National MLTSS Health Plan Association

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# The Value of Managed Long-Term Services and Supports

## Background on LTSS and the Value of Managed Care

Children and adults with disabilities and older adults who need support to perform activities of daily living (ADLs) 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 LTSS provided in the U.S.

States have moved in the last twenty years to provide broad Medicaid coverage through contracts with managed care plans. Increasingly, states are similarly moving non-medical LTSS services for older adults and persons with disabilities away from traditional "fee-for-service" payments to capitated payments under managed care. Today, nearly half of all states provide services for older adults and persons with disabilities through managed long-term services and supports (MLTSS) programs.

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 better and more coordinated care experience in MLTSS plans with a greater opportunity to remain independent in their homes and communities through increased access to home and community-based services (HCBS), resulting in improved health and quality of life outcomes. HCBS are typically less costly than institutional care (e.g. nursing homes), and so states are able to make greater use of limited resources to serve more beneficiaries, reduce waiting lists for services, and achieve better outcomes. **In summary the system as a whole benefits from managed care directing higher-quality, patient-focused services at a lower cost to people with the most complex care needs**, and we take a deeper dive into these benefits below.

## A better care experience for beneficiaries and their families

Medicaid originally covered long-term care services only in a nursing facility, which are part of the set of mandatory benefits for all states to provide under Medicaid. Since the late 1990s, however, Medicaid has been increasingly paying for HCBS as an alternative to institutional care.[1] In traditional fee-for-service Medicaid, navigating the complex and highly-fragmented world of HCBS can be overwhelming for

[1] Despite this, HCBS still remains an optional benefit for states to provide through Medicaid, which requires states to pursue waivers and state plan amendments.

beneficiaries and their families. Often, beneficiaries require a number of care professionals to provide services at different times throughout the day and week. Coordinating amongst these professionals can be difficult as their availability changes for one reason or another. In addition, these care professionals may lack a formal channel of communication to coordinate between themselves to ensure they are up-to-date on any developments in a beneficiary's condition. **Individuals who enroll in MLTSS plans realize almost immediately the added value they get from the assistance, coordination, and seamless service experience in a managed care plan.**

### Key features and services that MLTSS plans provide to improve the experience of care for beneficiaries and their families:

- Person- and Family-Centered Care Planning: Through the assistance of a care manager, beneficiaries set their goals and priorities in order to develop a plan of care with actionable metrics for maintaining or improving their quality of life.
- Assessment: Upon enrollment, plans perform a comprehensive assessment to establish a relationship with the member, comprehensively assesses an individual's needs and available resources, determine the services and supports necessary to support the beneficiary, and provide care management.
- Care Management: Care managers serve as a single point of contact for the beneficiary to ensure the beneficiary has consistent access to a trusted source of information and support. Care managers coordinate medical, behavioral health, and LTSS providers; help support caregivers; monitor changes in conditions; assist in modifying the care plan as needed; and reduce inappropriate or duplicative care.
- A Coordinated Care Team: By facilitating formal channels of communication, MLTSS plans help create a team of social service agencies, in-home providers, medical care, and mental health providers around the beneficiary and their caregiver to ensure needed services are provided.
- Person-Centered Services and Supports: Plans work 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.

**A Major Benefit** to persons with disabilities and their families who are enrolled in MLTSS is having a care manager, which is not normally available in the traditional fee-for-service 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, which helps the beneficiary achieve his or her personal goals.

- Community Integration and Engagement: By facilitating increased access to HCBS, plans enable individuals to live more independently, better engage socially, and participate in employment opportunities in their communities with greater satisfaction with services and quality of life.
- Attention to Quality: Accountability to state and federal governments for the quality of the care provided and success in meeting the goals and preferences of the individual ensures plans continuously strive to improve their operations.

***Evidence points to high levels of satisfaction and increased quality of life for Medicaid beneficiaries enrolled in managed care plans.***

- ***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 similarly percentage rated the quality of their providers as good or excellent.[2]***
- ***The state of Florida found that 77% of beneficiaries who responded to a state survey reported an improve quality of life since joining an MLTSS plan.[3]***
- ***When asked to comment on the role of their care manager, Virginia MLTSS beneficiaries "overwhelmingly…indicated that respondents were particularly pleased with care coordinators' helpfulness, compassion, friendliness, ability to listen, efficiency, responsiveness, politeness, information, and communication style."[4]***

## 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:

- higher utilization of HCBS instead of nursing homes and other institutional care, enabling people to move to and receive support in the most-integrated setting appropriate to their needs (i.e. residing in the general community with persons who do not disabilities);

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[2] IPRO. Managed Long-Term Care: 2015 Member Satisfaction Survey. Summary Report. December 2015.

[3] MLTSS Institute. Dobson, Camille; Gibbs, Stephanie; Mosey, Adam; Smith, Leah. Demonstrating the Value of Medicaid MLTSS Programs. May 2017. Available at <https://www.chcs.org/media/FINAL-Demonstrating-the-Value-of-MLTSS-5-12-17.pdf>

[4] A. Cuellar, G. Gimm, and C. Gresenz. A Survey of EDCD Waiver Participants who were Enrolled in the Commonwealth Coordinated Care (CCC) Program for Dual-Eligibles. George Mason Uni - versity Department of Health Administration and Policy. September 2016. Available at: http://www.dmas.virginia.gov/Content_atchs/altc/CCC_Tel_ Mail_Survey%20Findings_Enrollees_16-9-2.pdf

- 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 the goal of rebalancing toward HCBS, increasing access, 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. HCBS can be provided for less than half the cost of traditional institutional care.[5]

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.**

- ***A CMS evaluation of seven states who transitioned to MLTSS found that "two states eliminated the wait for services and four states decreased the number of people on their waiting lists after the MLTSS programs began. The rate of decrease ranged from 12 percent in New Mexico to 92 percent in Wisconsin."[6]***
- ***Arizona established the first Medicaid MLTSS program in 1989. Since then, the state has seen rates of nursing home use decrease from 95 percent[7] to 27***

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[5] 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

[6] Center for Medicare and Medicaid Services (CMS). Saucier, Paul; Kasten, Jessica; Amos, Angie. Do Managed Care Programs Covering Long-Term Services and Supports Reduce Waiting Lists for Home and Community-Based Services? Available at < https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-ib6-508-mltss-hcbs-waiting-lists.pdf>

[7] 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

***percent of the enrolled population in 2014 [8]—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).[9]***
- ***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.[10]***
- ***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.[11]***
- ***The state of New Jersey credited its shift to MLTSS as increasing access to HCBS by nearly doubling the percentage of individuals receiving care in their homes or in a community setting. Additionally, the number of individuals residing in nursing homes substantially decreased.[12]***
- ***Through a combination of federal programs to rebalance LTSS towards HCBS along with a transition to MLTSS, the state of Illinois increased the capacity of its Persons with Disabilities waiver to serve an additional 4,300 individuals.[13]***

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[8] Joint Legislative Budget Committee (2015) *Program Summary: Arizona Long Term Care System*. Available at: http://www.azleg.gov/jlbc/psaxsaltcs.pdf

[9] 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

[10] 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

[11] http://www.politico.com/states/florida/story/2016/12/senate-begins-examination-of-medicaid-managed-long-term-care-108104

[12] IBM Watson Health. Selected Characteristics of 10 States With the Greatest Change in Long-Term Services and Supports System Balancing, 2012–2016. Lewis, Elizabeth. April 2019. Available at < https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltss-toptenreport.pdf>

[13] *Ibid*

## 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. In the Medicaid program, 6% of individuals require some form of LTSS and account for approximately 42% of all Medicaid spending.[14] 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 impact unnecessary or avoidable medical utilization in the following ways:

- 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.
- 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:***

- ***Several evaluations performed by RTI on the impact of the Financial Alignment Initiative and the Medicare-Medicaid Plans (MMPs) found that these plans had a positive impact on health care utilization, expenditures, and plan member satisfaction in Minnesota, Ohio, and Illinois. For example,***

[14] MACPAC. Long-term Services and Supports. Available at < https://www.macpac.gov/topics/long-term-services-and-supports/>

***compared with individuals enrolled in Medicaid-only MLTSS plans, individuals enrolled in fully integrated plans were 48% less likely to have an inpatient hospital stay and 6% less likely to have an outpatient emergency department (ED) visit.*** [15]

- ***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.***[16]
- ***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.***[17]
- ***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.***[18]
- ***In Wisconsin, a study of Family Care program found that Family Care participants had lower outpatient and inpatient hospital costs than the comparison group.***[19]

Notably, states may not directly benefit from reduced medical utilization by Medicaid beneficiaries who are covered under Medicare (i.e. dual-eligible beneficiaries) due to a lack of "shared savings." However, 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.

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[15] Medicare-Medicaid Coordination Office. State-Specific Evaluation Reports. RTI. Available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>

[16] 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

[17] 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.

[18] 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

[19] 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

## Conclusion

States had gradually chosen to shift their Medicaid LTSS programs from fee-for-service systems, which pay for individual services in an uncoordinated and piecemeal fashion, to MLTSS programs that provide a per capita amount for each member to a managed care plan to coordinate and provide LTSS. This transition has enabled states to provide a better care experience for beneficiaries and their caregivers, reduce unwanted outcomes, expand the state's capacity to serve more individuals, and improve the future sustainability of these programs 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; and
- Reduced use of expensive medical care in emergency rooms and hospitals, with a consequent reduction in medical spending.