

## The Value of Managed Long-Term Services and Supports

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Children and adults with disabilities and older adults who need support to perform daily tasks of living must rely on a variety of services and supports over an extended period. Medicaid provides the only coverage for these long-term services and supports (LTSS), other than limited private insurance. Today, Medicaid pays for 60 percent of the paid LTSS provided in the U.S.

States have moved in the last twenty years to provide Medicaid coverage through contracts with managed care plans, but have typically carved out services for older adults and persons with disabilities, leaving LTSS to be provided through traditional “fee-for-service” payments to service providers. Recently, states have moved to bring these populations into managed care. Today, nearly half of the state Medicaid programs provide services for older adults and persons with disabilities through managed long-term services and supports (MLTSS) plans.

MLTSS plans offer substantial value to beneficiaries and their families, to state governments, and to the public, relative to the care provided previously through traditional “fee-for-service” Medicaid. Beneficiaries have a much better experience in MLTSS plans with a greater opportunity to remain independent through increased access to home and community-based living, resulting in improved health and quality of life outcomes. These services are less costly than institutional care, and so states are able to make greater use of limited resources to serve more beneficiaries and achieve better outcomes. The public benefits from lower levels of health care expenditures directed to the people with the most complex care needs.

### **A better care experience for beneficiaries and their families**

Medicaid originally covered long-term care only in a nursing facility. Since the late 1990s, however, Medicaid has been increasingly paying for home- and community-based services (HCBS) as an alternative to institutional care. In traditional fee-for-service Medicaid, navigating the complex and highly-fragmented world of home- and community-based services and supports can be overwhelming for beneficiaries and their families. Individuals who enroll in MLTSS plans realize almost immediately the added value they get from the assistance, coordination, and seamless service experience they get in a managed care plan.

*Key features that improve the care experience for beneficiaries and their families include:*

- Person- and Family-Centered Care Planning: in which beneficiaries set goals and priorities, comprehensively assess needs, evaluate available resources, and develop a plan of care.
- Assessment: upon enrollment helps establish a relationship with the member and determine the services and supports necessary to meet the level of care and support a beneficiary requires and ensures appropriate care management is provided.
- Care Management: providing a single point of contact for the beneficiary, coordinating medical, behavioral health and LTSS providers, supporting the family caregiver, monitoring changes in conditions, modifying the care plan as needed, and reducing inappropriate and duplicative care.
- A Care Team: coordinating social service agencies, in-home providers, medical care and mental health providers, and the family caregiver to ensure needed services are provided.
- Person-Centered Services and Supports: working with community partners to provide the combination of services and supports that best meets the needs and goals of the individual; including adult day care services, personal care services, medication adherence, transportation, meal preparation, home modifications.
- Community Integration and Engagement: through increased access to services delivered in the person's home or community-based setting; enabling the individual to live more independently, better engage socially, and participate in employment opportunities in the communities in which they live; with greater satisfaction with services and quality of life.
- Attention to Quality: with accountability to state and federal governments for the quality of the care provided and success in meeting the goals and preferences of the individual.

Having a care manager is a major benefit of MLTSS plans for persons with disabilities and their families that is not normally available in the traditional Medicaid program.

It greatly reduces the complexity of arranging and managing care for a family and increases the ability of the individual to have a seamless care experience that can help the beneficiary achieve his or her personal goals.

*Evidence points to high levels of satisfaction for Medicaid beneficiaries enrolled in managed care plans. For example, a 2015 survey of enrollees in New York State managed long-term care plans found 87 percent rated their plans as good or excellent and a similar percentage rated the quality of their providers as good or excellent.<sup>1</sup>*

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<sup>1</sup> IPRO. Managed Long-Term Care: 2015 Member Satisfaction Survey. Summary Report. December 2015.

## An incentive to support people in their homes, including support of family caregivers

MLTSS plans receive a per-capita payment (“capitation”) from the state for each member and are obligated to provide all care and services needed for the individual under the capitation payment. The incentives that result from this arrangement encourage:

- Home-and-community-based services (HCBS) instead of nursing home and other institutional care, enabling people to move to and receive support in the most-integrated (with non-disabled persons) setting appropriate to their needs.
- Training and supporting family caregivers who are providing services for a loved one – services which often prove cost effective.
- Investing in affordable housing and home modifications, falls prevention programs, and other preventive services and supports to avoid a failure in care or an incident that would result in an expensive ER visit, hospital admission or readmission, or a nursing home placement.

## Assistance to States in meeting goals of rebalancing toward HCBS and managing expenditures

MLTSS plans partner with states in meeting their goals of expanding the capacity to serve beneficiaries in their homes and communities, reducing the reliance on expensive institutions, and managing Medicaid expenditures for LTSS. Home- and community-based services can be provided for less than half the cost of traditional institutional care.<sup>2</sup>

MLTSS plans can use the funds a state is currently spending on its Medicaid LTSS programs, and, by reducing per capita costs, enable the state to serve more beneficiaries. MLTSS plans, through assessment, care planning and care management, achieve savings by lowering the use of institutions, supporting family caregivers, better coordinating care, and better aligning the use of paid services with the goals and preferences of the individual and family.

*Evidence shows that MLTSS reduces the use of nursing homes. While there has been a general shift in Medicaid toward greater use of home- and community-based care, the decline in institutional care has been particularly pronounced in States that have had MLTSS in place for some time.*

- *Arizona established the first Medicaid MLTSS program in 1989. Since then, the state has seen rates of nursing home use decrease from 95 percent<sup>3</sup> to 27*

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<sup>2</sup> CMS.gov “Home- and Community-Based Services” <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/hcbs.html>

<sup>3</sup> J. Libersky and J. Verdier (2014) *Financial Considerations: Rate Setting for Medicaid (MLTSS) in Integrated Care Programs*. Available at: [http://www.mathematica-mpr.com/~media/publications/PDFs/health/dual\\_eligibles\\_ML\\_TSS\\_rate\\_setting.pdf](http://www.mathematica-mpr.com/~media/publications/PDFs/health/dual_eligibles_ML_TSS_rate_setting.pdf)

percent of the enrolled population in 2014<sup>4</sup>—all of whom are nursing home certifiable.

- In Massachusetts, the Senior Care Options (SCO) program has provided integrated care since 2004. A study comparing SCO participants and similarly complex individuals in fee-for-service Medicaid who were eligible for SCO found that the integrated program kept members in the community longer and decreased the utilization of skilled nursing facilities (SNFs).<sup>5</sup>
- Family Care, Wisconsin's MLTSS program, wraps around the standard Medicaid medical benefit for beneficiaries with a nursing home level of need. An independent evaluation of the program in 2005 concluded that Family Care increased access to HCBS and significantly decreased the cost of providing LTSS for its high-need beneficiaries compared to a similar group of Medicaid beneficiaries not enrolled in the program.<sup>6</sup>
- In Florida, the acting State Medicaid Director stated in December 2016 testimony to the Florida Senate that including nursing facilities in the state's MLTSS program had helped the state avoid \$430 million in nursing home expenditures.<sup>7</sup>

### Lower medical expenditures for the highest users of medical care

While people with disabilities of all ages are a relatively small part of the U.S. population, they account for a large portion of overall medical utilization and resulting health care expenditures. Providing these individuals with effective LTSS for as long as possible in their homes and communities greatly reduces unnecessary and expensive use of medical care.

An older adult without adequate supports who falls out of bed in the middle of the night and calls 911 triggers a cascade of expensive medical activity: an ambulance ride to the ER, followed by a hospitalization, and a post-acute stay in a skilled nursing facility; all for an event that could have been managed in the home with a care manager and a care team.

### MLTSS plans:

- Reduce re-hospitalizations by providing effective transitions-in-care from hospital to home, and stabilization and support in the home.
- Support individuals with mental health conditions and/or substance abuse disorders, resulting in reduced unnecessary emergency room visits.

<sup>4</sup> Joint Legislative Budget Committee (2015) *Program Summary: Arizona Long Term Care System*. Available at: <http://www.azleg.gov/jlbc/psaxsaltcs.pdf>

<sup>5</sup> Jen Associates (2013) "Massachusetts Senior Care Option 2005-2010 Impact on Enrollees: Nursing Home Entry Utilization." Available at: <http://www.mass.gov/eohhs/docs/masshealth/sco/sco-evaluation-nf-entry-rate-2004-through-2010-enrollment-cohorts.doc>

<sup>6</sup> APS Healthcare, Inc. "Family Care Independent Assessment: An Evaluation of Access, Quality and Cost-Effectiveness for Calendar Year 2003-2004." Washington, DC: APS Healthcare, Inc., 2005. Available at: <https://www.dhs.wisconsin.gov/familycare/reports/ia.pdf>

<sup>7</sup> <http://www.politico.com/states/florida/story/2016/12/senate-begins-examination-of-medicaid-managed-long-term-care-108104>

- Reduce default use of ambulances and emergency rooms for non-emergency events by providing a care manager who is a single point of contact with responsibility for anticipating needs and responding quickly to events that might otherwise result in an ER visit or hospitalization.
- Ensure preventative services and supports are provided that can help prevent falls, manage chronic disease, and avoid other serious medical issues that would require an ER visit or hospitalization.
- Promote social inclusion, community engagement, and enhanced coordination of services, increasing overall satisfaction with service delivery which helps individuals achieve optimal health and quality of life outcomes.

Often identification of a simple need early and provision of a small service or support can prevent an event in the home that would precipitate more expensive use of medical care.

*Evidence shows that MLTSS plans reduce medical utilization:*

- *In Texas's "STAR+PLUS" MLTSS program, enrollees in the program experienced significantly fewer inpatient admissions, emergency room visits, and shorter hospital lengths of stay than Medicaid beneficiaries in the traditional fee-for-service (FFS) program.<sup>8</sup>*
- *A 2003 evaluation found that Minnesota Senior Health Options (MSHO) members in nursing homes had fewer hospital admissions and days, fewer preventable hospital admissions, and fewer emergency room visits and preventable emergency room visits than control group members. Differences were similarly positive but not as large for community MSHO members.<sup>9</sup>*
- *A recent survey of enrollees in Cal MediConnect - California's integrated program for Dual beneficiaries – revealed significantly lower frequency of recent hospitalizations for enrollees in the program than for Duals who opted out of the program.<sup>10</sup>*
- *In Wisconsin, a study of Family Care program found that Family Care participants had lower outpatient and inpatient hospital costs than the comparison group.<sup>11</sup>*

<sup>8</sup> Texas A&M Public Policy Research Institute. "STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness," 1999, and Texas A&M Public Policy Research Institute. "Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness of the STAR+PLUS Program," 2002

<sup>9</sup> Kane, Robert L., and Patricia Homyak. "Minnesota Senior Health Options Evaluation Focusing on Utilization, Cost and Quality of Care." Minneapolis: University of Minnesota School of Public Health, Division of Health Services Research and Policy, 2003.

<sup>10</sup> The SCAN Foundation and the Field Research Corporation (2016) "Large majorities of Cal MediConnect enrollees continue to report confidence in their ability to manage their health conditions and satisfaction with their health care services" Available at: [http://www.thescanfoundation.org/sites/default/files/wave\\_4\\_press\\_release.pdf](http://www.thescanfoundation.org/sites/default/files/wave_4_press_release.pdf)

<sup>11</sup> APS Healthcare, Inc. "Family Care Independent Assessment: An Evaluation of Access, Quality and Cost-Effectiveness for Calendar Year 2003-2004." Washington, DC: APS Healthcare, Inc., 2005. Available at: <https://www.dhs.wisconsin.gov/familycare/reports/ia.pdf>

While states may not directly benefit from reduced medical utilization by Medicaid beneficiaries who are covered under Medicare, the federal government and the country as a whole benefit from interventions that can significantly lower medical utilization of the persons with the most complex care needs.

## Conclusion

The shift in state Medicaid long-term services and supports (LTSS) programs from paying for individual services in a piecemeal fashion to providing a per capita amount for each member to a managed care plan to coordinate and provide LTSS is enabling states to get greater value for beneficiaries and taxpayers with the limited resources they have for this purpose.

### *The value is evident in:*

- A more comprehensive, seamless, and person-centered care experience for the member and the member's family.
- The ability and incentive to provide support for family caregivers and engage them more effectively in providing care.
- Greater attention to quality of care and the alignment of outcomes with the member's goals and preferences.
- Greater capacity to support individuals in the settings of their choice for as long as possible, with a reduced reliance on institutional care.
- Reduced use of expensive medical care in emergency rooms and hospitals, with a consequent reduction in medical spending.