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Managed Long-Term Services and Supports

Helping Those Most in Need

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COMMUNITY & STATE

Long-term services and supports (LTSS) refers to a broad range of medical, functional, and social services that are needed by individuals who have complex health needs due to aging, chronic illness, or disability.

The need for LTSS affects individuals of all ages and is generally measured by limitations in one's ability to perform activities of daily living such as eating, bathing, dressing, or walking, and activities that allow individuals to live independently in the community, including shopping, housework, and meal preparation. Services and supports typically covered include personal care (e.g. clothing, bathing), home-delivered meals, transportation, home health aide services, and supported employment. LTSS are delivered in a variety of settings, including institutional (e.g., intermediate care facilities for people with intellectual and developmental disabilities and nursing homes), and home and community-based settings (e.g., adult day services and personal care/homemaker services).

It's predicted that the demand for LTSS will increase dramatically in the coming years due to an aging population and individuals continuing to live longer. In 2013, more than 5 million individuals received LTSS with Medicaid serving as the largest payer of those services and supports. In fiscal year 2016, the most recent year for which data are available, over $150 million in Medicaid funding was spent by the federal government and states on LTSS—an increase of almost 5 percent from the previous year. In addition, a substantial amount of LTSS is provided by family members and other informal caregivers. In fact, by one estimate, approximately $470 billion in care was provided by 'informal' or family caregivers in 2016. As a result, the total expenditures associated with LTSS are considered to be underestimated. Unfortunately, the availability of family caregivers for those aging is shrinking, which will only increase the need for and costs associated with 'formal' LTSS benefits.

The high cost of caring for people in need of LTSS presents a growing challenge for states given competing budget priorities. These costs are generally driven by the cost of nursing home care, which is many times greater than the cost of care in the community. As a result, an increasing number of states are providing LTSS through managed care organizations — referred to as Managed Long-Term Services and Supports (MLTSS). As of 2017, 24 states operated MLTSS programs serving more than 1.8 million individuals, compared to just 16 states covering 800,000 individuals in 2012. Managed long-term services and supports programs provide a cost-efficient and sustainable solution to help states meet the needs of individuals with complex care needs while affording them greater flexibility and control over their lives. By shifting LTSS from fee-for-service to managed care, states can also anticipate better care coordination and more efficient use of home- and community-based services (HCBS).

What are the benefits of MLTSS?

States have an opportunity to improve the sustainability of their Medicaid programs, reduce the reliance on costly services, and increase access and availability of HCBS by developing an MLTSS program that changes the way individuals eligible for LTSS are managed. MLTSS programs:

- Address the main driver of increased costs associated with individuals in need of LTSS by avoiding nursing home placement and encouraging transition back into the community through enhanced care coordination and expanded access to LTSS services.
- Support individuals living in the least restrictive setting by helping them achieve personal health goals and coordinating care that delivers the right services, at the right time, and in the right setting.
- Reduce adverse events that lead to nursing home placement through identification and coordination of benefits and health services for individuals with complex issues.
- Reduce the administrative burden on states and providers by reducing duplication in care coordination.
- Save money through improved coordination of services and more effective oversight of services delivered to the individual.

States have seen significant improvement in the delivery of LTSS services by implementing MLTSS programs.

Arizona Long-Term Care System (ALTCS)

Since 1989, ALTCS has served members in Arizona who are eligible for nursing home placement. According to the most recent data, Arizona has been able to steadily reduce the number of individuals being placed in nursing homes from 95 percent to 29 percent by providing the care they need at home and in the community.[1]

Tennessee CHOICES

At the time that Tennessee added LTSS benefits to the TennCare program, more than 80 percent of eligible individuals were served in nursing homes with very limited investment in and access to HCBS. Based on the most recent data, the number of nursing home-eligible individuals accessing HCBS and living in community settings is now at 44 percent.[2]

Hawaii QUEST Integration

Formerly QUEST Expanded Access, QUEST Integration has increased the percentage of nursing home level of care individuals receiving HCBS from 40 percent in 2008 to 77 percent in 2018.[3]

1/3 Individuals using long-term services and supports (LTSS) represent just 5.9 percent of the Medicaid population, yet they account for one-third (31 percent) of total costs.[4]

2X On average, specialized nursing home care costs twice as much as custodial care in a community-based setting.[5]

3:1 On average, Medicaid dollars can support roughly three people with home and community-based services for every person in an institution.[6]

90 Nearly 90 percent of those over age 65 want to stay in their residence for as long as possible.[7]

70% Someone turning 65 today has a 70 percent chance of needing LTSS in the future.[8]

[1] https://medicaiddirectors.org/wp-content/uploads/2015/08/trends_in_medicaid_long_term_services_and_supports.pdf
[2] https://www.chcs.org/media/FINAL-Demonstrating-the-Value-of-MLTSS-5-12-17.pdf
[3] https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/ATT_B_-_Interim_Eval_Report.pdf
[4] https://www.everycrsreport.com/files/20170228_R43328_5834413c5243a128f3e91f6ed70e7e0f074bca6c.pdf
[5] Elder Care Costs Compared: In-Home Care, Assisted Living, Nursing Homes, April 29, 2015, http://www.aplaceformom.com/senior-care-resources/articles/elder-care-costs
[6] AARPR, Across the States 2012: Profiles of Long-Term Services and Supports, 9th Edition, 2012.
[7] Teresa A. Keenan, Ph.D., Home and Community Preferences of the 45+ Population (Washington, D.C.: AARP, 2010), 4.
[8] https://www.americanprogress.org/issues/healthcare/reports/2019/04/10/468290/state-options-making-wise-investments-direct-care-workforce/

What are program design considerations in MLTSS?

The fundamental MLTSS program components that will support state efforts to reduce fragmentation of care, promote access and community inclusion, and provide high-quality, person-centered, and cost-effective care include:

- **Broad Populations –** In addition to individuals who meet nursing home eligibility, including aged, blind and disabled (ABD) individuals, MLTSS programs can reach dually eligible individuals and specialty populations. This approach ensures early detection of risk in individuals to prevent future decline, eases the administrative burden for the state by creating a single program versus maintaining multiple programs, and increases a state's ability to effectively rebalance institutional services through early identification and alignment of less costly HCBS.
- **Eligibility Standards –** MTLSS programs increase access to LTSS earlier and minimize barriers to waiver participation to support the overall program goal of rebalancing. States may also consider creating tiered eligibility to encourage the use of home and community-based services for individuals who meet nursing home level of care, in addition to those at risk of nursing home placement.
- **Benefit Design –** MTLSS programs will encourage a holistic, person-centered approach inclusive of a broad array of services that include medical, behavioral, pharmacy, and social services, and reduce fragmentation that can lead to cost shifting, program inefficiencies, increased program costs, and decreased quality.
- **Medicare/DSNP Alignment –** MLTSS programs serve a high-proportion of individuals dually eligible for both Medicaid and Medicare. States should leverage Dual Special Needs Plans (DSNPs) to better integrate and coordinate care for this dually eligible population by aligning the delivery of LTSS services through a DSNP platform.
- **Mandatory Enrollment –** An enrollment process that provides individuals with the ability to change plans within the first 90 days, followed by a 12-month lock-in period, ensures program viability, achieves optimal savings, and improves quality and budget predictability. Auto-enrollment algorithms that balance enrollment among managed care organizations (MCOs) support continuing investment and program improvements. As programs mature, states may consider adopting quality-based, auto-enrollment algorithms as incentives to MCOs delivering high-quality results.
- **Health Plan Engagement –** Limiting the number of MCOs serving LTSS-eligible individuals simplifies state administration of the program and oversight of MCOs. Additionally, fewer MCOs reduces the administrative burden on a provider community that may lack organizational and technical resources.
- **Clinical Model –** Clinical models that enable optimal program effectiveness to include the following key elements:
    - Flexibility in the timing of assessments. For example, one best practice is to assess individuals with the highest risk and/or needs first and then use a more extended timeframe for assessing individuals with lower risk and/or needs.
    - The use of evidence-based assessments that have been shown to effectively identify functional status and service need.
    - Appropriate utilization and care plan development by enabling MCOs to align care management resources and coordinate the most effective, comprehensive array of services for each individual.
    - Sufficient incentives to encourage repatriation and nursing home avoidance using payment terms and quality monitoring that place real incentives on MCOs to decrease and avoid the need for nursing home placements.
- **Other Elements –** Establishing actuarially sound rates; utilizing rate cells that adequately reflect the needs of the population; supporting provider and individual transitions; network adequacy; and quality measures can be developed following a decision to implement an MLTSS program.

How do states implement a managed LTSS program?

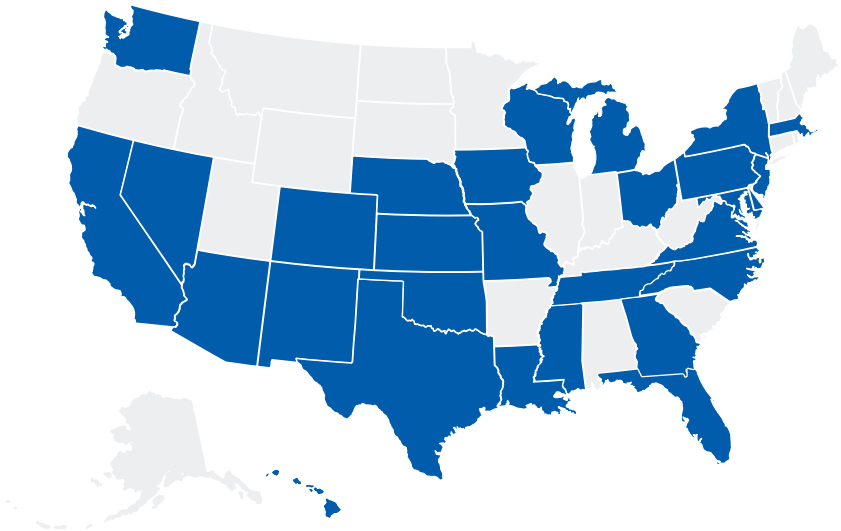
Once a state has decided to implement a MLTSS program, the state will need to put operational resources into place, select contractors, engage with key stakeholders, and obtain state and federal approval.

Each state must evaluate early on the legislative and federal authority to implement an MLTSS program. Legislative and budgetary engagement for program implementation is important to ensure broad support. States should consult early on with the Centers for Medicare and Medicaid Services (CMS) about federal authority options for MLTSS. CMS can provide states with recommendations on program structure.

States should also ensure continuous engagement of all stakeholders, including beneficiaries, providers, advocacy groups, community-based organizations, and the state legislature to ensure success. Working together, stakeholders can shape MLTSS programs to ensure that quality, holistic care will be delivered and that community resources are aligned to meet beneficiary needs. Open dialogue continues to be critical as the program becomes operational because stakeholders can help identify early problems or concerns and assist with the transition process to managed care. To ease the transition to managed care and to stay consistent with CMS guidance, states must develop a communication plan to involve stakeholders throughout implementation using various strategies, such as regular standing community partner meetings, advisory committees, workgroups, beneficiary interviews and surveys, and web sites and social media.

UnitedHealthcare's Experience

UnitedHealthcare has extensive experience helping states successfully transition from fee-for-service to more fully managed LTSS programs. Since the late 1980s, we have been at the forefront of supporting states as they develop and implement acute and LTSS programs that help improve quality, contain costs, and give members more choice to make health care decisions that support their personal health goals and preferences. We understand and uphold the principles of person-centered care, and we work with individuals and families collaboratively in care planning to ensure that we support what is most important to the person receiving services. **Today, we serve more than 280,000 individuals in 11 MLTSS programs nationally.**



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