



# DEMONSTRATING THE VALUE OF MEDICAID MLTSS PROGRAMS



**MLTSS  
INSTITUTE**

**Where Policy and  
Practice Meet**



**CHCS** Center for  
Health Care Strategies, Inc.

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The NASUAD **MLTSS Institute** was established in 2016 in order to drive improvements in key 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.

The **National Association of States United for Aging and Disabilities (NASUAD)** 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 home and community based services for older adults and individuals with disabilities.

The **Center for Health Care Strategies (CHCS)** is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve beneficiaries of publicly financed care, especially those with complex, high-cost needs.

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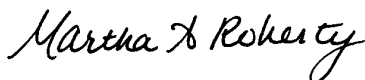
## THE MLTSS INSTITUTE

Managed long-term services and supports (MLTSS) is a growing trend across the country. States seeking to modernize and improve their long-term services and supports systems continue to turn to 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. NASUAD has been deeply engaged in providing technical expertise and assistance to our member states as they plan, design, implement, and evaluate their MLTSS programs. In fact, NASUAD is uniquely positioned to assist our members because we can:

- Arrange and facilitate peer-to-peer information exchange and mentoring relationships among the states using existing infrastructure and practices;
- Readily reach key, high-level state MLTSS decision-makers and serve as a trusted and secure medium for vetting challenges and preliminary, innovative MLTSS concepts; and
- Deliver solid, reliable technical assistance tailored to state officials and their key staff.

However, our Board of Directors recognized that staff capacity to provide technical assistance was outstripping the states' demand for it. This recognition led to the creation of the MLTSS Institute in 2016. The MLTSS Institute is intended to drive improvements in key MLTSS policy issues, 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. Creating opportunities for thoughtful policy development, meaningful state interaction, and more effective use of limited state resources is critical to the maturation and success of MLTSS programs.

I am 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-managed and high quality MLTSS programs benefit us all, and are willing to invest their time and resources to that end.



**Martha Roherty, Executive Director**  
NASUAD

## EXECUTIVE SUMMARY

States are increasingly implementing comprehensive Medicaid managed long-term services and supports (MLTSS) programs, but there is limited evidence of their value. To help fill this gap, this report presents results of a survey of states with MLTSS programs. The twelve states responding to the survey—Arizona, Florida, Iowa, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, and Virginia—account for more than half of the states 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—

- **Rebalancing Medicaid LTSS Spending.** A key goal for all states was 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. Many states have specific rebalancing targets, as well as financial incentives for MLTSS plans to meet them. Eight states reported that they were making progress toward their rebalancing goals, which aligns with national trends in MLTSS rebalancing.
- **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. Nine states said that they collect data on quality of life, and 10 states collect data on consumer and family satisfaction. Among states reporting outcomes, MLTSS consumers had improved quality of life and high levels of satisfaction. One challenge highlighted by states was that 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. Six 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. Five states identified Medicaid cost containment as a goal and seven states identified budget predictability as a goal. While states report they are “bending the cost curve,” inadequate data are a barrier to states' ability to demonstrate these outcomes.

This survey provided compelling examples demonstrating that states are meeting their MLTSS program goals, but it 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.

## INTRODUCTION

Since the 1970's, state Medicaid agencies have contracted with managed care organizations (MCOs) to coordinate and manage care for Medicaid consumers. Managed care is a delivery system whereby the state Medicaid agency contracts with an MCO to provide Medicaid benefits to consumers. States pay each MCO a fixed—also known as capitated—per-member, per-month 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 get any more funds from the state. Similarly, if the MCO keeps consumers healthy and manages service utilization appropriately, it may keep some or all savings from the amount paid by the state.

More recently, however, 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 include a broad array of medical and social services that aid older adults and individuals with chronic illnesses and significant disabilities to perform 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 are increasingly implementing comprehensive Medicaid managed long-term services and supports (MLTSS) programs in order 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, to date, few studies on the value of MLTSS programs have been conducted. Additionally, states are mindful of the fact that they will need to carefully monitor the quality of the care provided by the MCOs to these vulnerable consumers. This report aims to partially fill the gap in evidence, as well as highlight promising practices and insights from leading states in the hope of spurring further interest and additional research on MLTSS and its attendant opportunities and risks.

## METHODOLOGY

NASUAD partnered with the Center for Health Care Strategies to research and write this report. Its conclusions are based on a NASUAD survey of states with MLTSS programs, the purpose of which was to elicit state perspectives on MLTSS; identify promising practices and innovative initiatives; and gather examples for states that are in the process of developing, or thinking of implementing an MLTSS program. The states surveyed include both those with long-standing MLTSS programs and those with new programs. The survey was sent to the following 19 states:

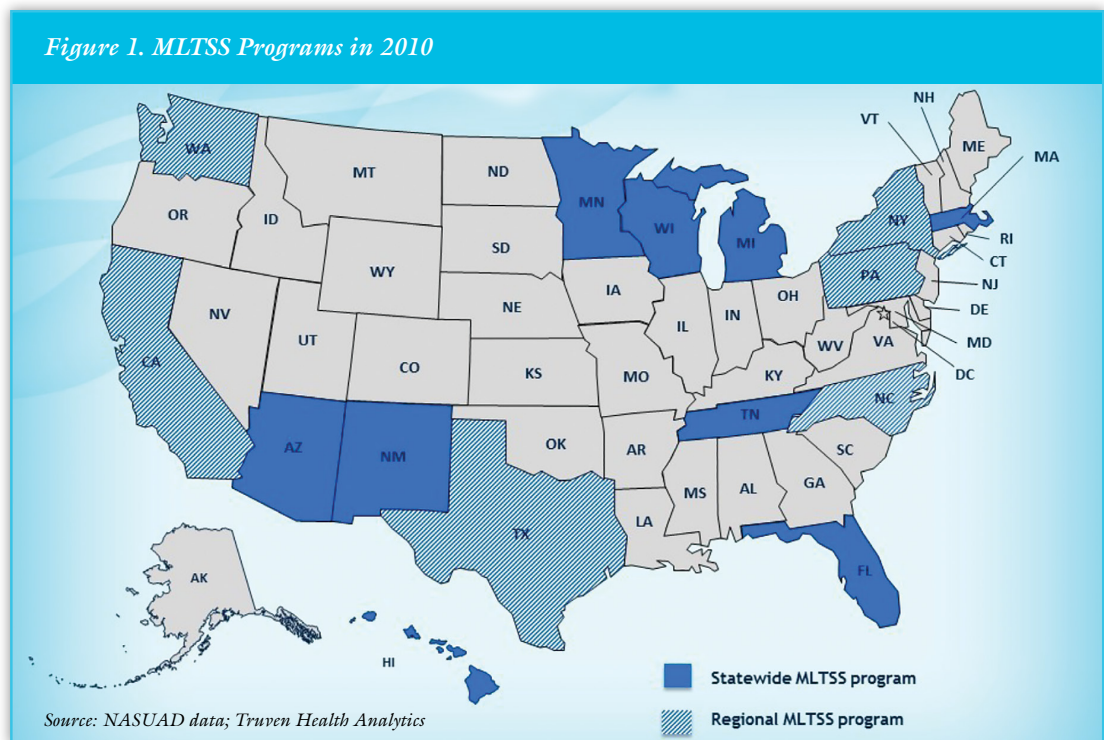
- Arizona
- California
- Delaware
- Florida
- Iowa
- Kansas
- Massachusetts
- Michigan
- Minnesota
- New Jersey
- New Mexico
- New York
- Ohio
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Virginia
- Wisconsin

The survey was fielded from December 22, 2016 through January 31, 2017, after which NASUAD sought clarification and further detail from some states. The survey consisted of 37 questions and touched upon a variety of different MLTSS policy areas. NASUAD obtained responses from 12 states (Arizona, Florida, Iowa, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, and Virginia), which account for more than half of the states operating MLTSS programs. Additional information from published literature and other reports was used to frame and supplement the states' responses.

## TRENDS IN MLTSS PROGRAMS

### Growth in MLTSS Programs over Time

In 1989, Arizona was the first state to have a Section 1115 waiver approved by the Centers for Medicare & Medicaid Services (CMS) to implement MLTSS.<sup>1</sup> Over the next 15 years, MLTSS program development was spotty. However, between 2004 and 2010, the number of MLTSS programs increased from eight to 15 (see Figure 1).

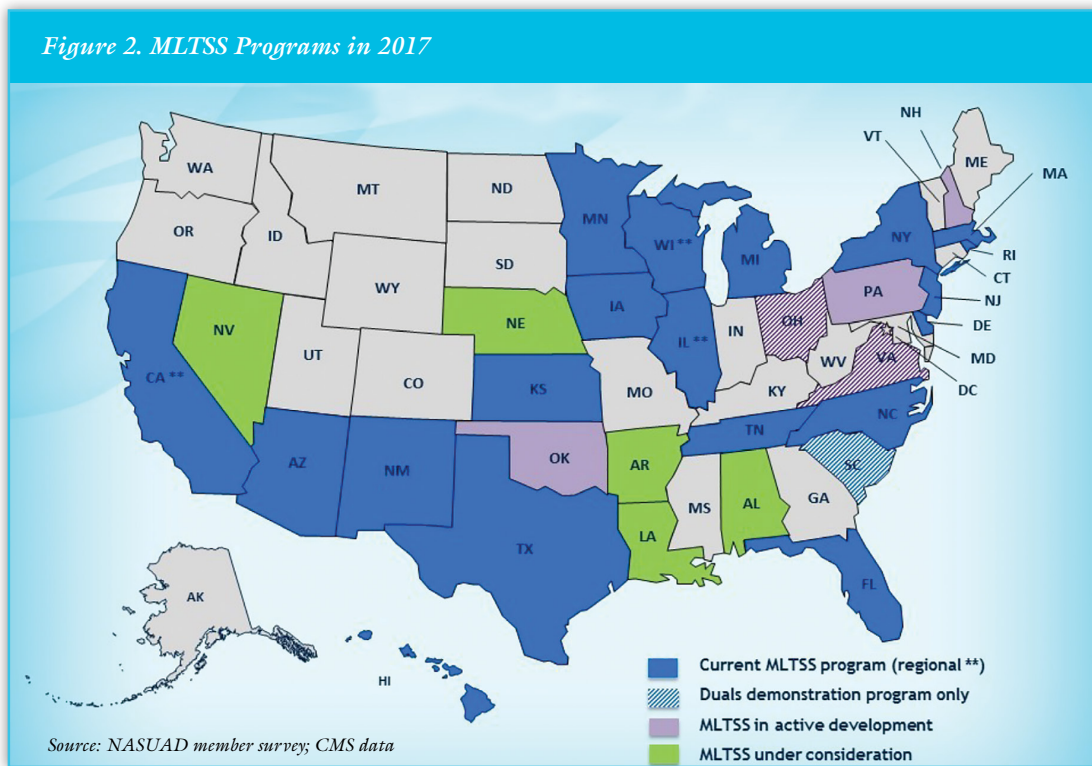


Today, there are 19 states operating MLTSS programs (see Figure 2). Another three states operate MLTSS only within the confines of a Financial Alignment Initiative demonstration, which coordinates care and aligns benefits for individuals eligible for both Medicare and Medicaid (known as dually eligible beneficiaries).<sup>2</sup> Five states (New Hampshire, Ohio, Oklahoma, Pennsylvania and Virginia) were developing new or significantly modifying existing MLTSS programs in early 2017, and five more are exploring the possibility of doing so. States have implemented MLTSS using various Medicaid waiver authorities, including: Section 1115, 1915(b), 1915(a), 1915(c), and 1932(a) waivers; Financial Alignment Initiative demonstrations; and other concurrent authorities.

Four of the five states with MLTSS program development underway intend to use a 1915(b)/(c) combination waiver for their MLTSS programs; Virginia is pursuing Section 1115 authority. North Carolina also has a pending Section 1115 waiver with CMS that will, if approved, alter its current limited MLTSS program and change its operating authority for MLTSS. For more information on states' MLTSS program waivers, see the Appendix.



Figure 2. MLTSS Programs in 2017



## Populations Included in MLTSS Programs

The most vulnerable populations are generally enrolled in MLTSS programs in order to provide the benefits of care coordination.<sup>3</sup> Older adults are the most commonly included population, followed by individuals with physical disabilities. Some states also enroll children with disabilities, dually eligible beneficiaries, individuals with traumatic brain injuries (TBI), and those with intellectual/developmental disabilities (I/DD). Individuals with I/DD have typically been the last population to be enrolled in MLTSS programs; as state agencies and MCOs gain further experience with effectively coordinating care and gaining stakeholder support, this trend is expected to continue. States are also increasingly including persons with behavioral health conditions into MLTSS programs, as they seek to better integrate physical and behavioral health services.

## Benefit Integration

States take different approaches to providing benefits under MLTSS programs. The most common approach is to provide a comprehensive benefits package to the populations enrolled. That type of benefits 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.

Other states provide only LTSS benefits in their MLTSS programs, which means that consumers get 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, 70 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).

Some states have used their Section 1115 demonstrations to provide limited HCBS benefits to consumers that otherwise would not be eligible for LTSS.

Michigan and North Carolina approach LTSS differently than most states, 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, as in the case of California’s Medicaid program Medi-Cal, where LTSS is integrated into MCOs in only seven counties. Furthermore, some states, including Delaware, Hawaii, Rhode Island, and Tennessee have used their Section 1115 demonstration authority to provide a more limited set of HCBS to individuals at risk of needing LTSS.<sup>4</sup>

### States’ MLTSS Goals

States responding to the survey had several goals in implementing their MLTSS programs (see Figure 3). They included 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
- Increasing budget predictability
- Improving consumer health and satisfaction
- Containing costs
- Reducing Medicaid HCBS waiver waiting lists

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. Improved health outcomes can then, in turn, reduce costs.

Each of these goals for states' MLTSS programs and their reported progress in meeting those goals is examined below. Challenges that states face regarding data collection to support these goals are also discussed. While many states reported examples of ongoing data collection, monitoring and evaluation in key program areas, a significant opportunity exists to improve information collected about MLTSS program outcomes. For example, 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 are challenged in this effort because they often have:

- limited systemic information to benchmark their fee-for-service LTSS programs;
- limited staff resources to collect and analyze data; and
- difficulty attributing program outcomes solely to the MLTSS program when it is part of comprehensive state Medicaid or integration efforts.

## Rebalancing Medicaid LTSS Spending

**Goals.** Rebalancing Medicaid LTSS spending toward home- and community-based care and providing more options for individuals to live in and receive services in the community—if that is consistent with an individual's goals and desires—is a key goal of MLTSS programs in all of the states responding to the survey.

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, it developed a method to adjust health plan payments annually to provide incentives for them to meet rebalancing targets.<sup>5,6</sup> 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 don't, they lose money.<sup>7</sup>

States expect that successfully rebalancing LTSS toward 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.<sup>8</sup> Rebalancing is also a key objective for TennCare CHOICES, which has goals of serving more people with its already existing LTSS funds, and creating a more sustainable program.<sup>9</sup> Lastly, Rhode Island's goal is to spend half of its Medicaid long-term care dollars on nursing facility care and half on HCBS. As of February 2017, Rhode Island is spending 79 percent of Medicaid dollars on institutional care.<sup>10,11</sup> The state plans to accomplish its rebalancing goals through several healthy aging initiatives, including building age-friendly communities, enhancing community living and respite supports, strengthening the Executive Office of Health and Human Services and Medicaid interventions, and creating value-based payment opportunities and system transformation through partnerships with industry.<sup>12</sup>

**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.<sup>13</sup> Nationally, the percentage of LTSS

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

—*Arizona survey respondent*

spending on HCBS increased each year since 1995.<sup>14</sup> Fiscal year 2013 was the first year that HCBS accounted for just over half of LTSS spending in the United States. Between 2013 and 2014, the percentage of Medicaid LTSS funds spent on HCBS increased from 51 percent to 53 percent.<sup>15</sup> Beginning in 2016, CMS required states to report the estimated percentage of MLTSS dollars spent on institutional care and HCBS,<sup>16</sup> so that specific MLTSS rebalancing expenditure data would become more readily available.

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. Tennessee began its MLTSS program, TennCare CHOICES, with only 17 percent of Medicaid consumers receiving services in community settings.<sup>17</sup> As of August 2015, fully 44 percent are living in community settings. Likewise, New Mexico by 2015 had reduced the percentage of Medicaid consumers residing in nursing facilities from nearly 19 percent to 14 percent.<sup>18</sup> Since its MLTSS program was implemented, Florida has had a 12 percent decrease in the number of Medicaid consumers receiving care in nursing facilities.<sup>19</sup>

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.<sup>20</sup> New Jersey reported that it analyzed enrollment and living arrangement data to monitor MCOs’ abilities to make appropriate nursing facility placements. As of December 2016, approximately two-thirds of the state’s MLTSS consumers were receiving HCBS services, and its nursing facility population had decreased by about 1,000 since program implementation in 2014.<sup>21</sup>

## 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, improving 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 other. The improvement of health outcomes may be more likely when a program includes all services—physical health, behavioral health, and LTSS—under one MCO. 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 with the MLTSS program as a whole often depends on the extent to which consumers feel that their managed care plans 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. 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, is an important tool to monitor program success.

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 in coordinating the full array of services offered through the program.

**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 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 where several Medicaid delivery system initiatives may have been implemented at the same time in a state. However, 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.<sup>22</sup> Florida reported that in a survey it developed for its MLTSS program enrollees, nearly 60 percent of respondents said their overall health improved since their enrollment. Other states measure outcomes using data on health care utilization and preventable high-cost events. Between 2013 and 2014, Texas saw modest decreases in potentially preventable hospital admissions and readmissions rates in its STAR+PLUS program.<sup>23</sup> The U.S. Department of Health and Human Services' Assistant Secretary for Planning and Evaluation released a study in March 2016 comparing the outcomes of consumers from 2010 to 2012 in the Minnesota Senior Health Options (MSHO) program with similar individuals outside of the program.<sup>24</sup> 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. Additionally, MSHO consumers were also 13 percent more likely to receive HCBS and were 6 percent less likely to have an outpatient emergency department visit—of those who did visit the outpatient emergency department, 38 percent had fewer subsequent visits. Through the Kansas KanCare program, primary care physician visits increased by 80 percent, “costly hospital stays” decreased by 29 percent, and emergency department use decreased by seven percent.<sup>25</sup> Non-emergency transportation use was also up 56 percent, an indication that KanCare consumers might have been attending more appointments with providers.<sup>26</sup>

“A successful MLTSS program will think about care planning beyond traditional support services.”

—Tennessee survey respondent

Eleven states (Arizona, Florida, Iowa, Kansas, Minnesota, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, and Virginia) use consumer and/or family surveys to collect information on consumer and family satisfaction with the MLTSS program. Nine of these states also collect information on the quality of life of consumers participating 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 Use to Collect Data on MLTSS Consumer Quality of Life and Satisfaction*

<i>State</i>	<i>Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey</i>	<i>National Core Indicators— Aging &amp; Disabilities (NCI-AD™)</i>	<i>State-Developed Tools</i>	<i>HCBS Experience of Care Survey*</i>
Arizona				✓
Florida			✓	
Iowa			✓	
Kansas		✓		
Minnesota		✓		
New Jersey		✓		
New Mexico	✓			
Rhode Island	✓			
Tennessee		✓		
Texas		✓		
Virginia			✓	

*\* The HCBS Experience of Care survey has been added to the CAHPS family of surveys and is now known as CAHPS HCBS*

Florida noted 77 percent of respondents to its state survey reported an improved quality of life since joining an MLTSS plan. In Texas, consumers receiving MLTSS services reported that having HCBS gave them a sense of independence and personal space that was important for their quality of life. In Virginia, consumers in the state’s Commonwealth Coordinated Care demonstration program were asked to comment on the one thing they liked or disliked most about their care coordinator. The 291 comments received were overwhelmingly positive and indicated that respondents were particularly pleased with care coordinators’ helpfulness, compassion, friendliness, ability to listen, efficiency, responsiveness, politeness, information, and communication style.<sup>27</sup> New Jersey, Tennessee, and Texas are using information gleaned from the NCI-AD™ survey to implement quality improvement activities for their MCOs.

While some states find value in reviewing family and member satisfaction annually, other states find “real-time” or regular check-ins with consumers and families on their care experiences to be important for guiding program modification on a more rapid cycle. Among other methods, Tennessee uses computer tablets to gather point-of-service consumer satisfaction during visits with the care coordinator.<sup>28</sup> New York also frequently assesses consumer satisfaction with its MLTSS program.<sup>29</sup>

**Challenges in Collecting Quality of Life Data.** One of the most valid and reliable ways to assess quality of life outcomes for MLTSS programs is to survey consumers and their caregivers (as appropriate). However, in-person or phone surveys are time and labor-intensive. States have limited capacity to conduct and oversee data collection efforts across the scope of questions needed to cover all aspects of the MLTSS program. New Jersey reported that data collection by state and local staff is labor-intensive. Texas reported that its expansive geography was a challenge because survey contractors must travel extensively to complete in-person surveys, making data collection time- and resource-intensive. Another state noted lack of funding as the reason why it does not collect satisfaction data from individuals and families. Because quality of life outcomes are so important to assessing the success of an MLTSS program, continued effort must be made to make the collection of this data less burdensome and timelier. States should also look for other ways to measure satisfaction and quality outcomes—for example, the National Quality Forum’s recently released framework for HCBS quality measurement.<sup>30</sup>

## 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. In 2015, there were over 600,000 individuals on HCBS waiver waiting lists in 35 states.<sup>31</sup> MLTSS programs may reduce or eliminate waiting lists, which, in turn, would result in increased access to LTSS. Six states (Florida, Iowa, Kansas, New Jersey, New Mexico, and Tennessee) 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.<sup>32</sup> 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 home level of care, and, through its Section 1115 demonstration, it also provides individuals needing a lower level of care with a narrower package of services to prevent or delay transitions to nursing homes.<sup>33,34</sup> Other states reported that they reinvested savings achieved through 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.<sup>35</sup>

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. From 2013 to 2014, all seven MCOs in Florida’s MLTSS program offered between five to 12 expanded benefits (i.e., vision services, non-medical transportation, and hearing evaluations).<sup>36</sup> All seven plans provided support for nursing facility transitions, dental services, and over-the-counter medications as expanded services. 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 prevent an individual from developing a condition that would require more costly treatment in the future, such as institutionalization.<sup>37</sup> 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.<sup>38</sup> 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 not covered by MassHealth.<sup>39</sup>

Many Medicaid agencies work with MCOs and sister state agencies to address challenges with access to services. Transportation services to medical appointments can make it easier for individuals with chronic conditions to remain living in their home, and consumers frequently identify this benefit as highly valuable.<sup>40</sup> Several states increased access to services by providing expanded transportation options. For example, Massachusetts MCOs participating in the Senior Care Options program can directly coordinate and pay for transportation services for medical appointments, which minimizes the burden often associated with managing these services under the fee-for-service system. Other states have focused on expanding provider recruitment and other related activities in underserved areas. New Jersey strives to increase access to services and critical providers, especially for those in underserved areas, in different ways. The state uses financial incentives to encourage providers to serve these areas and plans to incorporate more evidence-based telehealth technologies and programs, like Project ECHO (Extension for Community Healthcare Outcomes), into the service delivery system.<sup>41</sup> New Mexico also uses Project ECHO in its Centennial Care program.

## 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. Seven states (Florida, Iowa, Kansas, Massachusetts, New Jersey, Rhode Island, 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. Five states (Florida, Iowa, New Jersey, New Mexico, and Virginia) identified Medicaid cost containment as a goal for MLTSS implementation. Virginia believes that

the features of Commonwealth Coordinated Care Plus, its soon-to-be-launched MLTSS program, will also reduce costs over time.<sup>42</sup> In Florida, quality and efficiency are goals of the state's MLTSS program, while transitions from institutions to HCBS are also viewed as opportunities to achieve savings.<sup>43,44</sup> To emphasize this point, Florida estimated that without the nursing facility-to-community transitions facilitated by its MLTSS program, Medicaid LTSS might 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.<sup>45</sup>

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.”<sup>46</sup> Similarly, one of the goals for KanCare

is to “control Medicaid costs by emphasizing health, wellness, prevention, and early detection, as well as integration and coordination of care.”<sup>47</sup> Kansas believes that by requiring MCOs to meet certain outcomes and performance goals and tying these to financial incentives, quality will improve and costs will decrease.<sup>48</sup>

**Progress to Date.** Seven states (Florida, Iowa, Massachusetts, New Jersey, New Mexico, Rhode

“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



Island, 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 used to monitor program sustainability and cost effectiveness.

Florida reported that shifting to a capitated, risk-adjusted MLTSS program enhanced the predictability and management of its MLTSS program.<sup>49</sup> 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.<sup>50</sup> Massachusetts also reported meeting its goal of budget predictability for its “otherwise volatile and high-cost populations” enrolled in the Senior Care Options.<sup>51</sup>

To decrease administrative burden, states may also restructure their Medicaid agencies and streamline some responsibilities that are delegated to MCOs. Three states (Florida, Massachusetts, and Texas) reported that implementing MLTSS decreased administrative burden in their Medicaid programs. However, 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, shifting the state’s infrastructure to “manage” managed care.<sup>52</sup> 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, inadequate 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. For example, Texas MLTSS is part of a larger program that integrates MLTSS and acute care services to provide consumers with comprehensive care. The savings achieved through the integrated program have been evaluated, but not in terms of the specific impact of MLTSS. Texas intends to evaluate the impact of the managed care implementation of the Community First Choice option once sufficient data are available. New Jersey noted that because they rely on self-reported data from its MCOs, the data may not always be reliable. 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 TennCare CHOICES implementation 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.

“Florida has seen a 12 percent decrease in the number of consumers receiving services in nursing facilities, a decrease that can be attributed to the MLTSS program and payment incentives to ensure consumers receive care in the least restrictive setting. The MLTSS program has resulted in cost savings to the state and better budget predictability—an important factor in serving a growing aging population.”

—Florida survey respondent

## CONCLUSION

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.


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 the need to continue strengthening efforts to monitor the performance of MLTSS plans, in order to assure the best outcomes for their consumers.

States reported lessons learned related to the challenge of better demonstrating program value, including the necessity for standardized quality measures across MLTSS programs to assess person-centeredness and outcomes, as well as better monitoring of managed care performance as an essential obligation. Other take-aways included:

- Collecting and analyzing encounter data and other programmatic data is challenging;
- Developing an oversight structure for MLTSS programs is complex; and
- To achieve a smooth transition from a fee-for-service system, dedicate more staff resources and refine existing staffing strategies for MLTSS implementation and oversight.

One recommended solution for states is to collect baseline measures on consumers' health status, as well as other program variables like cost and service utilization, in order to tie outcome measures to these benchmarks:

- 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.



Another solution for states is to ensure that MCO contract requirements 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.<sup>53</sup> NASUAD created the MLTSS Institute to capitalize on its capacity to deliver solid, reliable technical assistance tailored to each state's program and needs. NASUAD staff are available to 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.

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## APPENDIX: STATE MLTSS PROGRAMS

State	Managed Care Authority Used	Populations Enrolled					Covered Benefits	
		Seniors	PD	DEB	I/DD	BH	Comprehensive	Other
Arizona <sup>i</sup>	1115	✓	✓	✓	✓		✓	
California	1115; FAI	✓	✓	✓			✓ (DEB only)	LTSS
Delaware	1115	✓	✓				✓	
Florida	1915(b)/(c)	✓	✓					LTSS
Hawaii	1115	✓	✓	✓			✓	
Iowa	1915(b)	✓	✓		✓		✓	
Illinois	1915(b); FAI	✓	✓	✓			✓	
Kansas	1115	✓	✓	✓	✓		✓	
Massachusetts	1915(a); FAI	✓		✓			✓	
Michigan	1915(b); FAI			✓	✓	✓	✓ (DEB only)	LTSS; BH
Minnesota	1915(a); 1915(b)	✓		✓			✓	
New Jersey	1115	✓	✓	✓			✓	
New Mexico	1115	✓	✓	✓			✓	
New York	1115; FAI	✓	✓	✓	✓		✓ (DEB only)	LTSS
North Carolina	1915(b)				✓	✓		LTSS; BH
Ohio	FAI			✓			✓	
Rhode Island	1115; FAI	✓	✓	✓			✓	
South Carolina	FAI			✓			✓	
Tennessee	1115	✓	✓	✓	✓		✓	
Texas <sup>ii</sup>	1115; FAI	✓	✓	✓	✓		✓	
Virginia <sup>iii</sup>	FAI			✓			✓	
Wisconsin	1915(b); 1932(a)	✓	✓	✓	✓		✓ (DEB only)	LTSS

Source: NASUAD 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

<sup>i</sup> 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.

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

<sup>iii</sup> Virginia intends to terminate its FAI in December 2017 and instead implement a broader MLTSS program to include both dually eligible and non-dually eligible.

## ENDNOTES

- <sup>1</sup> Arizona has always provided LTSS through a managed care delivery system, and so never transitioned from fee-for-service to MLTSS.
- <sup>2</sup> 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>.
- <sup>3</sup> States also can 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.
- <sup>4</sup> M. Watts, M.B. Musumeci, and P. Ubri. Medicaid Section 1115 Managed Long-Term Services and Supports Waivers: A Survey of Enrollment, Spending, and Program Policies. Kaiser Family Foundation. January 2017. Available at: <http://files.kff.org/attachment/Report-Medicaid-Section-1115-Managed-Long-Term-Services-and-Supports-Waivers>.
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- <sup>6</sup> As of July 2016, 46,805 MLTSS consumers in Florida lived in HCBS settings, while 42,161 lived in nursing facility settings. Source: Ibid.
- <sup>7</sup> B. Kidder. “Florida Medicaid: Managed Care Rate Setting.” Agency for Health Care Administration presentation to Florida House Health Care Appropriations Subcommittee, January 11, 2017. Available at: [http://ahca.myflorida.com/medicaid/recent\\_presentations/House\\_Health\\_Care\\_Appropriations\\_Subcommittee\\_Managed\\_Care\\_Rate\\_Setting\\_2017-01-11.pdf](http://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Care_Appropriations_Subcommittee_Managed_Care_Rate_Setting_2017-01-11.pdf).
- <sup>8</sup> New Mexico Human Services. *Centennial Care 1115 Waiver Renewal Subcommittee Long-Term Care Brief*. December 2016. Available at: <http://www.hsd.state.nm.us/uploads/files/Long%20Term%20Care%20Brief%20-%20Waiver%20Renewal%20Committee%20Dec%2016%202016.pdf>.
- <sup>9</sup> P. Killingsworth. “State of Tennessee Managed Long Term Services and Supports.” Presentation during Wisconsin Managed Care Discussions. November 2015.
- <sup>10</sup> As of February 2017, Rhode Island spent 79 percent of its Medicaid long-term care dollars on institutional care and 21 percent on HCBS. “Healthy Aging in the Community: Rebalancing Long-Term Care in Rhode Island.” Rhode Island Executive Office of Health and Human Services presentation to the Rhode Island Lt. Governor’s Long Term Care Coordinating Council, February 2017.
- <sup>11</sup> Rhode Island Executive Office of Health and Human Services. *State Annual Report on Long-Term Care System Reform and Rebalancing*. April 6, 2016. Available at: [http://www.eobhs.ri.gov/Portals/0/Uploads/Documents/Reports/LTSS\\_Reform\\_Rebalancing\\_April2016.pdf](http://www.eobhs.ri.gov/Portals/0/Uploads/Documents/Reports/LTSS_Reform_Rebalancing_April2016.pdf).
- <sup>12</sup> Rhode Island Executive Office of Health and Human Services, op. cit.
- <sup>13</sup> Twelve states responded to the survey AZ, FL, IA, KS, MA, MN, NJ, NM, RI, TN, TX, and VA; however, some states did not respond to each question.
- <sup>14</sup> S. Eiken, K. Sredl, B. Burwell, and P. Saucier. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014: Managed LTSS Reached 15 Percent of LTSS Spending*. Truven Health Analytics. April 2016. Available at: <https://www.medicare.gov/medicaid/tss/downloads/tss-expenditures-2014.pdf>.
- <sup>15</sup> Ibid.
- <sup>16</sup> Ibid.
- <sup>17</sup> Killingsworth, op. cit.
- <sup>18</sup> “Centennial Care Next Phase.” New Mexico Human Services Department presentation to 1115 Waiver Renewal Subcommittee, December 16, 2016. Available at: <http://www.hsd.state.nm.us/uploads/files/Presentation%20-%20Dec%2016%202016%20Waiver%20Renewal%20Committee.pdf>.
- <sup>19</sup> B. Kidder. “Medicaid Long-term Care Program.” Agency for Health Care Administration presentation to Florida House Health and Human Services Committee, February 14, 2017. Available at: [http://ahca.myflorida.com/medicaid/recent\\_presentations/Medicaid\\_Long-term\\_Care\\_Program\\_HHHSC\\_2017-02-14.pdf](http://ahca.myflorida.com/medicaid/recent_presentations/Medicaid_Long-term_Care_Program_HHHSC_2017-02-14.pdf).
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- <sup>21</sup> “Comprehensive Medicaid Waiver Renewal.” NJ Family Care presentation, January 23, 2017. Available at: [http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC\\_Meeting\\_Presentations\\_1\\_23\\_17.pdf](http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_1_23_17.pdf).

- <sup>22</sup> Health Management Associates, op cit.
- <sup>23</sup> The Institute for Child Health Policy, University of Florida. *Texas Medicaid Managed Care and Children's Health Insurance Program: External Quality Review Organization Summary of Activities and Trends in Healthcare Quality*. January 2016. Available at: <https://hhs.texas.gov/sites/hhs/files/eqro-2015-summary-of-full-report-Activities-and-Trends-in-Healthcare-Quality.pdf>.
- <sup>24</sup> United States Department of Health and Human Services Assistant Secretary of Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. *Minnesota Managed Care Longitudinal Analysis*. March 2016. Available at: <https://aspe.hhs.gov/system/files/pdf/204996/MNmclida.pdf>.
- <sup>25</sup> Supplemental data on waiver utilization provided by Kansas Medicaid officials in response to the NASUAD survey.
- <sup>26</sup> Ibid.
- <sup>27</sup> A. Cuellar, G. Gimm, and C. Gresenz. *A Survey of EDCD Waiver Participants who were Enrolled in the Commonwealth Coordinated Care (CCC) Program for Dual-Eligibles*. George Mason University Department of Health Administration and Policy. September 2016. Available at: [http://www.dmas.virginia.gov/Content\\_atchs/altc/CCC\\_Tel\\_Mail\\_Survey%20Findings\\_Enrollees\\_16-9-2.pdf](http://www.dmas.virginia.gov/Content_atchs/altc/CCC_Tel_Mail_Survey%20Findings_Enrollees_16-9-2.pdf).
- <sup>28</sup> Killingsworth, op. cit.
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- <sup>32</sup> Killingsworth, op. cit.
- <sup>33</sup> Ibid.
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- <sup>46</sup> Killingsworth, op. cit.
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- <sup>48</sup> Ibid.
- <sup>49</sup> B. Kidder. "Statewide Medicaid Managed Care Program," op. cit.
- <sup>50</sup> Florida State University, op. cit.
- <sup>51</sup> Health Management Associates, op. cit.
- <sup>52</sup> Killingsworth, op. cit.
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