Chapter 3:

Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution

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Key Points

- People who use long-term services and supports (LTSS) make up a diverse group that includes all ages, with needs stemming from a wide range of physical and cognitive limitations.

- Medicaid beneficiaries who use LTSS are among the program's most vulnerable and account for a disproportionate share of Medicaid spending. In fiscal year 2013, Medicaid spending for beneficiaries who used LTSS through fee-for-service arrangements was approximately 42 percent of total Medicaid spending, despite these beneficiaries comprising only about 6 percent of Medicaid beneficiaries that year.

- In managed long-term services and supports (MLTSS) programs, states contract with managed care plans to deliver LTSS. The number of states implementing MLTSS programs grew from 8 states in 2004 to 24 states as of January 2018.

- States may operate multiple MLTSS programs, often targeting them to different populations. In total, the 24 states with MLTSS operate 41 programs.

- States can use several Medicaid authorities to implement MLTSS: either Section 1115 waivers or combining Section 1915(c) home and community-based services (HCBS) waiver authority with Section 1915(a), Section 1915(b), or Section 1932 managed care authorities. MLTSS plans must adhere to the same regulations as other Medicaid managed care plans and are subject to additional MLTSS-specific regulations and guidance.

- Whether delivering LTSS through fee for service or managed care, Medicaid programs face common challenges, such as limited HCBS workforce capacity. But even for states and plans experienced in using managed care to deliver acute care, using managed care to deliver LTSS presents a new set of challenges. For example, because Medicaid is the nation's primary payer for LTSS, the implementation of MLTSS presents a major change to the provider community, who may not have experience contracting with managed care plans.

- As states gain MLTSS experience, attention is turning to program outcomes. Although there is modest evidence of some successes, there are many unanswered questions. Limited baseline data and insufficient targeted quality measures have made evaluation difficult. Efforts to implement new quality measures and collect better encounter data may improve monitoring and oversight of MLTSS in the future.

- As MLTSS programs have evolved, their scope has expanded, with more states enrolling individuals with intellectual or developmental disabilities or aligning MLTSS with Medicare managed care for individuals who are dually eligible for Medicare and Medicaid.

CHAPTER 3: Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution

State Medicaid programs increasingly use managed care as one of several strategies to improve care coordination and manage costs for populations with complex health care needs and disproportionately high Medicaid expenditures. As of January 2018, 24 states operate managed long-term services and supports (MLTSS) programs, in which state Medicaid agencies contract with managed care plans to deliver long-term services and supports (LTSS), up sharply from just 8 states in 2004 (Lewis et al. 2018). Although much of this growth has been fairly recent, a few states have operated MLTSS programs for many years, and in some cases, several decades. In fiscal year (FY) 2015, $29 billion, or 18 percent of Medicaid LTSS spending, was for MLTSS programs (Eiken et al. 2017).[1] Even though states typically adopt managed care for LTSS after they have gained experience with managed care for acute care benefits, the complex needs of people who receive LTSS and the wide range of services they use makes implementation of MLTSS more complex than managed care for acute care.

Given the growing role of managed care in serving people who receive LTSS, the Commission has undertaken a variety of activities in recent years to better understand this change and its effect on beneficiary outcomes and Medicaid LTSS spending. These activities have included site visits to states with MLTSS programs, research projects on network adequacy standards for home and community-based services (HCBS) providers and on how programs have been tailored to meet the needs of people with intellectual or developmental disabilities

(ID/DD), and presentations at MACPAC public meetings from a range of MLTSS stakeholders.

The purpose of this chapter is to provide an overview of MLTSS, review results of MACPAC's initial work in this area, and identify gaps in our knowledge about what drives success in MLTSS programs. While the discussion includes highlights of reports describing state MLTSS programs and program outcomes, there are few rigorous studies evaluating whether MLTSS programs are meeting their intended goals. States, managed care plans, providers, and beneficiary advocates all have identified potential benefits of MLTSS and the challenges of operating these programs, but lack of baseline data prior to the changeover to MLTSS and standardized LTSS quality measures have limited our ability to compare states' experiences and outcomes. Adoption of new LTSS quality measures and recent efforts to improve MLTSS encounter data offer the potential to improve evaluation and oversight activities in the future.

This chapter begins with background information on Medicaid-covered LTSS and Medicaid beneficiaries who receive LTSS. It then provides a status report on state adoption of MLTSS programs, a discussion of the range of goals that states are trying to achieve through MLTSS programs, and an overview of federal regulations specific to these programs. Next, it describes how MLTSS programs are implemented and operated, what is currently known about program outcomes, and emerging trends. As new states implement MLTSS and the programs of early adopters mature, more states are enrolling people with ID/DD into MLTSS and integrating Medicaid MLTSS with Medicare benefits for beneficiaries who are dually eligible for Medicare and Medicaid. States are also continuing to refine other aspects of their MLTSS programs, such as network adequacy requirements, payment approaches, and quality measures. The chapter concludes by raising issues that the Commission will explore and monitor as its deliberations on MLTSS continue.

Medicaid-Covered Long-Term Services and Supports

Medicaid is the nation's largest payer for LTSS (O'Shaughnessey 2014). In FY 2015, Medicaid spent $158 billion on LTSS, accounting for almost one-third of Medicaid benefit spending (Eiken et al. 2017). Medicaid LTSS spending growth has been modest in recent years, averaging 0.8 percent from FY 2011 to FY 2012, and 3.8 percent each year from FY 2013 to FY 2015 (Eiken et al. 2017).

LTSS covered by Medicaid and issues spanning delivery systems

State Medicaid programs must cover services provided in nursing facilities as well as home health services (e.g., nursing services). States may also elect to cover other LTSS including HCBS and services provided in intermediate care facilities for individuals with ID/DD, and all states do (CMS 2018a, Eiken et al. 2017). States can include HCBS in their Medicaid benefit package using both state plan and waiver authorities, and most states use more than one strategy.[2]

HCBS are delivered on a frequent or even daily basis and meet individuals' ongoing needs for assistance with activities of daily living (ADLs), such as bathing and dressing, and with instrumental activities of daily living (IADLs), such as managing medications and preparing meals; these services can also provide supervision to assist with behavioral or cognitive limitations. HCBS comprise a wide range of services, including personal care services provided in the home, services provided at adult day centers and in residential care settings, and supported employment services. HCBS also includes supports and other resources that help individuals live in the community, such as home modifications and meal delivery. In addition, they include services that beneficiaries may self-direct, for instance, by selecting their own direct care providers or exercising control over their own budget for care.

In 2015, Medicaid programs spent a majority (55 percent) of LTSS spending on HCBS, the third consecutive year that Medicaid programs spent more on HCBS than institutional care (Eiken et al. 2017).[3] This reflects specific programmatic efforts by the federal government and states to rebalance spending—that is, to shift the balance of Medicaid spending from institutional to home and community-based settings. These efforts include the Balancing Incentive Program, which targeted states spending less than 50 percent of LTSS on HCBS, and the Money Follows the Person demonstration program that gave states flexibility and funding to help certain beneficiaries transition from institutions back to the community (MAG and HSRI 2013, HHS 2017a). Rebalancing also reflects efforts to comply with legal decisions. In its 1999 *Olmstead v. L.C.* ruling, the Supreme Court held that Title II of the Americans with Disabilities Act (ADA, P.L. 101-336) and its implementing regulations obligate states to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities" (28 CFR 35.130).[4] Under *Olmstead*, states must operate public programs (including Medicaid) in a non-discriminatory fashion and furnish services in the most integrated setting appropriate to an individual's needs, by delivering services to persons with disabilities in community settings rather than in institutions when possible.

As the Commission considers Medicaid's role in serving individuals with LTSS needs, it recognizes several principles important for serving this population whether the delivery system is fee for service (FFS) or managed care. These include the importance of providing opportunities for beneficiaries to exercise choice and control over their authorized services through self-directed options, person-centered planning, and the acknowledgement of the dignity of risk (i.e., the right of individuals with disabilities to take risks when exercising choice and control over their lives). These concepts, discussed in more detail later in this chapter, are necessary components for LTSS delivery systems. The design of both FFS and managed care systems also must take into

account the contributions of and support the role of beneficiaries' informal caregivers through activities such as respite care and training.

Some challenges to the delivery of LTSS are present under both FFS and managed care. For example, as the population ages, a key challenge will be state capacity to meet demand for HCBS. The number of individuals on HCBS waiting lists nationally has been increasing since at least 2006—with 656,195 on waiting lists in 2016—even as some states have eliminated waiting lists (Watts and Musumeci 2018).[5] In addition, high turnover and shortages among the personal care workforce present a challenge to all states, particularly as demand for HCBS grows with an aging population (Stone and Harahan 2010). Lack of affordable, accessible housing is also a limitation for Medicaid programs aiming to serve more beneficiaries in the community (HHS 2017a).

Medicaid beneficiaries who receive LTSS

People who receive LTSS are among Medicaid's most vulnerable beneficiaries, given the complexity of their conditions and care needs, and are also among the program's most expensive. In FY 2013, Medicaid spending for beneficiaries who use LTSS under FFS arrangements was $171.7 billion, or approximately 42 percent of total Medicaid spending, a disproportionate amount given that this group comprised only about 6 percent of Medicaid beneficiaries that year (MACPAC 2017). Medicaid beneficiaries who use LTSS include a diverse group of individuals, spanning a range of ages and having different types of physical and cognitive disabilities, who often receive such services and supports for many years, or even decades. Beneficiaries may use institutional care or HCBS, and the types and intensity of services they require vary—both across and within subgroups.

- About half of Medicaid beneficiaries receiving LTSS are adults age 65 and older (MACPAC 2014). Given beneficiary preferences to age in place at home or in a home-like setting,

about half of these beneficiaries receive HCBS (Eiken 2017). For example, a beneficiary may receive a few hours of personal care services each day for assistance with bathing, dressing, and preparing meals. These hours usually supplement support from informal caregivers such as family members and neighbors. Although older adults may need increasing levels of support as they age, sometimes necessitating a move into a nursing facility, on average older adults use LTSS for a relatively short period of time (an estimated average of 2.5 years for women and 1.5 years for men) (Favreault and Dey 2016).

- Individuals with physical disabilities can include both young and older adults with functional impairment, such as individuals with spinal cord injuries that have left them with some form of paralysis, or individuals with traumatic brain injuries. Depending on the severity of their functional limitations, they may require different levels of services, and depending on the onset of disability, they may require services for many years. These individuals may also require assistive technologies that allow them to live in the community, such as wheelchairs or equipment to assist caregivers in moving them from a bed to a wheelchair.

- Individuals with ID/DD include people with conditions such as cerebral palsy and autism that originate at a young age.[6] Individuals with ID/DD may require LTSS for many years, and as their needs vary substantially over their lifespan, their services vary accordingly.[7] For example:

  - Infants born with ID/DD or diagnosed in early childhood may receive early intervention program services and Medicaid-funded special education services. Their families often also rely upon respite services, private duty nursing, home modifications, and durable medical equipment.

- – Children with ID/DD often receive school-based services.

- – Young adults with ID/DD may begin to receive non-residential services in adolescence, with these services continuing throughout adulthood, including prevocational services, supported employment (e.g., use of job coaches or other supports in the community or facilities), or other day services in group and community settings.

- – Young adult, middle-aged, and older people with ID/DD may receive residential services. In 2014, the majority (68 percent) of people with ID/DD receiving services lived with their families or in a home of their own, but others may have had group living arrangements (Larson et al. 2017). In particular, as individuals with ID/DD age, they may outlive family caregivers (or family caregivers may be less able to support individuals in the home as they age themselves), thus requiring individual or group living arrangements.

- – Some individuals with ID/DD, including those who have concurrent mental health disorders, also need support with challenging behaviors. Medicaid LTSS includes behavior interventions, including crisis respite, crisis response teams, and positive behavior interventions and supports.

- Individuals with severe mental illness, such as bipolar disorder and schizophrenia, also receive LTSS. Although these individuals make up a relatively small percentage of enrollment in state HCBS waiver programs, they have high per capita total Medicaid expenditures (GAO 2014, MACPAC 2014).

- In addition to the populations specified above, states also provide LTSS to other individuals who have medically complex conditions. This includes individuals who are ventilator dependent and children who are medically fragile, who may require assistive equipment and aids.

State Adoption of MLTSS and Program Design

State and federal policy makers have sought ways to manage LTSS spending growth while maintaining and improving beneficiary quality of care and quality of life. MLTSS is one tool being employed in pursuit of these goals. In MLTSS programs, states contract with plans to provide LTSS benefits, generally alongside other Medicaid benefits such as acute care services.

MLTSS programs differ in some ways from managed care programs for acute care for which there were existing private-sector models and well-established approaches for determining medical necessity. When providing managed care services to beneficiaries receiving LTSS, states must consider beneficiaries' complex and frequent service needs. Available Medicaid LTSS benefits also include non-medical services that go beyond those covered by traditional health insurance, including, for example, personal care assistance for those with ADL and IADL limitations, supported employment services for individuals with disabilities, and other services aimed at community integration. Finally, many MLTSS interventions target needs related to the social determinants of health. For example, some plans that provide MLTSS help beneficiaries locate affordable and accessible housing because it is in a plan's interest to avoid more costly institutionalization and to support more beneficiaries in the community. Although social determinants of health have been receiving greater attention across the health system, they have been recognized as an important aspect of MLTSS since the early years of these programs.

FIGURE 3-1. State Adoption of Managed Long-Term Services and Supports Programs, January 2018
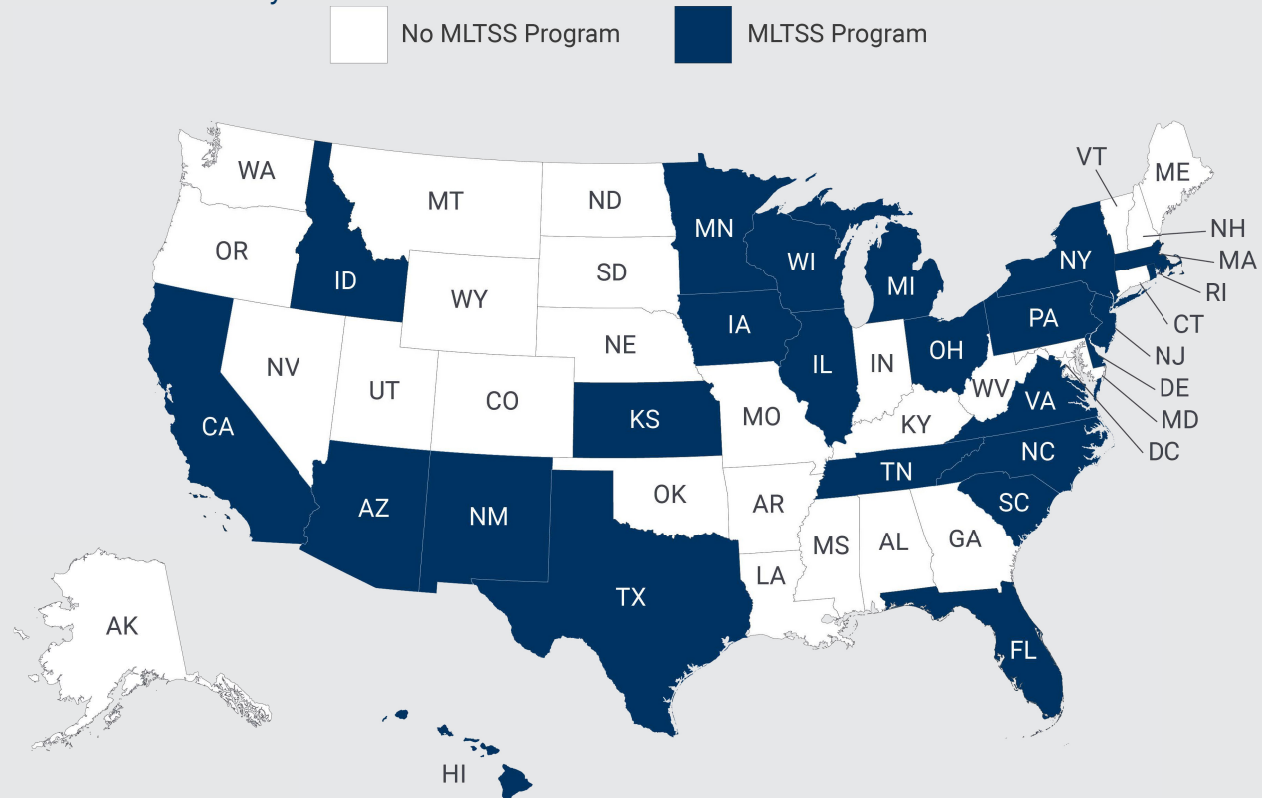
Notes: MLTSS is managed long-term services and supports.

Source: MACPAC, 2018, analysis of Lewis et al. 2018.

States with MLTSS

As of January 2018, 24 states operate MLTSS programs (Figure 3-1 and Appendix 3A, Table 3A-1).[8]

In 2017, 1.8 million beneficiaries were reported enrolled in MLTSS programs (Lewis et al. 2018).[9]

Arizona has operated MLTSS since 1989. Other early adopters include Wisconsin (1996) and Texas (1998) (Lewis et al. 2018). More recently, Virginia launched a statewide MLTSS program for older adults and individuals with physical disabilities on August 1, 2017, although the state had previously operated a regional MLTSS program for dually eligible beneficiaries under the Financial Alignment Initiative (FAI).[10] Pennsylvania began a regionally phased

implementation of a statewide MLTSS program on January 1, 2018 (PA DHS 2018a, VA DMAS 2018).

States that offer MLTSS often do so through more than one program. As of 2018, 24 states operated 41 MLTSS programs (Lewis et al. 2018). For example, the state of Tennessee operates the CHOICES program for older adults, adults with physical disabilities, and institutionalized children with disabilities. The state also operates the Employment and Community First CHOICES program for certain individuals with ID/DD.[11] States may also operate demonstration programs for dually eligible beneficiaries through the FAI while continuing other MLTSS programs for beneficiaries enrolled only in Medicaid or those who did not choose to enroll in an FAI demonstration program.

This is the case in New York, which has mandatory MLTSS for older adults and individuals with physical disabilities, but also operates an FAI demonstration program in which dually eligible beneficiaries may voluntarily enroll (Lewis et al. 2018).

MLTSS programs vary on a number of dimensions and each program is unique (Table 3-1). For example, some states require mandatory enrollment of individuals who are eligible for MLTSS and others allow beneficiaries the option to remain in the FFS system. States also vary in terms of which services are included in the MLTSS benefit package (Lewis et al. 2018).

TABLE 3-1. Selected Managed Long-Term Services and Supports Program Design Characteristics `T 3-1`

MLTSS program characteristics	Description
Managed care authorities	State options include: • Section 1115 waiver authority • A combination of Section 1915(a) and Section 1915(c) waiver authorities • A combination of Section 1915(b) and Section 1915(c) waiver authorities • A combination of Section 1932(a) state plan amendment and Section 1915(c) waiver authorities
Contract types	• Comprehensive managed care program that includes LTSS and non-LTSS benefits (some states limit enrollment to populations eligible for LTSS, others include all populations) • Plan that provides only LTSS benefits • Single comprehensive plan that covers Medicare and Medicaid benefits for individuals who are dually eligible for Medicare and Medicaid, such as those offered through the Financial Alignment Initiative
Populations covered	• Almost all state MLTSS programs cover older adults and individuals with physical disabilities • Most states exclude individuals with intellectual or developmental disabilities • Some states exclude children • Some states cover individuals with traumatic brain injuries
Mandatory or voluntary enrollment	• Many states mandate that beneficiaries in eligible populations enroll • Some states give beneficiaries the option of enrolling in an MLTSS plan or continuing to receive LTSS on an FFS basis
Geographic reach	• Statewide or only offered in certain regions
Inclusion of institutional coverage	• Most state MLTSS programs cover both HCBS and institutional care • A few states focus their MLTSS programs on beneficiaries currently receiving HCBS and they have delayed including current nursing facility residents or they limit their plans' risk for institutionalized beneficiaries

TABLE 3-1. (continued)

MLTSS program characteristics	Description
Number of plans participating	• State decisions on number of plans affect beneficiary choice and administrative complexity
Types of plans participating	• States can contract with for-profit, non-profit, or public entities
Payment policies	• States can make different decisions regarding payment incentives, for example, to promote HCBS
Integration with Medicare benefits	• States can align Medicaid MLTSS with Medicare Advantage dual-eligible special needs plans (D-SNPs) to integrate care for beneficiaries who are dually eligible for Medicare and Medicaid

Notes: MLTSS is managed long-term services and supports. LTSS is long-term services and supports. FFS is fee for service. HCBS is home- and community-based services.

Source: MACPAC, 2018, analysis of Lewis et al. 2018, Dobson et al. 2017, Libersky et al. 2016, and Saucier et al. 2012.

Reasons states pursue MLTSS

States implement MLTSS for a variety of reasons. In a recent survey of 12 states with MLTSS, states reported that their goals included:

- rebalancing LTSS spending—increasing the proportion of Medicaid LTSS spending used for HCBS while decreasing the proportion of spending for institutional services (12 states);

- improving beneficiary care experience by increasing care coordination to improve health and quality of life (12 states);

- reducing or eliminating HCBS waiver waiting lists to address access gaps and to provide care in the setting that the beneficiary chooses (6 states);[12] and

- providing budget predictability and potentially containing costs via rebalancing, efficiencies, and improved quality (7 states) (Dobson et al. 2017).

Another recent review of state documents, including waiver applications, fact sheets, contracts, and state websites, identified similar goals. The most frequently cited MLTSS goals were related to improved participant outcomes (67 percent of MLTSS programs reviewed), followed by increased access to HCBS and improved care coordination (both 46 percent), increased efficiency (41 percent), and improved consumer choice (15 percent) (Lewis et al. 2018).

However, some states are reluctant to pursue managed care for LTSS. For example, Indiana state law prohibits Indiana's Medicaid program from implementing MLTSS until after December 31, 2019 (Ind.Code § 12-10-11.5-8 (2017)). Such legislation may reflect resistance to MLTSS among LTSS providers and beneficiary groups. For example, a bill to implement MLTSS in Louisiana recently failed after encountering strong opposition from the state's nursing facility industry (Allen 2017). States with small populations may also be less likely to pursue MLTSS due to low enrollment numbers that would not support adequate risk sharing, particularly for small subpopulations with high average costs per person, such as individuals with ID/DD. Some states may also be satisfied with the performance of their FFS LTSS delivery system and achieve their programmatic goals through other activities. In Oregon, 82 percent of LTSS spending in FY 2015 was for HCBS, demonstrating that the state's FFS system is largely rebalanced (Eiken et al. 2017).

Federal Requirements for MLTSS

Federal requirements for LTSS include those for operating managed care or providing HCBS under various Medicaid authorities as well as additional guidance and regulations developed specifically for MLTSS programs.

Medicaid authorities used to implement MLTSS

MLTSS programs can operate under several Medicaid authorities. States may pursue different Medicaid authorities based on the different types of flexibility they provide and on other changes a state wishes to make to its Medicaid program. States must get approval from the Centers for Medicare & Medicaid Services (CMS) to deliver services through a managed care program, to provide HCBS, or both.

- Section 1115 waiver authority is the most common approach used for MLTSS (Appendix 3A, Table 3A-1). States have used this authority to waive comparability and statewideness requirements related to eligibility, benefits, service delivery, and payment methods. States often use this authority when an MLTSS program is rolled into a broader managed care system that may have many other demonstration components. Section 1115 waivers allow states to receive simultaneous approval for the delivery of services through managed care and to provide HCBS. Currently, most Section 1115 waivers must be renewed every five years.[13]

- States may also implement MLTSS by combining a managed care authority and an HCBS authority. For example, states can combine Section 1915(b) waiver authority, which allows states to achieve certain managed care goals and restrict beneficiary choice of providers, with Section 1915(c) waiver authority, which allows states to develop HCBS waiver services. Currently, Section

1915(b) waivers must be renewed every two years, or every five years if individuals who are dually eligible for Medicare and Medicaid are included. Section 1915(c) waiver authority is used for FFS and MLTSS to provide HCBS.[14]

- States can also use a combination of Section 1915(a) and Section 1915(c) authorities; the combination allows states to implement voluntary managed care plans that include HCBS.

- Finally, states can use Section 1932(a) authority, which allows states to implement mandatory managed care for all populations except individuals dually eligible for Medicare and Medicare, American Indians and Alaska Natives, and children with special health care needs (including children eligible for Medicaid on the basis of involvement with the child welfare system) through a state plan amendment (SPA). Section 1932(a) SPAs must be paired with a Section 1915(c) waiver to operate an MLTSS program.

Federal regulations and guidance on MLTSS

In general, MLTSS plans must adhere to the same regulations as other Medicaid managed care plans. In addition, as the MLTSS model has matured as a delivery system, CMS has released guidance targeted to MLTSS and has added specific MLTSS provisions to more general regulations for Medicaid managed care. Guidance released in May 2013 outlined what CMS referred to as key elements of an effective MLTSS program (CMS 2013). These key elements included:

- adequate planning and transition strategies, including readiness assessments at the state and managed care plan level and transition plans for beneficiaries;

- stakeholder engagement in the planning, implementation, and ongoing oversight processes;

- enhanced provision of HCBS, that is, providing opportunities for beneficiaries to live in the community, or in as integrated a setting as possible, in keeping with the requirements of the ADA and the Supreme Court's 1999 *Olmstead* decision, which requires that states serve beneficiaries in "the least restrictive setting possible";

- alignment of payment structures with MLTSS programmatic goals, which include improving the health and care experiences of beneficiaries, and reducing costs;

- support for beneficiaries, including enrollment counseling and an advocate or ombudsmen to help them navigate their health plans (e.g., how to handle disputes);

- person-centered processes for service planning, including participation by the beneficiary and his or her designee, and the opportunity for self-direction of HCBS;

- a comprehensive and integrated service package that covers all physical, behavioral health, and LTSS benefits or, in the absence of an integrated service plan covering all these services, contract provisions that allow and encourage coordination and referral;

- a provider network that includes qualified providers, including those who provide services that support community integration, such as employment supports;

- participant protections to safeguard beneficiaries from financial exploitation, neglect, emotional mistreatment, and to monitor critical incidents; and

- integrated LTSS and managed care quality systems that look at beneficiary outcomes in a holistic manner across services and provide sufficient oversight.

CMS codified the 2013 guidance in an update to federal managed care regulations released in May 2016 (CMS 2016).[15] Among provisions specific to

MLTSS, the agency set new standards related to network adequacy and quality strategies. CMS has directed states to develop and implement network adequacy standards other than time and distance for providers who travel to a beneficiary to provide care (e.g., personal care attendants). CMS has not specified any particular standards that states must use for HCBS network adequacy, nor has the agency required that states set different standards for different HCBS provider types. Instead, CMS commented that "states should establish standards based on their unique mix of services and characteristics and evaluate and amend these standards, as appropriate" (CMS 2016). However, each state is required to evaluate plans' network adequacy at least annually, and tell CMS that the state has determined plans' networks are in compliance with the rule. MACPAC's 2016 analysis of HCBS network adequacy standards found that all states had such standards in place although their approaches often differed (Box 3-1).

Operation of MLTSS Programs

The administration of MLTSS is generally similar to Medicaid managed care, but the mixture of services and the wide range of needs of beneficiaries who receive LTSS adds complexity, particularly for rate setting and care coordination.

MLTSS implementation

The initial implementation of MLTSS and subsequent contract reprocurements are critical periods for beneficiaries, because disruptions in care during these transitions may cause serious harm. Many beneficiaries using LTSS need services on the day the MLTSS program begins. Even one missed personal care visit could create a hardship for a beneficiary unable to perform ADLs such as bathing and toileting. Implementation can be designed to protect beneficiaries from disruptions in care; for example, by having continuity of care periods during which plans must contract with all of a beneficiary's

BOX 3-1. MACPAC Research on Network Adequacy Standards for Home- and Community-Based Services

In 2016, MACPAC contracted with Health Management Associates (HMA) to identify existing home- and community-based services (HCBS) network adequacy standards in contracts between states and plans. HMA reviewed 33 contracts in 23 states, for established managed long-term services and supports (MLTSS) programs as well as for several programs scheduled to launch in 2017. The review of state contracts showed that all states had existing HCBS network adequacy standards in place, including measures other than time and distance for providers who travel to the beneficiary. However, these standards took many forms. The most common HCBS network standards were the following:

- continuity of care standards beyond federal time requirements (23 contracts), including standards to promote a smooth transition from a non-participating HCBS provider to a participating HCBS provider when a beneficiary is newly enrolled in a health plan, or when a provider discontinues participation in the health plan network;

- time and distance metrics (22 contracts) that establish the maximum allowable travel time or mileage between a beneficiary's residence and HCBS providers to which the beneficiary travels (e.g., adult day health and day habilitation centers);

- criteria for number of providers (16 contracts), which define a minimum number of providers by type or require reporting to the state of the total number of participating HCBS providers in a defined geographic service area;

- reporting requirements for gaps in service (14 contracts), which require reporting to the state of missed HCBS visits and gaps or delays from the time of service authorization to service delivery;

- any willing provider provisions (14 contracts), which require that plans reimburse for care delivered by any willing HCBS provider;

- rate requirements (11 contracts) that require plans to pay providers at least Medicaid fee-for-service rates; and

- single case agreement provisions (10 contracts), through which plans provide time-limited access to out-of-network providers for continuity purposes or for services that are not otherwise available from a participating network provider (also referred to as single source agreements).

HMA also found that network adequacy standards are evolving as states gain experience with MLTSS. Stakeholder interviews indicated that some standards, such as requiring a minimum number of each provider type, were considered to be a starting point for HCBS network adequacy, particularly when states first implement MLTSS, but were not the end goal. Such standards may be relatively easy to implement and enforce but were viewed as insufficient for monitoring whether beneficiaries receive the services authorized in their care plan.

Stakeholders said a preferred standard is a gaps-in-service standard, found in 14 contracts, which requires tracking—and often reporting—of instances when a beneficiary was authorized to receive a service, but the service was not provided, either on one or more dates, on time, or at all. Three states also require plans to submit annual network adequacy reports detailing the composition of their network. Plans may also be required to demonstrate their processes for monitoring the timeliness of care provided to beneficiaries and for addressing deficiencies.

existing providers. In addition to mitigating harm, minimizing disruptions can build confidence in an MLTSS program, especially amid uneasiness by stakeholders unaccustomed to managed care.

As noted above, in both guidance and regulation, CMS has stressed the importance of adequate transition planning to minimize care disruptions (CMS 2013). States determine plans' ability to begin accepting enrollees and providing services through the readiness review process, which is meant to ensure that certain procedures are in place prior to program launch. For example, one review of MLTSS programs noted that Tennessee's readiness review process included having plans demonstrate they would be able to produce state-required reports and monitor timeliness of service delivery, among other items (Lipson et al. 2012). Another review identified factors that officials in five states noted as being important to consider in readiness review, for example, ensuring that information technology systems were ready to store information on beneficiaries' service plans, submit information to providers and state systems, and support timely provider payments (Flowers 2013). State MLTSS contracts typically include provisions to promote continuity of care, such as requirements that plans pay providers Medicaid FFS rates or allow any provider willing to serve plan enrollees to receive payment during a transition period (Saucier et al. 2013).

Through site visits, interviews, listening sessions, and panel presentations, the Commission has also heard from stakeholders about several potential success factors in MLTSS implementation. First, a successful roll-out of MLTSS is carefully planned, deliberate, and incremental. An incremental approach can mean several things. It can mean beginning an MLTSS program in one geographic area, making adjustments, then moving on to the next region to give plans and states time to ramp up the program. It could also mean starting MLTSS with certain populations, such as older adults and individuals with physical disabilities, before enrolling others, such as individuals with ID/DD. Some states might first pilot MLTSS through small programs such

as the FAI before rolling out a larger program based on what they learned through the demonstration process. Other states have used a combination of such approaches.

Second, implementation of MLTSS represents a major change in the delivery system for providers, and a successful roll-out requires appropriate training. Unlike managed care for medical services, for which providers may be used to dealing with Medicaid plans and commercial insurance plans for people with employer-sponsored insurance, few payers other than Medicaid cover LTSS. Thus, transitioning to managed care may mean that, for example, instead of submitting claims to the Medicaid agency, LTSS providers must learn to contract with plans for rates—something they may have never done before—and adjust to new billing systems. This might be particularly challenging in circumstances where several managed care companies operate in the same region or state, each with its own processes and interfaces for payment and billing. On our site visits, several states emphasized the need for robust training programs to prepare the existing provider community (including private agencies, other governmental agencies, and quasi-governmental entities) for the transition to managed care.

Third, stakeholder engagement of beneficiaries, advocates, and providers is commonly cited as a key factor in successful transitions to MLTSS. As noted earlier, providers often experience the transition as a major change and thus must be prepared to ensure the prompt delivery of services on day one. Stakeholders also stress the importance of engaging beneficiaries in the planning and ongoing oversight process. States may establish advisory councils for this purpose or require plans to implement their own stakeholder groups. One state that has adopted MLTSS for individuals with ID/DD specifies the particular advocacy groups that the plans must consult. The ID/DD community is particularly engaged in advocacy work, as is discussed later in this chapter.

Finally, payment policy is important in determining the financial viability of MLTSS plans. Plans must be paid enough to incentivize participation of high quality providers. During recent interviews with stakeholders in states that have implemented MLTSS for individuals with ID/DD, we heard about instances in which payments to providers had been reduced substantially in the transition to MLTSS.

Setting capitation rates and payment incentives

Factors involved in setting capitation payment rates for MLTSS include accounting for the range of services included, the wide variability in the needs of beneficiaries receiving LTSS, and the need to promote program goals through financial incentives. Unlike other health care services, LTSS are often used daily and may not be paid on an FFS encounter basis with clear billable units. In addition, the needs of beneficiaries receiving LTSS can be difficult to predict given the diversity of functional limitations, even among those with the same medical condition. A recent review of factors that affect the cost of MLTSS identified age, geographic region, race and ethnicity, and household composition among factors influencing the cost of LTSS (Libersky and Lipson 2016). For example, the number of individuals living in the home of a beneficiary receiving LTSS may influence the amount of personal care services needed, because household members may provide some of the needed supports for some portion of the day.

Collecting information about the diverse needs of individuals receiving LTSS can help states create risk-adjusted capitation rates, but research has identified limitations in states' ability to use information on functional needs for this purpose. As we noted in the chapter on functional assessments for LTSS in our June 2016 report to Congress, states currently use a wide range of assessments (MACPAC 2016). Some states require all MLTSS plans to use the same assessment tool to collect information on beneficiaries' functional limitations while others allow each plan to select its own

tool (MACPAC 2016). Use of validated tools can promote equity in service determination by removing some subjectivity from the assessment process. Research on rate setting in MLTSS has noted that the use of multiple tools can complicate states' ability to have comparable data across their LTSS populations (Lipson et al. 2016). Ideally, states would link data from functional assessments with encounter data, because functional limitations (e.g., information on ADLs and IADLs) are key predictors of beneficiary spending (Lipson et al. 2016). New York and Wisconsin leverage their functional assessment data for risk adjustment, but this approach has been challenging for most other states (Dominiak and Bohl 2016, Lipson 2016).

States can use payment rates to incentivize program goals such as rebalancing. To achieve this goal, many states have structured their contracts to incentivize rebalancing; for example, by including both HCBS and institutional care, and subsequently paying blended capitation rates that assume a certain mixture of both (Dominiak and Libersky 2016). Plans gain financially if they serve more beneficiaries in the community than assumed in the rate setting methodology. In addition, states can structure payment rates to adjust annually so that plans are incentivized to meet transition targets each year to make continued progress toward a goal. This is the case in Florida, which has a long-term goal of having no more than 35 percent of its MLTSS-enrolled beneficiaries residing in nursing facilities. (Kidder 2017a, 2017b).

The payment structure of MLTSS programs also permits plans to provide value-added services that target social determinants of health (Soper 2017). A recent review of eight health plans targeting dually eligible beneficiaries found plans provide value-added services to fill gaps in Medicare- and Medicaid-covered services, avoid inpatient hospital and nursing facility admissions, and improve physical health. Plans reported providing services such as housing-related supports, non-medical transportation, nutritional supports, and opportunities for socialization. For example, Tennessee allows plans to provide cost-effective

alternative services such as bed bug treatment to reduce admissions to nursing facilities (Soper 2017).

Care coordination procedures

Care coordination is a key element of MLTSS programs. Care coordinators are typically nurses or social workers who either work for a plan or a community-based organization that contracts with the plan (Saucier and Burwell 2015). Once a beneficiary has been enrolled in an MLTSS plan, the care coordinator is responsible for assessing their needs to determine what plan-covered services the beneficiary is qualified to receive. The assessment is often conducted in the beneficiary's home. Care coordinators then work with the beneficiary to develop a care plan, connect the beneficiary to providers, ensure that these services are delivered according to the care plan, and conduct periodic reassessments of the beneficiary's needs so they can adjust the care plan as those needs change (GAO 2017a). Care coordination also enforces principles important to delivering services to people who receive LTSS, such as person-centered planning, providing opportunities for self-direction, and recognizing the dignity of risk:

- Person-centered planning relates to the way in which care planning is conducted. In a person-centered planning process, a care coordinator's goal is to help the beneficiary identify which services and supports will help achieve a beneficiary's self-identified goals. For example, if an individual with ID/DD would like to work, or would like to live independently of family members, then the care plan should reflect these goals, incorporating, for example, supportive employment or housing-related services.

- Self-direction provides people who receive LTSS with a high degree of choice over how HCBS are delivered. There are two primary approaches for self-direction. Employer authority allows individuals to recruit, hire, and train their own personal care attendant. They

may be assisted by a managed care plan or state agency in locating caregivers, or they may find their own caregiver, for example, a family member. Under the second approach, budget authority, beneficiaries oversee a budget of Medicaid funds allotted based on their level of care needs and devise their own plan of services (ICRC 2017a).

- The concept of the dignity of risk asserts that individuals with disabilities should have the ability to make decisions about their lives with the same degree of autonomy as individuals without disabilities (Lewin Group 2015). This means that the care planning and service delivery process should honor individuals' choices and not insulate them from risks, just as individuals without disabilities encounter risks in their daily lives. For example, helping individuals live in the setting of their choice is important despite the inherent risks of living alone, so care planners should find ways to mitigate the risks involved in community living rather than counseling them to live in a setting that others might consider safer.

States specify certain care coordination requirements in their contracts with MCOs. A review of 19 state MLTSS programs for older adults and individuals with physical disabilities shows a wide variety of contract requirements related to care coordination. For example, about half of the contracts required care coordinators to have previous experience serving individuals with LTSS needs or disabilities (Saucier and Burwell 2015). Other common care coordination requirements included specifying the time period within which care coordinators must make contact with new members and requiring a single point of contact for beneficiaries to coordinate across the members of the care management team (Saucier and Burwell 2015).

Although care coordination generally serves the same broad functions and states specify certain requirements, each plan may take a different approach to care coordination within the parameters set by the state. For example, plans

may employ care coordinators using one of three models:

- in-house, where plans use their own care coordination staff;

- shared function, in which plan staff perform some functions while the plan contracts out other care coordination functions to community-based organizations (CBOs) such as area agencies on aging, centers for independent living, and aging and disability resource centers; and

- delegated models, where plans contract with an outside agency to conduct care coordination (e.g., a coordinator embedded within a health provider) (Saucier and Burwell 2015).

There are advantages and disadvantages to each of these approaches. For example, in-house approaches allow plans to adjust care coordination capacity easily. However, particularly in a state with a new MLTSS program, an in-house approach may not fully take advantage of existing care coordination capacity in the community available through partnering with CBOs (Saucier and Burwell 2015).

Care coordination also varies by plan in the extent to which it is tailored to specific subpopulations of individuals who receive LTSS. Earlier this year, as part of MACPAC's examination of MLTSS programs enrolling individuals with ID/DD, staff and contractors interviewed several managed care plans on their approach to care coordination for this population. One plan used a team approach; that is, although the plan had staff with experience serving individuals with ID/DD, they did not restrict case managers to serving only individuals with ID/DD. The plan representative explained that the plan deploys individuals with expertise in particular areas to assist a case manager when a beneficiary is in need of those specialized services. In contrast, other plans may connect individuals with ID/DD with case managers who specialize in serving individuals with those conditions.

MLTSS Outcomes and Oversight

As states gain experience with MLTSS, attention is turning to whether these programs have achieved their intended outcomes. There have been few rigorous evaluations of the effects of MLTSS implementation, and states typically do not collect the baseline data necessary for reliable and valid assessments of beneficiary outcomes (Dobson et al. 2017). Published studies show some evidence of success, but lack of standardized beneficiary-focused outcome measures has historically limited the ability to make comparisons across states. Over time, the recent efforts to develop quality measures for both LTSS generally and MLTSS specifically may result in data that will allow evaluations to say more about beneficiary and program outcomes.

MLTSS studies and evaluations

Much of what is known about MLTSS outcomes draws from descriptive analyses of state programs and surveys of states. In a review on the value of MLTSS published by the National Association of States United for Aging and Disabilities and the Center for Health Care Strategies, 8 of 12 states reported that MLTSS had supported their rebalancing efforts. For example, Arizona, which has structured its contracts to incentivize serving beneficiaries in community settings, reported that it served 86 percent of beneficiaries in community settings. In the same survey, seven states reported that MLTSS had helped to improve enrollees' physical health. States cited surveys and encounter data as support; for example, in Florida, 60 percent of surveyed beneficiaries reported improved health (Dobson et al. 2017).

As noted earlier, a number of states cite reductions in waiting lists as a motivating factor in pursuing MLTSS. A recent report published by CMS examined the effect of MLTSS adoption on HCBS waiver waiting lists (Saucier et al. 2017). The study found that after adoption of MLTSS, two of seven states that had previously maintained waiting

lists were able to eliminate them, and another four reduced the number of individuals on waiting lists. States gave multiple reasons for the reduction or elimination of waiting lists; MLTSS was not the sole cause (Saucier et al. 2017).

A few evaluations have been conducted that focus on state MLTSS programs. A study of Texas's managed care system found that the STAR+PLUS long-term care component resulted in an estimated 3.5 percent decrease in costs between state fiscal years 2010 and 2015 compared to what was expected under FFS (Hart and Muse 2015). A 2016 evaluation found that, after controlling for individual and area-level characteristics, beneficiaries enrolled in Minnesota's integrated care program for dually eligible beneficiaries were 48 percent less likely to have a hospital stay than enrollees in its non-integrated MLTSS program, and 6 percent less likely to have an emergency room visit (Anderson et al. 2016).

As part of a broader initiative to evaluate Section 1115 waiver programs, CMS contracted with Mathematica Policy Research to conduct an evaluation of MLTSS programs (Libersky et al. 2017). Specifically, the MLTSS evaluation is focused on understanding differences in beneficiary outcomes between FFS and MLTSS. The evaluation is focused on nine outcome measures related to hospitalization, receipt of HCBS versus institutional care, and pressure ulcers. It also includes some descriptive trends across all MLTSS programs, such as spending, utilization, and enrollment data. Due to the limited availability of encounter data, the researchers are focusing on MLTSS beneficiary outcomes in only two states, Tennessee and New York, relative to comparison groups of beneficiaries in FFS in other states (Libersky et al. 2017). The interim findings of the evaluation show mixed results. Enrollment in New York's MLTSS program was associated with a reduced probability of institutionalization over its comparison group, but there was no significant effect in Tennessee. Both states demonstrated higher use of personal care services than their comparison groups. Evaluators also found an increase in hospitalizations in

Tennessee, but a decrease in New York. A final evaluation will be completed in 2019 which will incorporate additional measures that may refine these results and possibly incorporate new data or other analyses (Libersky et al. 2018).

MLTSS quality measurement development

Successful monitoring and evaluation of the quality of care provided by MLTSS programs is partially dependent on the availability of quality measures that are appropriate for the population receiving LTSS. People who receive LTSS typically have chronic conditions and their functional ability is likely to decline over time due to the nature of their disability or age. Thus, quality measures focusing on beneficiary outcomes such as improvements in health status and function are not sufficient for monitoring LTSS programs. More appropriate LTSS quality measures include improvement in quality of life, community integration, avoidance or delay of institutionalization, and other outcomes that do not assume improvement in health and functional status. Measures must also address the varying needs of different populations; for example, certain outcomes may be more relevant to younger individuals with ID/DD (e.g., satisfaction with employment supports) than to older adults.

To date, measures used to assess LTSS quality have primarily focused on process. A 2016 inventory of state quality measurement initiatives conducted for MACPAC, found that most measures focused on compliance with waiver reporting requirements, for instance, confirming provider qualifications or that personal goals were included in service plans (SHADAC 2016). In 2013, a review of 17 MLTSS contracts similarly found that quality requirements tended to focus on processes, such as timeliness of receipt of covered services and the process of handling critical incidents, with only a few related to outcomes, such as the rate of nursing facility admission (Rivard et al. 2013).

A number of efforts are underway to develop and test quality measures for LTSS that are more

appropriate for users of these services and which may be of more interest to policymakers. These efforts place more emphasis on beneficiary experiences and outcomes, and can be used to strengthen quality oversight efforts in both Medicaid FFS and MLTSS:

- CMS developed the Experience of Care (EoC) Survey as part of the Testing Experience and Functional Tools (TEFT) demonstration. TEFT has granted nine states awards to test HCBS quality measurement tools and develop LTSS information technology infrastructure. The EoC Survey is a beneficiary survey that covers beneficiaries with all types of disabilities. Following testing by states in 2015, this survey has now been incorporated into the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program as the CAHPS Home and Community-Based Services Survey. The National Quality Forum has also endorsed 19 quality measures derived from the survey. TEFT-participating states are currently collecting a second round of survey data, which is intended to give them information to assess and improve their HCBS programs (CMS 2017c).

- The National Core Indicators for Aging and Disabilities is a survey of beneficiaries that can be used in both FFS and managed care programs. Implemented in 2015, this survey was modeled after the National Core Indicators for Intellectual and Developmental Disabilities survey, which began in 1997. Both surveys focus on beneficiaries' reports of their quality of life and outcomes, and can be used across different delivery systems (Bradley et al. 2017).

- CMS contracted with the National Quality Forum to convene a group of stakeholders to identify domains for HCBS quality measure development. In 2016, NQF's report identified 11 areas where there are gaps in measurement, including areas such as service delivery and effectiveness, community inclusion, and caregiver support (NQF 2016). The

report is intended to provide priorities for the development and testing of new HCBS measures.

In addition, CMS has contracted with Mathematica Policy Research and the National Committee for Quality Assurance to develop standardized MLTSS quality measures. In the first phase, contractors reviewed existing measures and convened a technical expert panel to identify the most important measure gaps. The project recommended development and testing of eight measure concepts including assessment and care planning, rebalancing and institutional utilization, and fall risk reduction. The second phase, which is currently underway, consists of field testing the recommended measures to determine the feasibility of collecting required data elements from health plans and testing the results for validity and reliability (Ross 2017). CMS has begun making the technical specifications for the measures that have been tested available to states, beginning with the four comprehensive assessment and care planning measures. These technical specifications will allow states to implement these measures if they desire to do so (CMS 2018b).

Federal oversight of MLTSS

With nearly half of all states implementing MLTSS for at least some subpopulations, increasing attention is being paid to federal efforts to oversee these programs. Two recent reports by the U.S. Government Accountability Office (GAO) have identified areas where federal oversight may be lacking. First, in a study of CMS's monitoring of payment rates, GAO found that five of six state MLTSS programs included payment rates that supported rebalancing through blended capitation rates. However, most of the states did not link payments directly to performance in achieving program goals, for example, by making a portion of payment conditional on their performance on outcome measures. GAO also found that CMS had not consistently required states to report on how their payment structures achieved program goals such as rebalancing (GAO 2017a). CMS's

requirements were inconsistent across study states; three were required to report on their MLTSS programs' achievement of goals related to providing HCBS and the other three were not. GAO recommended that CMS require such reporting across all states. In its response to the report, the U.S. Department of Health and Human Services (HHS) said it would release guidance clarifying that states must include certain measures related to quality of life, rebalancing, and community integration among the other measures they report on in their required managed care annual reports (GAO 2017a).

A second GAO report examined CMS's oversight of access and quality in MLTSS programs. Again, GAO found inconsistencies across states regarding CMS reporting requirements for key elements of MLTSS programs (GAO 2017b). In particular, GAO found inconsistencies in information CMS required states to report regarding network adequacy, critical incidents, and appeals and grievances. CMS officials told GAO that they do not have a consistent approach because MLTSS monitoring is customized to each state. GAO recommended, and HHS concurred, that more steps should be taken to identify and obtain information on MLTSS access and quality to make federal oversight more effective (GAO 2017b).

Even as gaps identified in federal oversight of MLTSS are addressed, oversight will be difficult without sufficient encounter data to support Medicaid claims analysis, and—as noted earlier— adequate outcome data also are needed. CMS and states are working to implement the Transformed Medicaid Statistical Information System (T-MSIS). As of March 2018, all state Medicaid agencies but one were in the production phase of T-MSIS, meaning they have begun submitting information to the system and are either up to date in their reporting or in the process of catching up (CMS 2018c). T-MSIS data are not yet available for analysis by outside entities because the agency is still testing the data for completeness and quality. However, CMS plans for T-MSIS include improved encounter data for managed care plans, including

MLTSS programs, which should assist oversight efforts.

The Future of MLTSS

As more states pursue managed care as a delivery model for LTSS, and as existing programs mature, the MLTSS model continues to evolve. For example, we heard in our research on network adequacy that as states learned what works and found limitations to their existing approaches, the reprocurement process provided opportunities to implement new contract requirements informed by past experience. We can similarly expect continued changes in other program areas over time. In addition, the MLTSS plan market will likely evolve, particularly as larger organizations gain experience in multiple states. As noted earlier, there are opportunities to learn more about MLTSS program outcomes, such as the effect of MLTSS on access to care, and to gain insight into areas such as how plans make service plan decisions.

The Commission has begun to explore two areas of MLTSS evolution in particular. First, state interest in enrolling individuals with ID/DD into managed care is growing. However, the ID/DD population has special considerations which may influence how states approach enrollment of this group. Second, states are increasingly aligning MLTSS with Medicare benefits to integrate care for beneficiaries dually eligible for Medicare and Medicaid. One particular arrangement, aligning MLTSS with Medicare Advantage dual-eligible special needs plans (D-SNPs) may gain additional traction now that special needs plans (SNPs) have been permanently authorized.

Enrollment of individuals with ID/DD into MLTSS programs

Throughout the 1980s and 1990s, states expanded use of HCBS waivers and also moved to implement managed care. However, for people with ID/DD, these two Medicaid program reforms occurred on

separate tracks, only intersecting in states such as Arizona and Wisconsin, which began using managed care for individuals with ID/DD in 1988 and 1999, respectively. Most states that have implemented managed care for people with ID/DD have not incorporated LTSS, and continue to cover such services under FFS. Several factors likely play a role in why services for individuals with ID/DD have historically been excluded from MLTSS:

- Managed care plans and ID/DD service providers lack experience with each other. Given that Medicaid is the dominant payer of services for individuals with ID/DD and these services have traditionally been paid on an FFS basis, many plans do not have experience working with ID/DD providers. In addition, many ID/DD providers do not have experience contracting with managed care.

- In addition to lacking experience with providers serving beneficiaries with ID/DD, managed care plans have not historically served individuals with ID/DD, who differ from other recipients of LTSS due to the types of services received (e.g., education and employment supports) and the length of time they are typically enrolled in LTSS plans. This lack of history contributes to stakeholder mistrust and resistance to moving this population to MLTSS.

- Organized and engaged ID/DD stakeholder communities exist at both the state and federal levels and they have historically resisted MLTSS. Individuals with ID/DD often need LTSS for many years, and sometimes for decades. As a result, advocates for individuals with ID/DD, including family members, professionals, and people with ID/DD themselves, are often personally involved in the provision of services and the relationships they share. In addition, strong stakeholder coalitions have been built over years of policy and program advocacy efforts to support the deinstitutionalization and community inclusion of people with ID/DD.

- Cost savings are difficult to achieve with the ID/DD population. Spending on LTSS for people

with ID/DD is largely rebalanced toward HCBS, limiting potential savings from transitioning beneficiaries to the community (Eiken et al. 2017). In addition, as life expectancy for individuals with ID/DD continues to increase, costs for this population are likely to persist or increase (AAIDD 2015).

Tailoring MLTSS programs for individuals with ID/DD. Several states have recently included individuals with ID/DD in the transitions to MLTSS, and others have indicated interest in doing so. Given that this group's needs differ from older adults and individuals with physical disabilities, the Commission recognized a need to better understand how MLTSS has been implemented for this population. In 2017, MACPAC employed HMA to review the eight state contracts representing, as of November 2017, all states administering comprehensive managed care programs or prepaid inpatient health plans including the majority or all HCBS for people with ID/DD (Arizona, Iowa, Kansas, Michigan, New York, North Carolina, Tennessee, and Wisconsin). The contract review found that ID/DD-specific provisions are more prevalent for separate programs designed for people with ID/DD than for programs that include other populations receiving LTSS. The prevalence of ID/DD-specific provisions also appears to be correlated with states that have underlying ID/DD policy goals, such as Tennessee's efforts to increase employment among people with ID/DD, and New York's focus on integration of Medicare and Medicaid services for people with ID/DD. States moving to managed care for all populations, such as Kansas and Iowa, had the fewest provisions targeted specifically to people with ID/DD.

Key findings from the contract review include:

- The most frequent ID/DD-specific requirements relate to training and experience of the case managers. For example, Tennessee case managers are required to have received training on cultural competency, family supports, transition planning for youth, health and safety training that includes acknowledgement of the

dignity of risk, housing options, and assistive technology. Kansas and New York require a care manager to have a certain amount of experience working with individuals with ID/DD.

- Three states (Kansas, North Carolina, and Tennessee) require plan staff (including senior leadership) to have ID/DD-specific experience, especially for medical directors and LTSS directors. Tennessee is the only state to require experience in integrated employment services for people with ID/DD.

- ID/DD-specific stakeholder engagement requirements are found primarily in states with MLTSS programs targeted to people with ID/DD. Arizona and New York both require ID/DD-specific advisory committees that include members and families to provide input into the plan. Tennessee goes further by identifying specific ID/DD organizations that the MCOs must include in their stakeholder engagement efforts.

- Five states include ID/DD-specific quality provisions or measures important to people with ID/DD. For example, New York includes the Council on Quality and Leadership Personal Outcome Measures in its quality improvement program, and notes that the New York State Office for People with Developmental Disabilities will develop a customized review process for outcomes of care management for individuals with ID/DD. Tennessee notes that quality monitoring will be developed by the state's Department of Intellectual and Developmental Disabilities.

In addition to reviewing contracts, HMA conducted a series of interviews with states, managed care plans, consumer advocates, and provider associations. Slow, incremental program transitions (by region, eligibility category, or both) were cited as a factor of success. Another factor cited as being important to program and policy success was stakeholder engagement, which helped overcome reluctance to the move to MLTSS,

particularly among beneficiaries and advocates. Examples of stakeholder engagement efforts that plans undertook include having a member advocate on staff, hiring family members and people with disabilities, involving advocacy and stakeholder organizations in service coordinator training and review of training materials, supporting and participating in local disability events and conferences, and hosting regularly scheduled stakeholder meetings in a variety of geographic locations.

Integrating care for dually eligible beneficiaries

People who are dually eligible receive both Medicare and Medicaid benefits by virtue of their age or disability and low incomes. For dually eligible beneficiaries, Medicare is the primary payer of physician services, inpatient and outpatient acute care, and post-acute care. Medicaid wraps around Medicare's coverage by providing assistance with Medicare premiums and cost sharing and by covering some services that Medicare does not cover, such as LTSS. Among full-benefit dually eligible beneficiaries in FFS in 2013, 42 percent used LTSS (MACPAC and MedPAC 2018).[16]

Generally, care for dually eligible beneficiaries is not well integrated across Medicare and Medicaid. The two programs cover different benefits and have different program and payment rules, which can result in confusion for beneficiaries and providers. Because policies and benefits are not integrated, there are missed opportunities to help both programs reduce costs while improving the beneficiary experience. For example, better management of care transitions following an acute inpatient hospital admission (paid for by Medicare) for dually eligible beneficiaries who are receiving HCBS (paid for by Medicaid) could help reduce avoidable rehospitalizations.

In recent years, states interested in integrating care for dually eligible beneficiaries have pursued several options. The FAI, authorized under Section

3021 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) to enable states to test models to integrate primary, acute, behavioral health, and LTSS for their dually eligible beneficiaries, is currently operating in 11 states. As of April 2018, 383,324 dually eligible beneficiaries were enrolled in the capitated model being tested in nine states (ICRC 2017b). In the capitated model, states enter into a three-way contract with CMS and the integrated Medicare-Medicaid plans. Most demonstrations are scheduled to end in 2019 or 2020 (MACPAC 2018a).

States may choose to align their managed care (including MLTSS) programs with Medicare Advantage D-SNPs. Medicare Advantage is the managed care component of Medicare and D-SNPs are a type of Medicare Advantage health plan designed specifically for dually eligible beneficiaries. Since 2008, D-SNP enrollment has grown from 829,000 to about 2 million dually eligible beneficiaries, nearly 20 percent of all dually eligible beneficiaries (MedPAC 2017).

Alignment of MLTSS and D-SNPs occurs on a continuum, ranging from limited benefit coordination to fully integrated plans, as follows:

- States may use D-SNPs to provide limited benefit coordination. Federal law requires D-SNPs to have a contract with the state Medicaid program to operate in a state; however, a state may choose not to use the D-SNP as a vehicle to closely align Medicare or Medicaid benefits.[17] In such cases, D-SNPs may meet only the minimum requirements to provide or coordinate Medicaid benefits required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), but states have the flexibility to impose additional requirements.[18] Dually eligible beneficiaries may see some benefits of shared information between the two programs, but the minimum MIPPA requirements do not provide a high degree of benefit integration.

- States may require close coordination between D-SNPs and MLTSS plans. States

may selectively contract with D-SNPs by only contracting with D-SNPs that offer MLTSS plans within their state or requiring that the MLTSS plans in their state offer a companion D-SNP. State contracts may align multiple areas of the two programs, but the beneficiary is technically enrolled in two plans. For example, Minnesota includes the D-SNP requirements in their Medicaid MLTSS contracts and Arizona establishes requirements for D-SNPs in a separate contract (Verdier et al. 2016). When one parent organization offers both an MLTSS plan and a D-SNP, states and the plan can encourage (but not require) beneficiaries to enroll in the companion D-SNP. When beneficiaries are enrolled with the same parent organization for both their Medicare and Medicaid benefits, the parent organization coordinates all of the benefits.

- States may contract with a fully integrated dual-eligible special needs plan (FIDE-SNP). In this case, beneficiaries are enrolled in a single integrated plan that typically includes LTSS, behavioral health, and other Medicaid benefits that vary by state (ICRC 2017c). These plans operate similarly to the FAI capitated plans in that Medicare and Medicaid benefits can be provided through the same parent organization, thereby providing a seamless experience to the beneficiary despite services being paid for by two different programs. The FIDE-SNP may receive an additional Medicare payment from CMS through a frailty adjustment if their beneficiaries have an average acuity level as high as beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly. In Minnesota, the Minnesota Senior Health Options (MSHO) program requires that beneficiaries who choose to enroll receive all their benefits from one plan and all of the MSHO plans are FIDE-SNPs (ICRC 2017c).

D-SNP and FIDE-SNP authority was made permanent in the Bipartisan Budget Act of 2018 (P.L. 115-123).[19] Removing uncertainty over the future of D-SNPs could potentially prompt some

of the states that have not yet aligned MLTSS with D-SNPs to consider doing so. The law also takes other steps to promote greater integration of Medicare and Medicaid benefits through D-SNPs. It requires that D-SNPs meet one of several new requirements related to the integration of Medicaid and Medicare benefits. For example, under one option, D-SNPs coordinate LTSS, behavioral health services, or both through integration activities such as notifying the state in a timely manner when a beneficiary has been hospitalized, has visited the emergency room, or has been discharged from a hospital or nursing home. The law also directs the Secretary of HHS, through the Medicare-Medicaid Coordination Office, to establish a uniform process for disseminating information to states related to contracts with D-SNPs and to establish resources for states interested in exploring D-SNPs as a platform for integration.

Looking Ahead

This chapter provides an overview of MLTSS in Medicaid and issues of key importance as this delivery system evolves. During the course of the Commission's work, we have identified areas for further exploration. In particular, the Commission is interested in better understanding how states are aligning MLTSS with D-SNPs to integrate care for dually eligible beneficiaries. We expect our future work to focus on identifying state activity to develop integrated care models and the key components of these models. We are especially interested in learning how states and plans have overcome barriers to integration and whether these strategies can be replicated in other states.

Another issue of concern is the adequacy of federal and state oversight efforts and the extent to which information used in federal oversight efforts reflects the breadth of information collected by states from MCOs, such as information about complaints and grievances and results of beneficiary surveys. States collect a great deal of information from plans; however, as GAO found, inconsistencies

in state reporting to CMS means that little of this information is comparable across states, and this information could be better disseminated.

We will also monitor research on the cost and quality of MLTSS programs, particularly how costs and quality of services provided in MLTSS compare to services in FFS, how different state design decisions influence outcomes, and how plans deal with the challenges of managing care and costs. We will also track CMS's efforts to develop HCBS and MLTSS quality measures, and the adoption of these measures by states. Improved outcome data would help the Commission understand the successes and challenges faced by CMS and states, and enhance our ability to advise Congress on any steps that need to be taken to improve the oversight and operation of MLTSS programs.

Endnotes

[1] The $29 billion figure may represent an underestimate due to data limitations in spending on MLTSS. The Centers for Medicare & Medicaid Services (CMS) required states to report estimates of MLTSS spending beginning in FY 2016, which may improve future data reporting (Eiken et al. 2017).

[2] For more information on how state Medicaid programs deliver LTSS and how Medicaid-covered LTSS have evolved over time, see the chapter on Medicaid's role in providing assistance with LTSS in MACPAC's June 2014 report to Congress (MACPAC 2014).

[3] Medicaid beneficiaries receiving LTSS vary in the proportion of LTSS spending attributable to HCBS. For individuals with ID/DD, over 70 percent of LTSS was for HCBS in FY 2015. In contrast, only 44 percent of Medicaid LTSS spending in 2015 was for HCBS for older adults and persons with disabilities (Eiken et al. 2017).

[4] *Olmstead v. L.C.* 1195.Ct. 2176 (1999).

[5] In some states, individuals on waiting lists may not yet have been determined to be eligible for HCBS, and in other states, HCBS waiting lists are at least partially attributable to a lack of state funding to meet demand.

[6] The terms intellectual disabilities and developmental disabilities refer to different conditions. As described by the American Association on Intellectual and Developmental Disabilities, intellectual disability originates before the age of 18 and includes substantial limitations both in intellectual functioning (e.g., reasoning, learning, problem solving) and in adaptive behavior. Developmental disabilities appear before the age of 22 and are likely to persist throughout life. They include intellectual disability and other physical and cognitive disabilities that appear during childhood (AAIDD 2018).

[7] The closure of state-run and other public institutions over the past 50 years, along with litigation and consent decrees stemming from the *Olmstead* decision have helped to hasten the provision of HCBS for individuals with ID/DD. Spending on LTSS for people with ID/DD is now largely rebalanced toward HCBS, with 76 percent of Medicaid LTSS spending for people with ID/DD residing in the community in FY 2015 (Eiken et al. 2017).

[8] The state of Washington once operated an MLTSS program, but ended it in 2012 (Lewis et al. 2018).

[9] Enrollment estimate based on most recent year of data available, either 2016 or 2017. In addition, data for eight MLTSS programs in seven states (California, Hawaii, Massachusetts, Michigan, North Carolina, Texas, and Virginia) were unavailable (Lewis et al. 2018).

[10] The CMS Medicare-Medicaid Coordination Office has implemented the FAI to improve care and reduce program costs for dually eligible beneficiaries as well as to improve coordination between the Medicaid and Medicare programs. As of December 2017, 13 states participated in the FAI either under a capitated model, a managed FFS model, or an alternative model. Demonstrations in two states ended in December 2017, and 11 states continued their demonstrations into 2018 (MACPAC 2018a).

[11] Tennessee's enrollment of individuals with ID/DD is limited to those who became eligible as of July 1, 2016. Beneficiaries who were eligible prior to that date can continue to receive their LTSS through FFS (TN HCFA 2018).

[12] Section 1915(c) waivers authorize states to provide HCBS as an alternative to institutional care in nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and hospitals. States are permitted to impose caps on waiver program enrollment and average costs per person to ensure that they do not exceed the waiver's cost-neutrality limit.

[13] Some waivers may be extended for periods of 10 years. CMS has indicated that it will approve routine, successful, non-complex Section 1115(a) waiver extensions for up to 10 years (CMS 2017a). In December 2017, CMS approved the Mississippi family planning waiver for 10 years (CMS 2017b).

[14] Presently, states must use a combination of these authorities to implement MLTSS. In our March 2018 report, the Commission recommended that Congress should revise Section 1915(c) waiver authority to permit Section 1915(c) waivers to waive freedom of choice and selective contracting. In addition, the Commission recommended that Congress extend approval and renewal periods for Section 1915(b) waivers from two to five years (MACPAC 2018b).

[15] In a letter to governors in March 2017, HHS indicated it would review the managed care regulations to give greater weight to beneficiary outcomes and state priorities. It is currently unknown when this review will be complete and any changes to these regulations that might occur (HHS 2017b).

[16] Full-benefit dually eligible beneficiaries receive the full range of Medicaid benefits offered in a given state. For partial-benefit dually eligible beneficiaries, Medicaid provides assistance with Medicare premiums and cost sharing. Most dually eligible beneficiaries (72 percent) are eligible for full Medicaid benefits (MACPAC and MedPAC 2018).

[17] States may also choose not to contract with a prospective D-SNP.

[18] MIPPA, as amended by the ACA, required that Medicare Advantage organizations seeking to offer D-SNPs have a contract with the state Medicaid agency by calendar year 2013 and in each year thereafter (42 CFR 422.107). MIPPA enacted a minimum set of requirements for what D-SNP contracts must cover: (1) the Medicare Advantage organization's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits; (2) the categories of eligibility for dually eligible beneficiaries to be enrolled under the D-SNP, including the targeting of specific subsets; (3) the Medicaid benefits covered under the D-SNP;

(4) the cost sharing protections covered under the D-SNP; (5) the identification and sharing of information about Medicaid provider participation; (6) the verification process of an enrollee's eligibility for both Medicare and Medicaid; (7) the service area covered under the SNP; and (8) the contracting period (CMS 2016). States can add additional requirements beyond the minimum MIPPA requirements.

[19] D-SNPs were originally authorized as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). They began operating in 2006. The authority granted under MMA expired in December 2008 but was extended by MIPPA and subsequently extended by other legislation.

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APPENDIX 3A: State MLTSS Programs

TABLE 3A-1. State MLTSS Program Populations and Enrollment   T 3A-1

State	Program	Year implemented	Medicaid managed care authority	Eligible enrollment populations				Enrollment in 2017
				Older adults	Adults with physical disabilities	Adults with ID/DD	Children with disabilities	
Arizona	Arizona Long-Term Care System	1989	1115	✓	✓	✓	✓	60,044
California	Cal Medi-Connect	2014	1115	✓	✓	–	–	118,096
	Managed Medi-Cal Long-Term Services and Supports	2014	1115	✓	✓	✓	–	N/A
Delaware	Diamond State Health Plan Plus	2012	1115	✓	✓	–	✓	12,666[1]
Florida	Statewide Medicaid Managed Long-Term Care Plan	2013	1915(b)	✓	✓	–	–	93,843
Hawaii	Quest Integration	2015	1115	✓	✓	✓	✓	N/A
Idaho	Medicare-Medicaid Coordinated Plan	2014	1915(a)	✓	✓	–	–	2,489[1]
Illinois	MLTSS	2016	1915(b)	✓	✓	–	–	28,640
	Medicare-Medicaid Alignment Initiative	2014	1932(a)	✓	✓	–	–	52,004
	Integrated Care Program	2011	1932(a)	✓	✓	✓	–	114,365
Iowa	Health Link	2016	1915(b)	✓	✓	✓	✓	36,825[1]
Kansas	KanCare	2013	1115	✓	✓	✓	✓	33,615
Massachusetts	One Care	2013	1115	–	✓	✓	–	17,938
	Senior Care Options	2004	1915(a)	✓	–	–	–	N/A
Michigan	MI Health Link	2015	1915(b)	✓	✓	✓	–	39,965
	MI Choice	2013	1915(b)	✓	✓	–	–	N/A

TABLE 3A-1. (continued)

State	Program	Year implemented	Medicaid managed care authority	Eligible enrollment populations				Enrollment in 2017
				Older adults	Adults with physical disabilities	Adults with ID/DD	Children with disabilities	
Michigan	Managed Specialty Services and Supports	1998	1915(b)	–	–	✓	✓	N/A
Minnesota	Senior Care Plus	2005	1915(b)	✓	–	–	–	16,265
	Senior Health Options	1997	1915(a)	✓	–	–	–	37,649
New Jersey	NJ FamilyCare	2014	1115	✓	✓			28,731[1]
New Mexico	Centennial Care	2014	1115	✓	✓	✓	✓	34,947[1]
New York	Medicaid Advantage Plus	2016	1115	✓	✓	–	–	8,356
	Fully Integrated Duals Advantage	2015	1115	✓	✓	–	–	4,468
	Fully Integrated Duals Advantage – I/DD	2015	1915(a)	–	–	✓	–	701
	Managed Long-Term Care Partial Cap	1998	1115	✓	✓	–	–	186,626
North Carolina	NC Innovations	2005	1915(b)	–	–	✓	✓	N/A
Ohio	MyCare	2014	1915(b)	✓	✓	✓	–	111,994
Pennsylvania	Community HealthChoices	2018	1915(b)	✓	✓	–	–	N/A
	Adult Community Autism Program	2009	1915(a)	–	–	✓[2]	–	147
Rhode Island	Integrated Care Initiative, Phase 2	2015	1115	✓	✓	✓	–	13,725[1]
	Rhody Health Options	2013	1115	✓	✓	✓	–	15,234[1]
South Carolina	Healthy Connections Prime	2015	1932(a)	✓	–	–	–	11,907
Tennessee	Employment and Community First CHOICES	2016	1115	–	–	✓	✓	1,389
	CHOICES	2010	1115	✓	✓	–	✓[3]	28,941

TABLE 3A-1. (continued)

State	Program	Year implemented	Medicaid managed care authority	Eligible enrollment populations				Enrollment in 2017
				Older adults	Adults with physical disabilities	Adults with ID/DD	Children with disabilities	
Texas	STAR Kids	2016	1115	–	–	–	✓	N/A
	Dual Eligibles Integrated Care Project	2015	1115	✓	✓	✓	–	41,182
	STAR Health	2015	1915(a)	–	–	–	✓[4]	30,912
	STAR+PLUS	1998	1115	✓	✓	✓	✓	519,105
Virginia	Commonwealth Coordinated Care Plus	2017	1915(b)	✓	✓	✓	✓	N/A
Wisconsin	Family Care	1999	1915(b)	✓	✓	✓	–	44,404
	Family Care Partnership	1996	1932(a)	✓	✓	✓	–	3,000

Notes: MLTSS is managed long-term services and supports. ID/DD is intellectual or developmental disabilities. MLTSS programs may carve certain benefits out of capitation. Enrollment data may include some beneficiaries who did not use LTSS.

✓ Check indicates population is included in an MLTSS program.

– Dash indicates that population is not included in MLTSS program. N/A indicates that enrollment data was not available.

[1] State enrollment figures are for 2016.

[2] In Pennsylvania, enrollment in the Adult Community Autism Program is limited to adults age 21 and older who have been diagnosed with autism spectrum disorder and meet certain clinical criteria.

[3] Includes only children who are nursing facility residents.

[4] Includes only children in foster care.

Source: MACPAC, 2018, analysis of Lewis et al. 2018, PA DHS 2018b, and NYS OPWDD 2018.