2024 REPORT

State of Medicaid Managed Care Report

A Closer Look at Managed Long-Term Services and Supports

A collaboration between

sellers dorsey

mhpa
Medicaid Health Plans of America

ACAP
Association for Community Affiliated Plans

National MLTSS Health Plan Association

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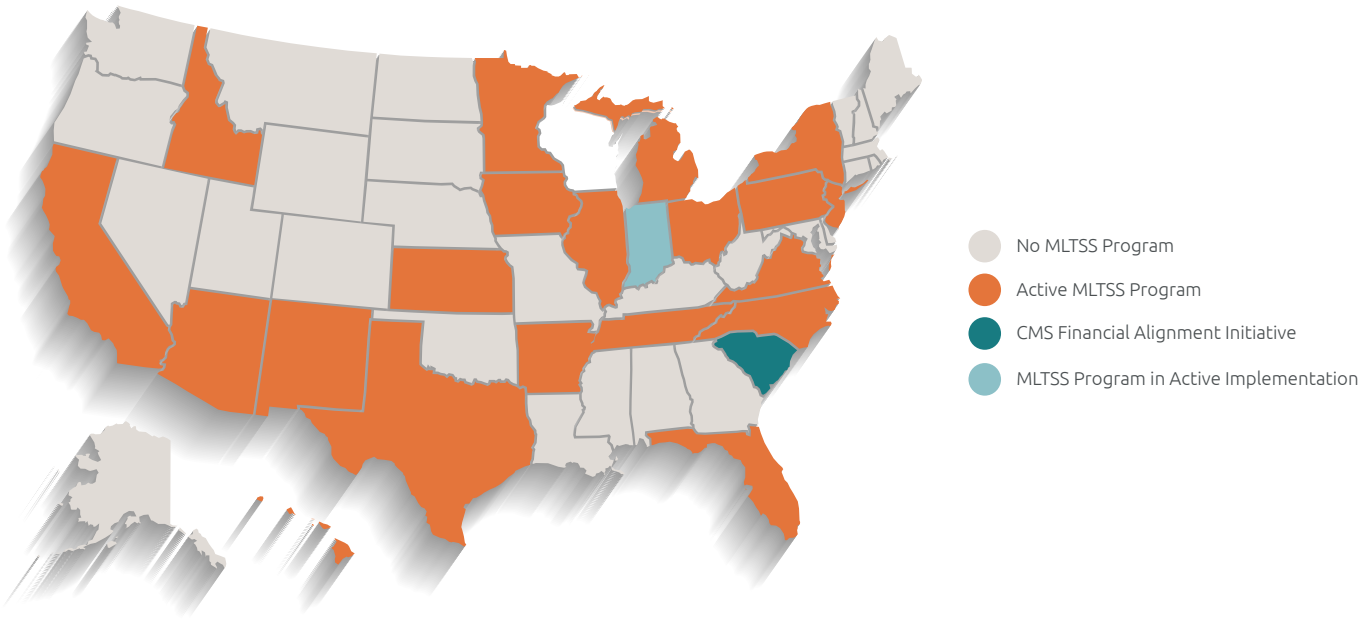
To better integrate care, achieve more predictable costs, and foster program innovation, states have increasingly turned to managed long-term services and supports (MLTSS) as a delivery system designed to integrate acute care and a portion of their LTSS benefit.

While states like Arizona have experimented with MLTSS for decades, expansion had been slow. According to a 2021 analysis from ADvancing States and the Center for Health Care Strategies, only eight states had implemented an MLTSS program by 2004. Since then, expansion into MLTSS has grown more rapidly, expanding to 15 states by 2010 and 25 states by 2023.

MLTSS Programs as of January 2024



State MLTSS programs vary widely in the populations and benefits included under managed care. While it has become common for states to "carve in" state plan and waiver services targeting the elderly and individuals with physical disabilities, fewer states have integrated waiver services for individuals with Intellectual and Developmental Disabilities (IDD). There are multiple federal authorities that states can use when designing and implementing an MLTSS program. While the most streamlined approach is to leverage an 1115 Demonstration waiver, states can also combine 1115, 1932(a), or 1915(b) managed care authorities with 1915(c) or 1915(i) authorities to design their programs.

To better understand the state of MLTSS, Sellers Dorsey, in partnership with MHPA, ACAP, and the National MLTSS Health Plan Association conducted interviews with officials from several state Medicaid programs and MCOs offering an MLTSS product. To help trace the history of MLTSS, we highlighted states that are in different stages of MLTSS implementation. Our report profiles three states – Delaware, Pennsylvania, and Indiana. We aim to show how states at various points in the development and evolution of their programs approach MLTSS.

To broaden our scope, we conducted a survey of states currently operating an MLTSS program on a variety of topics ranging from program priorities to dual eligible integration and more. We received responses from 16 states, more than half of all states operating MLTSS programs; this report summarizes the findings of our survey and state and MCO profiles to provide an overview of the MLTSS landscape.

1965
Title XIX of the SSA establishes Medicaid

1980
OBRA 80 establishes 1915(c) HCBS waivers

1988
Arizona becomes first state to implement MLTSS

1999
Olmstead decision

2012
Delaware implements MLTSS

2018
Pennsylvania begins implementing MLTSS

2023
Indiana awards contract for its MLTSS program to begin in 2024

"Where MLTSS programs have been implemented, we know that patients and states have benefited from innovative services, holistic and coordinated care, and budget predictability. As people live longer, interact with our healthcare system more frequently, and overwhelmingly prefer to age at home, the need and demand for MLTSS programs will undoubtedly increase. This research provides a strong foundation on which other states can rely to effectively and efficiently provide access to connected care that meets the unique and diverse needs of vulnerable and underserved populations."

– Craig Kennedy, President and CEO of MHPA

SECTION 1

Delaware

DELAWARE

Program Name
Diamond State Health Plan Plus

Established
2012

Program Authority
1115 waiver

MCOs
AmeriHealth Caritas of Delaware
Delaware First Health (Centene)
Highmark Health Options Blue Cross Blue Shield

Enrollment (October 2022)
15,107[2]

> **"We are so proud of our relationship with our members and their families, provider community, managed care organizations, as well as our ability to approach our program and the management, development, and oversight of the program as true partners."**
>
> – Kathleen Dougherty, Chief Medicaid Managed Care Operations, Delaware

Program Background and Overview

Delaware's Medicaid managed care program, the Diamond State Health Plan (DSHP), was approved by CMS through an 1115 demonstration waiver in 1995 and implemented in January of 1996. The state designed the program to mandatorily enroll eligible Medicaid beneficiaries into managed care organizations (MCOs) to streamline services and contain cost growth.[1] Years later, through an amendment approved by CMS in 2012, Delaware created the state's mandatory MLTSS program, the Diamond State Health Plan Plus (DSHP-Plus). Prior to the amendment, long-term services and supports were delivered through three separate 1915(c) waivers operated through various departmental divisions. With the 1115 amendment, Delaware was able to combine the 1915(c) waivers and establish a uniform delivery of services under a demonstration that allows more flexibility.

In establishing its MLTSS program, Delaware set out to achieve the following goals:

- Improve access to healthcare for the Medicaid population, including increasing options for those who need LTC by expanding access to HCBS.
- Rebalance Delaware's LTC system in favor of HCBS.
- Promote early intervention for individuals with or at-risk for having LTC needs.
- Increase coordination of care and supports.
- Expand consumer choices.
- Improve the quality of health services, including LTC services, delivered to all Delawareans.
- Create a budget structure that allows resources to shift from institutions to community-based services.
- Improve the coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles.
- Expand coverage to additional low-income Delawareans.

Covered Populations

The DSHP-Plus program was implemented in 13 months and provides long-term care for the elderly (65 years or older) and disabled. The amendment added more state plan populations to the MLTSS program, including:

- Elderly and disabled 1915(c) HCBS waiver enrollees,
- HIV/AIDS 1915(c) waiver enrollees,
- Individuals in nursing facilities who no longer meet the medical necessity criteria for nursing facility services,
- Adults and children with incomes below 250% of the Supplemental Security Income Federal Benefit Rate who are at risk for institutionalization.

Key Program Features

DSHP-Plus is split into two programs: the Nursing Facility Program and the Long-Term Care Community Services (LTCCS) Program. Both are entitlement programs with specific eligibility requirements. The 1115 waiver amendment that established the DSHP-Plus program expanded the HCBS service array previously available under the state's 1915(c) waivers to include cost-effective and medically necessary home modifications, chore services, and home-delivered meals. In addition to LTSS, the DSHP-Plus program provides acute, primary, and behavioral health care services to enrollees as well as a limited number of outpatient and inpatient behavioral health and substance abuse services.[2]

DSHP-Plus enrollees receive their services through one of the three state managed care organizations: Highmark Health Options Blue Cross Blue Shield, AmeriHealth Caritas, and Delaware First Health. There is additional provider flexibility for MLTSS enrollees as some benefits, such as attendant care services, can be participant-directed, meaning an enrollee can hire their own caregiver. Additionally, DSHP-Plus participants can reside in various settings including one's home, a family member's home, an adult foster care home, an assisted living facility, or a nursing home.[3]

PAY FOR PERFORMANCE[4]

To incentivize quality performance and advancement of value-based care, Delaware imposes several quality performance standards.

For quality performance, MCOs are required to achieve a satisfactory performance level on ten quality performance measures across five domains:

1. Primary care
2. Maternal and child health
3. Diabetes
4. Behavioral health
5. Other measures as determined by the state.

For value-based purchasing, MCOs are required to meet a threshold of 60 percent of provider contracts that leverage value-based strategies, such as upside or downside risk, in the initial contract year, with increasing percentages required each contract year. MCOs that fail to meet the baseline quality or value-based purchasing thresholds may be required to pay penalties of up to 2 percent of the plan's total net revenue for the performance year.

"MLTSS programs give seniors the resources they need to stay in their communities and live their fullest lives. Safety Net Health Plans have shown how Medicaid managed care can be an effective vehicle for delivering long-term care benefits."

– Margaret A. Murray, CEO, Association for Community Affiliated Plans

SECTION 2

Pennsylvania

PENNSYLVANIA

Program Name
Community HealthChoices

Established
2018

Program Authority
1915(b)/(c) waivers

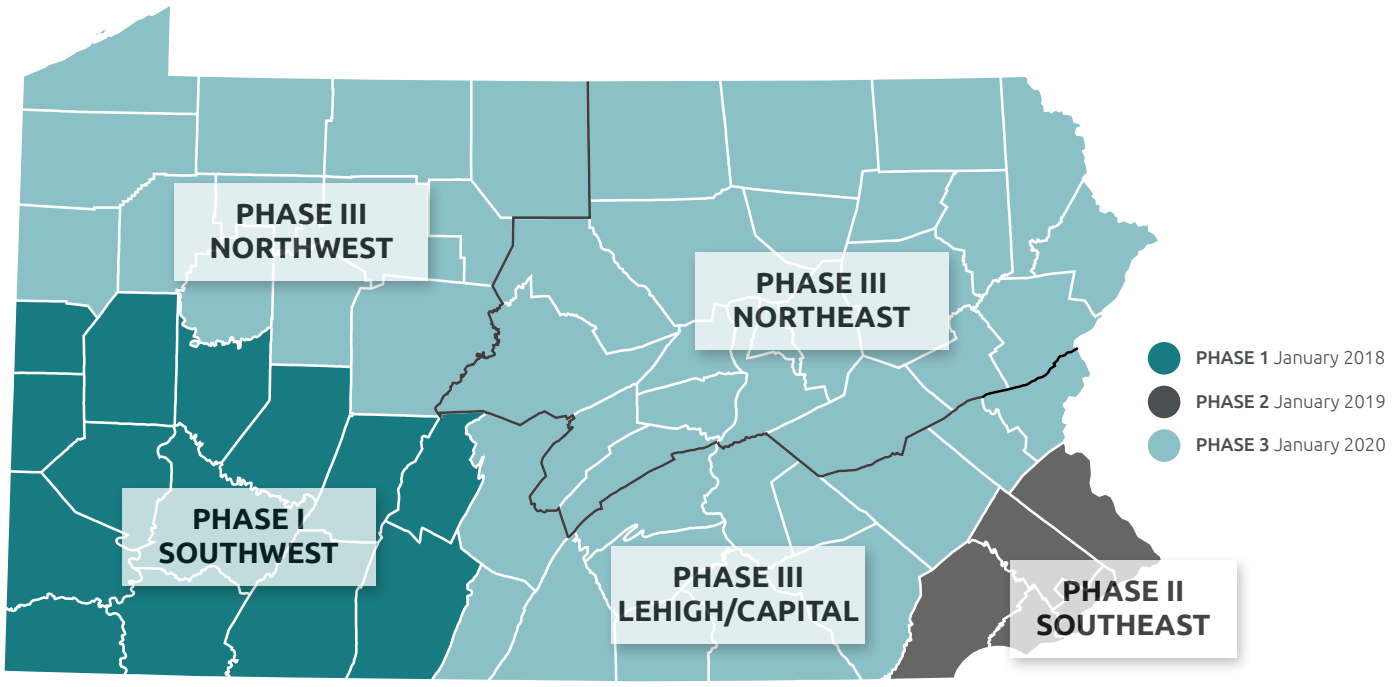
MCOs
AmeriHealth Caritas
PA Health and Wellness (Centene)
UPMC Health Plan

Enrollment (October 2022)
423,536[5]

Program Background and Overview

Pennsylvania's mandatory MLTSS program, Community HealthChoices (CHC), was developed to enhance access and improve coordination of medical care. CHC aimed to create a person-driven, long-term support system in which people have choice, control, and access to a wide array of quality services that provide independence, health, and quality of life.[6]

In implementing its program, Pennsylvania collaborated with providers, participants, and advocacy groups to publish a concept paper highlighting the program's design features and released a Request for Information (RFI), which received more than 4,000 comments. Ultimately, Pennsylvania decided to implement CHC geographically in three phases over two years, enabling the state to optimize the program gradually.[7]



Covered Populations

CHC covers individuals 21 years of age and older who are:

- Receiving both Medicare and Medicaid.
- Receiving LTSS in the Attendant Care, Independence, or Aging waivers.
- Receiving services in the OBRA waiver AND determined nursing facility clinically eligible.
- Receiving care in a nursing home paid for by Medicaid.
- An Act 150 participant who is dually eligible for Medicare and Medicaid.
  – Act 150 is Pennsylvania's state funded attendant care program that started in 1987. People who are eligible for this program are "mentally alert, but severely physically disabled and are at the greatest risk of being in an institutional setting."[8]

Key Program Features

CHC's key program features closely mirror those found in other states' MLTSS programs and include service coordination and MCO alignment with D-SNPs. During the initial rollout, the state mandated a six-month continuity of care period aimed at minimizing any disruption of existing care plans. Noteworthy is the state's collaboration with the Medicaid Research Center (MRC) at the University of Pittsburgh, a partnership established to complete the required independent audit for the waiver and begin early evaluation of the CHC program. The state recently opted to extend the agreement with the MRC to continue assessing the CHC program. Notably, the CHC-MCOs have collaborated to select single vendors for Electronic Visit Verification (EVV) and Financial Management Services (FMS).

Additionally, CHC participants are eligible to receive all Medicaid-covered physical health benefits and access to services offered through four approved 1915(c) HCBS waivers offered by the Office of Long-Term Living (OLTL).[9] The state chose to include participants enrolled in the Traumatic Brain Injury (TBI), Aging, Independence, and CommCare waivers while excluding those enrolled in the OBRA waiver. The OBRA waiver specifically serves participants with developmental physical disabilities requiring an intermediate care facility or other related conditions falling under this level of care.

PAY FOR PERFORMANCE[10]

PA Department of Human Services (DHS) conducts a Pay for Performance (P4P) Program that provides financial incentives for CHC-MCOs that meet quality goals. For plan year 2023, the state chose seven measures representative of NCQA and specific Pennsylvania Performance Measures (PAPMs) focused on impacting nursing home transition, long-term services and supports, overall health plan satisfaction, and participant satisfaction as quality measures using established statewide specific benchmarks. DHS selected these measures based on analysis of past data indicating the need for quality improvement across the CHC Program as well as the potential to improve services and support for CHC participants. The quality measures include the following:

1. Comprehensive Assessments and Update (CAU)
2. Comprehensive Care Plans Update (CPU)
3. Reassessments and Care Planning after Inpatient Discharge (RAC)
4. Shared Care Plan with Primary Care Practitioner (PCP) (SCP)
5. CAHPS Health Plan Survey- Overall Satisfaction with Health Plan (Aligned/Medicaid only population)
6. CAHPS Home and Community Based Services (HCBS) Survey- Person Centered Service Plan (PCSP) included all things important to participants, and
7. Successful Nursing Home Transitions

The P4P Program incentivizes MCOs demonstrating Benchmark Performance and Incremental Improvement Performance. DHS will award a Benchmark Performance payout for each measure that meets the statewide goal as shown in the table below. DHS will award an Incremental Improvement Performance payout amount for each measure in the table that will range from 0% up to and including 100% of the measure's value.

Basis	Baseline Year	Measurement Year	Description	Statewide Goal
HEDIS	CY2022	CY2023	Comprehensive Assessment and Update (CAU)	78%
HEDIS	CY2022	CY2023	Comprehensive Care Plan Update (CPU)	78%
HEDIS	CY2022	CY2023	Reassessment and Care Plan Update after Impatient Discharge (RAC)	38%
HEDIS	CY2022	CY2023	Shared Care Plan with Primary Care Practitioner (SCP)	55%
HEDIS	CY2022	CY2023	Overall Satisfaction with Health Plan (Aligned SNP/ Medicaid only population)	83%
HEDIS	CY2022	CY2023	PCSP included all things important to you	70%
HEDIS	CY2022	CY2023	Number of Participants who, as defined on Ops 32, were successfully transitioned from the NF to the community and remained there for at least six months	380 per MCO per year

The percent payout for each measure will be determined by the following sliding scale:

- ≥ 3 percentage point improvement: 100% of the measure value.
- ≥ 2 and < 3 percentage point improvement: 85% of the measure value
- ≥ 1 and < 2 percentage point improvement: 75% of the measure value.
- ≥ 0.5 and < 1 percentage point improvement: 50% of the measure value.

The maximum program payout amount will be proportionally split between the CHC-MCOs based on membership as of December 1, 2023. Each CHC-MCO's portion will then be split with 50% of the funds allocated to benchmark performance and 50% to incremental improvement. Within the benchmark allocation, each of the seven measures will be eligible for equal payment based on the achievement of the statewide goal.

The state also mandates that CHC-MCOs engage in value-based purchasing (VBP). MCOs "must achieve the following percentages through VBP arrangements: Calendar year 2023 – 15% of the medical portion of the capitation must be expended through VBP and 7.5% of LTSS payments through a value-based payment arrangement."

MCO Profiles

Pennsylvania has three Community HealthChoices MCOs that operate statewide: AmeriHealth Caritas Pennsylvania/ Keystone First Community HealthChoices, Centene subsidiary PA Health and Wellness, and University of Pittsburgh Medical Center (UPMC) Community HealthChoices. Sellers Dorsey completed interviews with key personnel from each MCO's CHC program.

AMERIHEALTH CARITAS PENNSYLVANIA/ KEYSTONE HEALTH (PHILADELPHIA ONLY)

In our interview, AmeriHealth Caritas Pennsylvania (AHC) emphasized their success with nursing home transitions. The plan asserts that collaborating closely with community partners has led to overwhelming success with keeping people out of nursing homes. By emphasizing early intervention and leveraging data, AHC believes it is positioned to ensure housing and supports are in place for successful transitions from facility to community. AHC's care coordination strategy focuses not only on coordinating with other payers, such as Medicare and behavioral health providers, but also on identifying wraparound services to improve quality of care for AHC's participants.

AHC has also developed focused housing initiatives for individuals who need intensive support to help stabilize

their home situation. AHC has partnered with the Senior Law Center for referrals from service coordinators to gain expert legal assistance to mitigate risks and help participants remain in a stable living situation.

AHC's Nutrition at Home program is an extended benefit in which AHC sets up two weeks' worth of meals for participants who are transitioning home. This benefit is available whether enrolled in LTSS or if they are a nursing facility ineligible (NFI) participant (NFI participants are deemed ineligible for CHC based on financial and clinical eligibility measures). AHC is then able to support the participant with nutritious meals until they settle in at home and gives caretakers time to go grocery shopping.

AHC's priorities for the coming year include increasing the utilization of participant-directed services and providing education for both participants and service coordinators to make sure both groups are aware of and can connect to all available services.

AHC believes that it can improve care and participant experience by empowering participants to lead their own care by interviewing, selecting, and training caregivers who are best able to meet their needs. AHC has found that participant direction can bolster continuity of care and increase instances of early detection (e.g., fall risk).

AHC also highlighted the importance of education when it comes to connecting participants with the services available to them. AHC plans to continue and expand the education of service coordinators, resulting in optimal preparedness to educate participants. Additionally, AHC assesses participants' eligibility for other programs outside of the MCO by partnering with the Benefits Data Trust (BDT). By recognizing participants who would benefit from cash assistance, SNAP, or other available benefits, AHC can broaden person-centered service plans (PCSPs) to include all the necessary services that help support holistic care for participants.

PA HEALTH AND WELLNESS (CENTENE)

PHW believes that one of the most innovative components of an LTSS program is the ability of the MCOs to leverage VBP programs to maximize Electronic Visit Verification (EVV) utilization, close gaps in care, and ensure compliance with state metrics around HEDIS measures. PHW continues to utilize these programs to increase quality, increase wages for direct care workers (DCWs), and target unique populations.

PA Health and Wellness was the first PA CHC-MCO to have all of its proposed Value-Based Payment (VBP) programs approved.

When asked about priorities for the upcoming year, PHW talked about four specific focus areas: delivering on quality and innovation, strengthening their relationship with the state, delivering on health equity, and continuing to evolve and improve services.

PHW emphasized its plan to develop and expand health equity initiatives over the next year and aims to work to eliminate disparities between health and healthcare through education and other community outreach initiatives. PHW has already identified areas of the state where there are significant disparities, and they plan to roll out programs to help address these disparities.

PHW highlighted the value of DCWs and their work to provide higher wages. PHW emphasizes the importance of including DCWs in broader discussions since they are working most closely with participants.

UPMC HEALTH PLAN

UPMC is a highly integrated delivery and finance system that collaborates well with the state and other partners to pursue high quality, value-based, and person-centered care for their CHC enrollees by emphasizing equity and diversity as well as local opportunities. By doing so, UPMC believes they are better able to streamline care coordination and identify needed services earlier.

UPMC continues to find innovative ways to provide care to participants across the state, including a pilot to provide assisted living as an In Lieu of Services (ILOS) and to support family caregivers. UPMC also discussed program process improvements that are leveraged by their ability to bring forward recommendations for providers and CHC-MCOs' consideration. Additionally, UPMC is focused on increasing equity and diversity in the delivery of care for individuals in the program and further driving quality for all populations by using data and technology.

UPMC highlighted their internal controls over customer service, allowing them to develop training and expectations that will be maintained throughout each department, and preserve consistency. Doing so allows different departments to synchronize received information and streamline operations. Additionally, UPMC receives data on service utilization, hospital discharge notifications, and Medicaid eligibility.

Through meetings with D-SNPs every quarter, UPMC learns what policy and operational changes are needed as well as those that can be expanded. UPMC understands that improved data capabilities, transparency, and accountability lead to better information about what is happening and changes or updates to participant care plans.

UPMC noted their desire to continue engaging with, building, and supporting the direct care workforce. They noted that by engaging them as members of the care team, providing them with additional training and coaching, and bringing natural supports to the forefront, it will strengthen the entire system. Similarly, UPMC is looking to find additional paths for flexibility when thinking about person-centered plans within certain boundaries, such as assisted living facilities. UPMC also plans to move toward additional self-directed services, allowing participants to have further autonomy over their care.

By focusing on the goals of the program, serving additional individuals, continuing to support alignment, and continuing to innovate while supporting the CHC population and its providers, UPMC believes that they can demonstrate their success in the CHC program.

UPMC operates the largest FIDE-SNP in the country, with most participants enrolled in their Medicare companion program, UPMC for Life Complete Care.

SECTION 3

Indiana

INDIANA

Program Name
Indiana Pathways for Aging

Established
Slated to launch in 2024

Program Authority
1915(b)/(c) waivers

MCOs
Anthem BCBS
Humana Health Horizons
United Healthcare Community Plan

Enrollment (2023)
N/A

Program Background and Overview[11]

As of publication, **Indiana will be the next state to implement an MLTSS program. The program, called Indiana Pathways for Aging (IPA), is slated to launch in the summer of 2024** and the planning, procurement, and implementation processes have taken several years to complete. In 2019, the Medicaid Advisory Committee of the Indiana Family and Social Services Administration (FSSA), the state Medicaid agency, convened stakeholder sessions to discuss LTSS system improvements with a focus on aging at home. Through those initial discussions, FSSA created a vision for its LTSS system reform and formed a collaborative group composed of inter- and intra-agency teams to leverage all available resources and foster alignment in how the State serves its residents. The collaborative created a case for LTSS system reform for it to be evaluated by the Indiana legislature. During the 2021 session, the Indiana General Assembly removed the moratorium that prohibited the FSSA from pursuing risk-based managed care for the aging population, allowing the agency to move forward with designing its MLTSS program.

Indiana's implementation of an MLTSS program is driven by four priority areas that the State wants to address:

1. Reducing the length of time to access care. Specifically, reducing the time it takes to determine financial eligibility.
2. Stabilizing the long-term financial viability of current service delivery with a growing population. Indiana's existing LTSS program overly incentivizes institutional care with more than 81% of the state's LTSS funding directed to nursing facilities or institutional care and only 19% HCBS, a trend the state had indicated is not sustainable.
3. Assuring adequate provider capacity to deliver LTSS services. The COVID-19 pandemic further exacerbated this in nursing facilities and highlighted concerns over quality in institutional care.
4. Improving consumer and provider awareness of options or how to prepare for LTSS care.

COVERED POPULATIONS[12]

The following groups will be enrolled in IPA:

- Nursing facility (NF) residents aged 60 or older.
- Aging & Disability 1915(c) waiver recipients aged 60 or older.
- Aged, blind, and disabled members aged 60 or older, who do not require LTSS.

IPA will not include anyone currently enrolled in the Family Supports Waiver or the Community Integration and Habilitation Waiver. IPA will encourage all Medicaid and Medicare Advantage (D-SNPs) benefits to be administered like a single benefit package and every member will have a care coordinator assisting them to navigate their care.

KEY PROGRAM FEATURES[13]

Through a competitive procurement process on March 1, 2023, FSSA announced the following vendors to serve as managed care entities (MCEs) for IPA and will begin the process of implementing and operationalizing the program:

- Anthem BCBS
- Humana Healthy Horizons
- United Healthcare Community Plan

FSSA will require any MCE to have a companion D-SNP. As such, the MCEs will have existing contract relationships with Indiana providers that serve older adults which would improve network contracting and credentialing in the IPA program.

Beneficiaries enrolled in the IPA program will receive all traditional Medicaid services (e.g., hospital care, labs, diagnostics, preventive care). MLTSS services will include NF services and individuals that meet a nursing facility Level of Care (LOC) will also be eligible to receive 1915(c) HCBS waiver services such as adult day services, respite, home modifications, and home-delivered meals.[14] Services that are carved-out and covered under FFS are Medicaid Rehabilitation Option (MRO), Adult Mental Health Habilitation Program (AMHH), and Behavioral and Primary Healthcare Coordination (BPHC), as well as certain high-cost drugs. FSSA has added three new HCBS waiver services (caregiver coaching and behavioral management, customized living, and goal engagement) and has expanded the use of self-direction.

PAY FOR PERFORMANCE[15]

Initiating a pay-for-outcomes strategy, FSSA has established a program where MCEs will receive additional compensation contingent upon meeting outcomes measures. FSSA has encouraged MCEs to share these earned incentive payments with members and providers. Moreover, FSSA will withhold a portion of the capitation payments from the MCE with the percentage withheld increasing each calendar year.

MCEs can be eligible to receive all or a portion of the withheld funds based on their performance on the measures determined for each calendar year. For calendar year 2024, FSSA has established the following outcomes measures, targets, and incentive payments:

1. Service Coordinator Person-Centered Planning Competency: Percentage of Service Coordinators completing training modules annually with demonstrated person-centered planning competencies, defined as a score of 85% or higher for each module. The measure is based on MCE reported data and data provided by the training vendor and comprises 35% of the total withheld funds.
2. Completion of Initial Health Needs Screening: Percentage of completed health needs screening (including SDOH screening) within 90 days of member MCE enrollment. The measure is based on MCE reported data and comprises 35% of the total withheld funds.
3. Participant Experience Assessing Care: Percentage of members who received their personal care services on time. The measure is based on Electronic Visit Verification (EVV) data and comprises 30% of the total withheld funds.

FSSA will also provide non-financial incentives for MCE performance as the IPA evolves. The agency is considering different initiatives that include, publicizing achievements of MCE(s) that attain superior performance and/or improvement or rewarding high performance MCEs through the auto-assignment logic considering factors such as MCE performance on clinical quality outcomes, enrollee satisfaction, network access, and other outcome measures.

SECTION 4

Survey of MLTSS States

Methodology

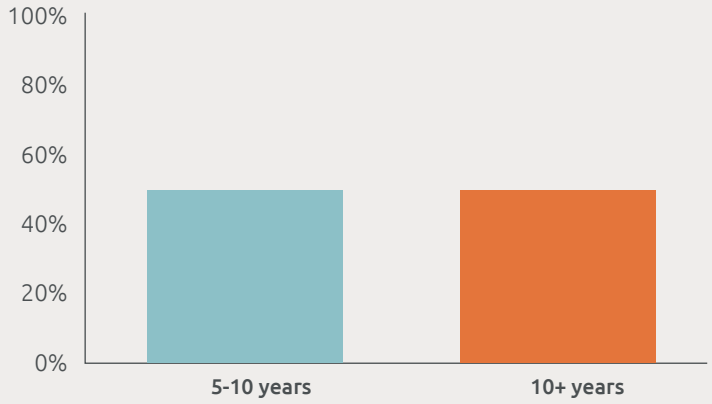
This survey was sent to state officials representing all 25 states with MLTSS programs at the time of this report. 16 responded: Arizona, California, Delaware, Hawaii, Idaho, Illinois, Massachusetts, New Jersey, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, and Wisconsin. The questions from the survey area are listed in **Table 1**.

TABLE 1. QUESTIONS IN THE MLTSS SURVEY

1	How long have you had an MLTSS program?
2	What are three priorities for you in LTSS this year?
3	How has the Public Health Emergency (PHE) unwinding impacted your MLTSS program?
4	What are your thoughts on the future of the MMP transition?
5	What do you think is key to integrating dual eligibles?
6	Do you have any other thoughts on the integration of dual eligibles?
7	What are innovative strategies you have used to address workforce challenges in LTSS?
8	What resources or flexibilities do you need to address workforce issues?
9	How do you think the Access Final Rule will impact LTSS and the workforce?
10	What are innovative programs or ideas in LTSS that you're excited about?
11	What has your state done particularly well with MLTSS?

Length of MLTSS Programs

The 16 survey respondents were **evenly divided**. Eight respondents have had their MLTSS programs for 5-10 years and the remaining eight have had their programs for longer than 10 years.



Current Landscape

Flexibility emerged as a common theme throughout the responses. In discussing the Public Health Emergency unwinding and return to post-pandemic policies, states noted that many stakeholders, including Medicaid beneficiaries, feel that it is important to retain HCBS waiver flexibilities. Some states mentioned that they are looking to maximize the use of self-directed care, which provides increased flexibility and independence for MLTSS members. States also discussed how the return to pre-COVID policies related to in-person work and assessments have resulted in some challenges. For example, Pennsylvania noted the large adjustment to pre-pandemic policies and is considering the effectiveness of remote work for future waiver amendments. Similarly, Idaho noted that there has been an operational strain due to the transition back to in-field work for assessments.

The need for flexibility was also noted concerning the Medicare-Medicaid Plan (MMP) transition required by CMS. In May 2022, CMS finalized a rule to sunset the MMP integrated care model, with a potential transition of these enrollees into integrated Medicare Advantage D-SNPs by 2025. MMPs had a three-way contract that allowed for passive enrollment, integrated member materials, and the ability to distribute shared savings to states. However, after several years, the evaluations did not find meaningful results to suggest cost savings. Despite this, MMPs had high ratings from members and other stakeholders, according to MACPAC. As a result of the findings, CMS is requiring states that participated in the MMP transition to sunset their programs and move to integrated D-SNPs by 2025. Notably, as discussed above, some elements of the MMPs such as the potential for shared savings with the state will not transfer to the integrated D-SNPs.[16]

Flexibility, member education, and innovative strategies to address workforce challenges are at the top of survey respondents' minds in MLTSS.

While not all states maintain the option for MMP plans, those that do speak to the flexibility of the program and their desire to see the same flexibility maintained within D-SNPs. For example, Massachusetts explained that they would like to have the opportunity to "put small waivers on top of D-SNPs" to retain their current flexibility under the MMP demonstration. They and other states seek to maintain the same level of high integration that they have with the MMP demonstration.

In addition to flexibility, education arose as a theme across programs. States discussed the importance of educating both the staff and members of MLTSS on what services are available.

Though MLTSS plans have the flexibility to offer value-added or ILOS, members may not understand what is available to them.[17] The Pennsylvania MCOs interviewed earlier in this report also referenced their efforts to improve quality and utilization by **educating** care coordinators and participants on available services. States also discussed the ability of exclusive alignment to help members better understand their healthcare and what options are available to them. However, states noted that doing this required limiting consumer choice, which some were hesitant to pursue.

The persistent challenges around recruiting and retaining a **workforce** was a message clearly transmitted by states that participated in the survey. These challenges are indeed national; an August 2023 report from the Bureau of Labor Statistics indicated that there were 2.3 open positions in the health care sector for every position filled.[18] States indicated that several strategies were in use to improve recruitment and retention; many included offering direct care workers a variety of options and benefits.

Nearly all states discussed the importance of raising reimbursement rates as a minimum. In conversations with workforce members, Massachusetts discovered that "incentives geared towards their [direct care workers'] children – like college tuition assistance, would make them more likely to stay in the field." Additionally, many states spoke to internal pathways for growth in the field. Respondents' full responses to the question about their MLTSS priorities are included as an appendix to this report on page 26.

SECTION 5

In-Depth Look at States

Eight states that answered the survey are highlighted in more detail here to share their experiences with their MLTSS programs: Arizona, Illinois, Hawaii, New Jersey, Pennsylvania, Rhode Island, Virginia, and Wisconsin.

PUBLIC HEALTH EMERGENCY

Flexibilities that were put into place for beneficiaries, providers, and employees within MLTSS were well received. As agencies transition back to in-person care, they have seen a significant amount of reluctance or opposition to seeing these flexibilities disappear.

In Arizona, AHCCCS allowed parent-delivered care for minors and is now seeking a waiver to allow permanent flexibilities for guardians due to the feedback received. The readjustment of the program also impacts MCO care management functions as mentioned by New Jersey and Illinois. Through Appendix K waivers, Pennsylvania was providing assessments, person-centered service planning, and certain HCBS virtually. The state noted that MCOs, providers, and participants are adjusting to pre-pandemic processes. Like Arizona, Pennsylvania explained that they are evaluating the effectiveness of some remote services for a potential waiver amendment in the future.

Hawaii discussed the potential impact of unwinding on participants as there may be a decrease in authorized hours. The state noted that health plans and their health coordinators will need to reach out proactively to members to ensure that all participants' needs are met within the allotted hours. As a result of the pandemic, Hawaii is looking for new ways to expand provider capacity in community settings, particularly for members who are medically complex or have behavioral health challenges. Additional highlights from unwinding include Wisconsin's ability to increase coverage for vital supports and implement a 2% rate corridor and Virginia's collaboration with the health plans to support outreach programs.

MMP TRANSITION

Within these eight state programs, New Jersey, Virginia, and Wisconsin have fully transitioned to D-SNP, while Arizona, Rhode Island, and Illinois have yet to do so. Two states, Hawaii and Pennsylvania, never participated in the MMP demonstration.

Of the three states still transitioning from the MMP model to D-SNP, Illinois shared their disappointment with the change while recognizing and supporting the goals of CMS to improve experience and outcomes for dual eligibles. Arizona was interested in learning more about what worked well in other states before making the change away from MMP. Rhode Island sees this as an opportunity to align their delivery systems; the state plans to expand its Medicaid Managed Care program to include integrated D-SNPs, which will serve the full-benefit dual eligible population and include LTSS as an in-plan benefit for all populations.

New Jersey offered practical advice for states seeking to move to an integrated D-SNP model and recommended that they codify integration into their contracts to ensure that they have a level of coordination like their previous MMP structure.

Among states that have already sunset their MMP programs, Wisconsin discussed their ability to expand the state's FIDE-SNP model but also spoke to two limiting factors: participant willingness and Medicare's ability to align with state Medicaid programs to coordinate administration and oversight. New Jersey offered practical advice for states seeking to move to an integrated D-SNP model and recommended that they codify integration into their contracts to ensure that they have a level of coordination like their previous MMP structure.

Though Pennsylvania did not participate in the MMP demonstration, they noted that there may be an impact on the state's D-SNPs through the CMS Final Rule related to the plans. In the Final Rule, CMS mentions lessons learned from the MMP that may potentially impact Pennsylvania's D-SNPs. This includes the requirement for D-SNPs to establish and maintain enrollee advisory committees; for SNPs to include more needs assessments across different domains in their comprehensive risk assessment tool; and, starting in 2025, requiring that the capitated contract include coverage of Medicaid behavioral health services. According to the state, under these new requirements, a D-SNP in Pennsylvania may no longer reach FIDE status.

DUAL ELIGIBLES

Outside of the MMP transition, states were asked if they had any additional thoughts about integrating dual eligibles into their program. Arizona mentioned that education was key to supporting members and helping them to make informed choices. Arizona also spoke to the importance of having MCOs be aware of the benefit structure and value-add, stressing that they need to make their programs "digestible and easy to navigate." Similarly, New Jersey addressed the importance of the internal staffing structure within the MCOs. In New Jersey, FIDE-SNP MCOs are structured so that if a member receives MLTSS that member is assigned to an MLTSS care manager rather than a FIDE-SNP care manager. They believe that having the already-established knowledge of LTSS is more crucial (and harder to train on) than that of Medicare, which is easier to learn.

Virginia and Wisconsin shared similar themes around organizational structure. Virginia discussed how closer integration of CMS and State fiscal and administrative processes and control was needed to better align Medicare and Medicaid. Wisconsin stated that there should be one entity responsible for the administration of benefits and service delivery on both the Medicare and Medicaid sides, including appropriate shared savings. Illinois touched on several of these themes by emphasizing the importance of a highly integrated program which in turn helps enrollees maximize their benefits and increase customer satisfaction.

Hawaii offered an extensive list of criteria that helped to integrate care for dual eligibles. The state implemented the FIDE-SNP model and mandated that their Medicare Advantage Organizations (MAOs):

- Unify plan-level appeals and grievances;
- Perform risk assessments for social determinants of health such as housing stability, food security, and access to transportation; and
- Utilize exclusively aligned enrollment.

Hawaii also mandates that the MAOs integrate member materials and communications. This includes providing a single member ID for both programs, an integrated provider and pharmacy directory, and an integrated formulary.

However, not every state has mandated aligned D-SNPs. Pennsylvania noted that while aligned D-SNPs or integrated payers would be beneficial in supporting dually eligible members, they have experienced challenges in achieving full integration.

WORKFORCE CHALLENGES

States across the country are experiencing workforce challenges and are working to address these issues. In Arizona, the state works with high school and community colleges to develop and implement direct care training and provide pathways for employment. These pathways also offer additional opportunities to grow into supervisory roles or transition into other clinical pathways.

Many states noted that they leveraged funding from the American Rescue Plan Act (ARPA) to support workforce development. New Jersey leveraged ARPA funding to provide financial assistance with continuing education, advanced or specialized certifications, access to transportation, and more. Wisconsin has recruited new direct care workers through marketing, recruitment efforts, and a career connection platform.

Pennsylvania used ARPA funding to increase rates for Personal Assistant Services and provide additional retention and recruitment payments for direct care workers. Notably, the state has used ARPA funding to improve the quality of HCBS services by purchasing remote support technology to allow for in-home documentation of participant conditions, as well as enhanced training on infection control practices.

Wisconsin has also increased the use of self-direction and participant hired workers. Virginia spoke to the importance of reimbursement rates and the use of directed payments through MLTSS to pay direct care workers higher rates. Finally, Illinois discussed the way that MCOs are highlighting additional employee benefits to attract and maintain more staff.

Arizona works with high school and community colleges to develop and implement direct care training and provide pathways for employment. These pathways also offer additional opportunities to grow into supervisory roles or transition into other clinical pathways.

Rhode Island tackled workforce shortages in a novel way: the state held a "Health Workforce Summit" in April 2022, co-hosted by EOHHS, the state Medicaid agency, the Rhode Island Department of Labor and Training, the Rhode Island Office of the Postsecondary Commissioner, and the Rhode Island Foundation. The Summit convened public and private partners across the state's health and education system to create innovative solutions to address these pressing issues. According to Rhode Island, since the Summit in 2022, more than 300 individuals from 128 organizations have contributed to developing and implementing solutions to workforce challenges. The state held their Second Annual Health & Human Services Workforce Summit in June 2023.

Hawaii had a unique perspective on these challenges: the state features a changing social landscape and a high cost of living. Hawaii noted that in previous generations, inter-generational households were more common and eased the cost of living in the state. But the cost of living has greatly exceeded current wages. As a result, younger generations are moving to the U.S. mainland, creating a smaller available workforce in the state. While employers are working to retain the workforce with higher wages and increased benefits, the state seeks other ways to attract providers to Hawaii.

They discussed collaborating with other state agencies and community partners to increase the access and availability of training programs to become nurses' aides or Community Care Foster Family Homes (CCFFHs). The state also noted that it is important to ensure that the application and approval process to become a provider is "well-communicated, easy-to-navigate, and that technical assistance is available if needed." Though these and other initiatives are important to attract new employees to the profession, Hawaii and other states are still looking to find additional ways to show their support of the existing workforce.

PROPOSED ACCESS RULES

Given the concerns around the direct care workforce, Sellers Dorsey asked states if they had any comments about the potential impact of the Proposed Access Rule. Some states were unsure of the impact but noted that this would bring significant changes to the program and increase transparency and member participation. Arizona noted that there was potential with the rule, but raised concerns about geographic constraints given that they have urban, rural, and frontier settings within their borders. In contrast, Illinois shared that they do not feel this will have a significant impact on their workforce given that they already have a 77% pass through rate for their direct care worker payments.

WHAT STATES' MLTSS LEADERS ARE LOOKING TOWARD FOR THE FUTURE

States were also given the opportunity to share their thoughts on what they were most excited about in the MLTSS space. Arizona mentioned the need for improved quality metrics that did not add administrative burden to the state. Illinois spoke to their two CMS MLTSS measures within their Pay for Reporting (P4R) measures: MLTSS

Comprehensive Care Plan and Update and MLTSS Successful Transition After Long-Term Facility Stay. These measures are included in the P4R measure set on a quarterly basis.

New Jersey was interested in oversight and quality monitoring to improve MCO accountability and members' quality of life. Pennsylvania's Office of Long-Term Living is working to implement a direct care worker referral and matching portal for MLTSS participants to increase opportunities for direct care workers and to strengthen the support for members who choose to self-direct services.

New Jersey, Arizona, and Wisconsin all touched on the importance of person-centered care and embracing whole-person health through various means.

Additionally, New Jersey, Arizona, and Wisconsin all touched on the importance of person-centered care and embracing whole-person health. New Jersey commented on implementing housing supports. Wisconsin is interested in developing an integrated medical and HCBS model to support high-acuity individuals at home. With a new procurement for their MLTSS program, Pennsylvania is looking to address various SDOH and health equity issues.

Hawaii is interested in expanding its capacity for more complex members in residential settings. Discussions with stakeholders surfaced the challenges to care faced by members with high levels of behavioral health need, as providers may not have the capacity or training to provide an adequate level of service. These challenges can cause provider burnout or result in providers turning away members with high behavioral health needs. As of the time of this survey, Hawaii is exploring different strategies to address this priority.

An innovative effort in Rhode Island is the state's LTSS Alternative Payment Model (APM). This program provides funding to home care agencies to increase their capacity to participate in the measure-based incentive program. Rhode Island stated that the program will have three phases: readiness, pay for reporting, and pay for performance. With this APM, Rhode Island aims to improve and ensure equitable access to HCBS and avoid unnecessary institutionalization; foster a sustainable network of high-quality HCBS providers that are equipped to meet the needs of diverse LTSS members; and finally, to enable and encourage all LTSS members and the aging population to successfully live in their communities.

STATE ACCOMPLISHMENTS

Finally, states shared their accomplishments in MLTSS. Wisconsin and Arizona have both had MLTSS programs for longer than 10 years and highlighted their maturity in this space. This has enabled them to be leaders in MLTSS and provide exceptional supports for their HCBS members. Wisconsin noted that they were able to reach HCBS entitlement for all elderly and disabled. Arizona discussed how their long-standing efforts in MLTSS allow them to focus on innovation. Like Wisconsin, New Jersey highlighted that they have been successful in rebalancing their services and shifted towards more HCBS. Similarly, Pennsylvania noted their continued success in rebalancing and bending the cost curve for LTSS. In addition, Pennsylvania managed to implement the largest and final phase of their MLTSS program during the COVID-19 pandemic.

Virginia and Illinois both highlighted their successes in compliance. Virginia noted that they have been pleased with their ability to monitor MLTSS activity and ensure contract compliance across MCOs, as well as facilitate resolutions between MCOs and providers. Illinois saw 10 of the 18 CMS performance measures average 90% or greater compliance overall in the Q1 CY 2023 EQRO review. In particular, the state has found success in waiver service planning, which includes enrollee goals that are identified in the health risk assessment and emphasize person-centered care. Hawaii noted that they had a prompt response to the COVID-19 pandemic and as a result few members contracted COVID-19. Hawaii was able to respond quickly with go-kits to care for members who contracted the virus.

Conclusion

States across the country are juggling multiple complex priorities around the PHE unwinding, workforce challenges, and the changing regulatory landscape. States with MLTSS have a unique opportunity to leverage their MCOs and create innovative solutions. As evidenced by the survey responses, states have found ways to create success from the COVID-19 pandemic and increase flexibility in their programs. Additionally, many states have devised innovative ways to support the existing direct care workforce and attract newcomers to the profession. States have also sought to collaborate with their MCOs along with other partners to address workforce issues. Looking to the future, all states were excited about continuing to improve their MLTSS programs. These included alternative payment models, improving quality and oversight, addressing social drivers of health and whole-person health, and creating opportunities for all members to live in the community. Though no two states are the same, all are working towards the common goal of helping members live healthier, more independent lives.

> **At Sellers Dorsey, we understand that equitable access to care is essential to improving health outcomes for underserved populations. In the complex landscape of managed care and Medicaid, MLTSS programs serve as a beacon of hope, ensuring that every individual, regardless of their unique challenges receives the care and support they deserve. I'm encouraged by the research in this report, and hope it serves as an example for other states who wish to implement MLTSS programs to further support the needs of their communities.**
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> – Gary Jessee, Senior Vice President of Sellers Dorsey

STATE MLTSS PRIORITIES

Arizona	• Enhancing workforce development strategy. • Implementing a caregiver support waiver. • Procuring new MCOs (natural cycle).
California	• Did not provide specific comments here.
Delaware	• Unwinding from PHE • Helping as many individuals as possible.
Hawaii	• Working closely with hospitals, MCOs, and HCBS and LTC providers to improve transition to LTC facilities and improve access/placement to HCBS residential settings. • Work with MCOs and community stakeholders to ensure an adequate workforce capacity to deliver needed HCBS services and supports with minimal to no gaps in care. • Ensuring person-centered delivery of MLTSS for our members, with an added focus on extended family and community support (oversight and quality).
Idaho	• Addressing specific PHE Unwinding issues. • Direct care workforce shortage. • Provider reimbursement rates.
Illinois	• Transitioning to pay for value and outcomes rather than volume and services. • Proactively using analytics and data to drive decisions and address health disparities • Moving individuals from institutions to the community.
Massachusetts	• MMP Demo transition to D-SNP. • Refining approach to care coordination. • Improving encounter data collection.
New Jersey	• Develop a quality strategy to ensure MCO accountability and member access to services in alignment with their 1115 waiver renewal. • Utilize ARPA funding to improve health outcomes by expanding service availability and newly approved 1115 services and support such as caregiver, nutritional, and housing supports. • Ensure person-centered planning and member quality of life through ongoing compliance monitoring with the HCBS Settings Rule.
North Carolina	• Integrating LTSS into Managed Care. • Expansion of PACE program. • Data integration platform.
Ohio	• Legally responsible individuals as direct care workers. • Budget based reimbursement increases. • FAI transition work.

APPENDIX

Pennsylvania	• Successful MA Unwinding. • Strengthening direct care workforce. • Advance program innovation to improve services that address SDOH (housing, employment, and food insecurity).
Rhode Island	• Medicaid Unwinding/PHE. • MCO Procurement. • Implementation of Conflict-Free Case Management.
Tennessee	• Addressing workforce challenges. • Developing value-based programs for HCBS and rewarding providers for supporting members in reaching person-centered outcomes. • Supporting the redetermination processes.
Texas	• Preparing for start of a new STAR+PLUS contract in 2024. • Continuing to refine compliance activities related to the HCBS setting regulations. • Successfully completing projects in Texas ARPA HCBS spending plan.
Virginia	• Ensuring members in nursing facilities can move to community settings if desired. • Re-procurement of MLTSS and the entire managed care program. • Exploring PACE expansion options within the state.
Wisconsin	• Workforce. • Rate development. • Oversight and quality.

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