated Medicare and Medicaid benefit package that has the potential to offer more integrated care than regular Medicare Advantage plans or traditional Medicare fee-for-service.

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States can strategically contract with managed care organizations as one option to promote integration and alignment of dually-eligible beneficiaries' Medicare and Medicaid services. In their contracts, states can require D-SNPs to cover a variety of Medicaid services, including LTSS. To achieve an even higher level of integration, states

can require D-SNPs to request designation from CMS as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). Driven by an individual state's integration policy, these plans can offer a full array of Medicare, Medicaid, and supplemental benefits within a single benefit package and one network of providers. The FIDE SNP model allows states to achieve a high degree of alignment between D-SNPs and their MLTSS plans. States can also promote further development of provider-led models of integration, like the PACE program or emerging Medicaid accountable care organization models.

Future Direction of MLTSS Programs

Examining states with well-established MLTSS programs allows a glimpse of the possible future direction of MLTSS activities. Trends in MLTSS are outlined in this section.

- **Expanding Enrollment in Aligned MLTSS Plans and D-SNPs**
- In addition to the contracting strategies described above, states are looking for opportunities to actively encourage enrollment in aligned D-SNPs and Medicaid MLTSS plans. Some states, such as Massachusetts and New Mexico, send letters to beneficiaries describing the benefits of enrolling in aligned plans. Other states, such as Arizona and Tennessee, have encouraged their D-SNPs to request permission from CMS to automatically enroll dually-eligible beneficiaries who are currently in their companion MLTSS plan into the D-SNP when those individuals become eligible for Medicare.
- **Improving Access to Housing and Addressing Social Determinants of Health**
- Addressing social determinants of health, including supportive housing needs, is critical for helping to transition individuals from institutional to community settings and for safely maintaining them in the community. Other important social services include transportation, food and nutrition services, and energy assistance. States, including Arizona, Tennessee, and Texas, are using their MLTSS programs to (1) create new partnerships between their Medicaid agencies and state housing and disability agencies to increase housing options for people using LTSS; (2) dedicate Medicaid resources to establish strong housing and MLTSS program linkages and require plans to do the same; and (3) develop new or expanded supportive housing services to address the unique needs of LTSS subpopulations.
- **Enhancing Program Capacity through Workforce Development**
- A well-trained, motivated workforce is key to providing high-quality LTSS delivery and enhancing beneficiaries' experiences. MLTSS programs may not be able to meet the needs of the growing population requiring LTSS unless they can expand the capacity of their workforce. New Jersey is examining ways to expand the scope of practice for LTSS providers, including nursing staff and other direct support professionals. Tennessee created a comprehensive LTSS workforce development strategy that includes credentials for direct support professionals who complete the state's training curriculum; college credits that can be used toward certificates and/or degrees; and mentoring, coaching, and career-planning opportunities.
- **Incorporating Value-Based Payment**
- States are beginning to explore value-based payment (VBP) arrangements in MLTSS programs, which link payment to the value of the services provided rather than the volume. In most states, emerging VBP strategies focus on primary and acute care services. States want their MLTSS plans to engage LTSS providers in VBP arrangements, but states have varying levels of capacity to influence uptake of VBP. Minnesota, an early innovator in MLTSS, has encouraged VBP arrangements in projects between its MLTSS plans and providers since 2013, and the state is compiling lessons from this work that can inform the efforts of other states (Minnesota Department of Human Services).
- **Advancing Rate Setting**
- States use capitation rate-setting methods for their MLTSS programs that address the diverse needs of the populations served and establish incentives to promote higher-quality services and more cost-effective care. As they become more sophisticated in their rate-setting approaches, states are focusing on collecting more accurate and complete claims data from plans and using that information to establish the appropriate numbers and types of rate cells/categories for the population groups enrolled. States also want to use data on enrollees' functional status to risk-adjust capitation rates, which requires reliable, unbiased data and an ability to predict the aspects of functional status that most drive costs.

Summary

An increasing need for LTSS and rising costs have prompted a growing number of states to provide Medicaid LTSS under capitated managed care contracts. These arrangements offer the potential to (1) rebalance state spending on LTSS; (2) increase access to HCBS; (3) improve beneficiaries' experiences and quality of life; and (4) provide budget predictability and, potentially, lower costs. MLTSS may also provide a platform for greater integration of care for dually-eligible beneficiaries. Although MLTSS offers many potential benefits, it also raises significant responsibilities for beneficiary protection and requires states to build their capacity to oversee these programs. As state Medicaid agencies become increasingly sophisticated in the design, implementation, and management of their MLTSS programs, they will become more able to garner greater value from this approach to organizing and delivering needed care to their most vulnerable beneficiaries.

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