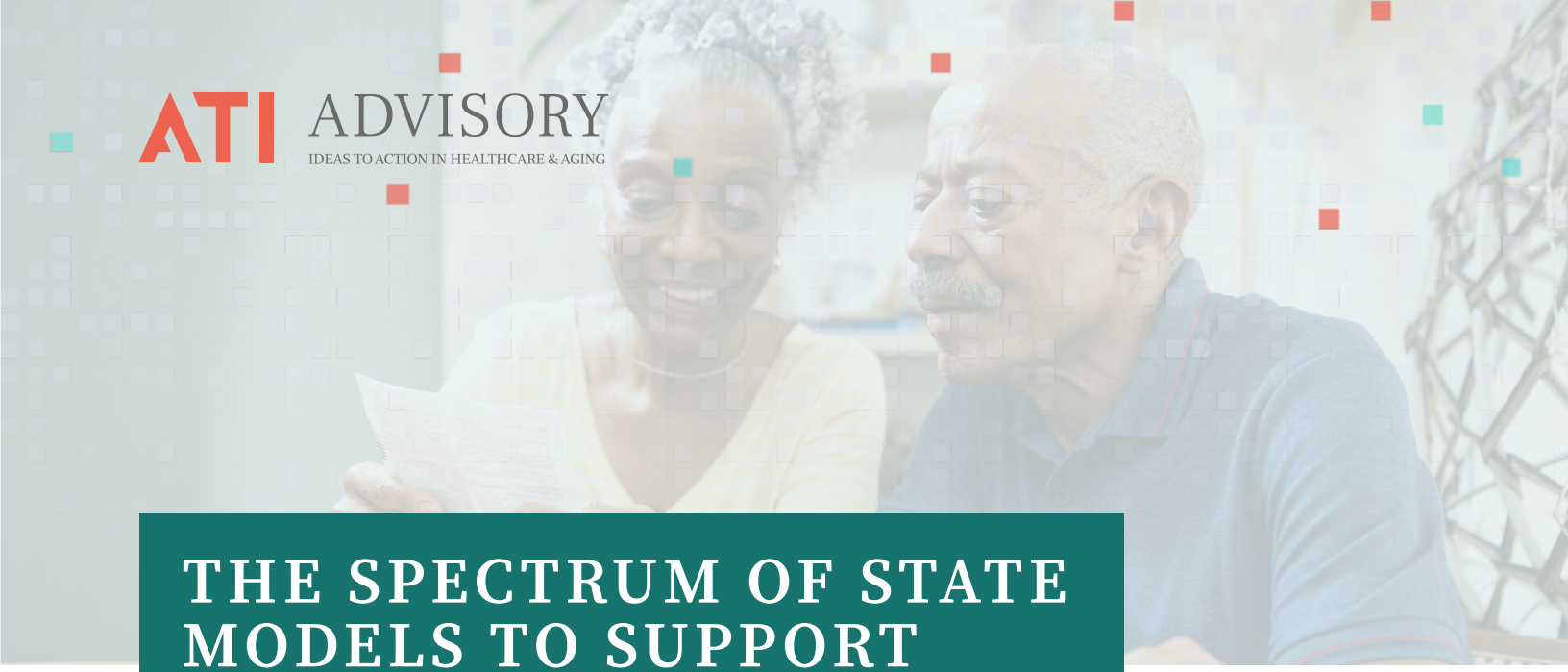


ATI ADVISORY
IDEAS TO ACTION IN HEALTHCARE & AGING

THE SPECTRUM OF STATE MODELS TO SUPPORT MEDICAID LTSS

Executive Summary

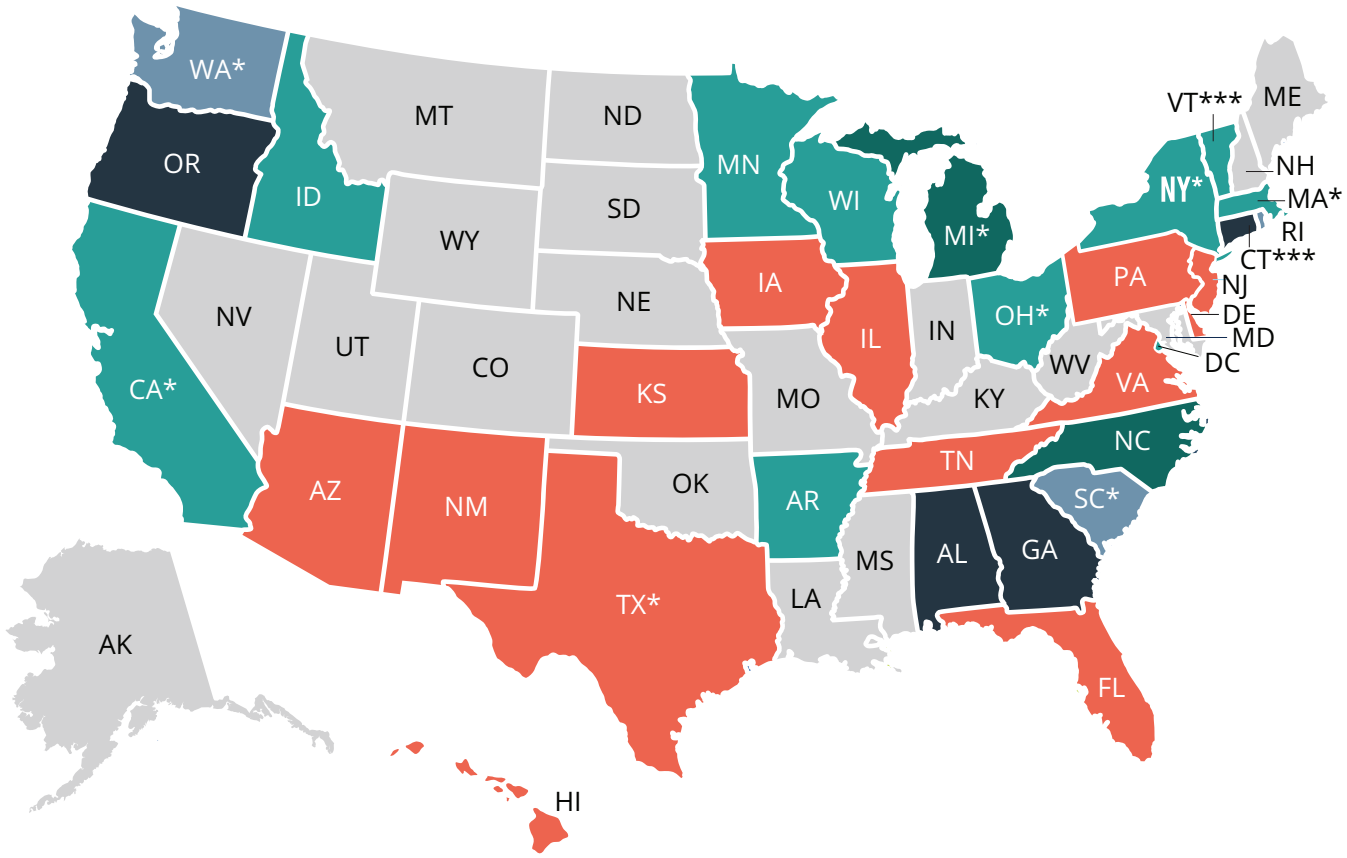
Medicaid Long-Term Services and Supports (LTSS) are provided to only 6% of Medicaid beneficiaries but account for 33% of total Medicaid spend.[1] LTSS provide critical support for activities of daily living (ADL), including eating, dressing, and bathing, or tasks necessary for independent community living such as shopping, managing finances, or house cleaning for frail older adults and individuals with disabilities. In anticipation of demographic shifts and growth in the population eligible for LTSS, states are increasingly considering policies that go beyond traditional fee-for-service (FFS) to reduce budget risk and balance institutional and community-based funding and services.

While some states accomplish their LTSS program goals by contracting with managed care organization (MCOs) to deliver Medicaid Managed LTSS (MLTSS), insurer-provider tensions and state goals, such as retaining funding within the state, have led other states to adopt alternative approaches that stop short of fully delegating programmatic administration to a third-party insurance company. In some instances, states have transitioned to an alternative model after trying and moving away from a traditional MLTSS program due to challenges with the program. In other instances, states leveraged alternative approaches from the outset. Currently, 13 states use mandatory, comprehensive MLTSS to administer LTSS statewide, 15 use a blend of MLTSS and traditional FFS or alternative FFS model, and the remaining 23 use traditional FFS or alternative FFS model to accomplish rebalancing and acute care integration goals (Figure 1).

In the current study, we evaluated alternative models across seven states (Alabama, Arkansas, Connecticut, Georgia, Massachusetts, Oregon, and Washington). Our research found that non-MLTSS models can successfully deliver against key strategic policy objectives such as balance and budgetary control, while demonstrating high beneficiary satisfaction with services. For example, Washington's Managed FFS (MFFS) model experienced year-over-year decreases in skilled nursing facility (SNF) admissions and long-stay nursing facility use, reflecting the program's care coordination efforts to improve transitions from the hospital to home. [2] Similarly, over the first eight years of Connecticut's MFFS model, the percentage of hospital discharges to SNFs decreased from 48% to 34%, while the percentage of discharges to home and community settings increased from 51% to 66%. Experiences and successes across the alternatives were varied, however, and critical to success is investment in state infrastructure, working directly with providers, and leveraging community-based and local organizations.

For Medicaid programs interested in improving their LTSS delivery and administration outside traditional MLTSS, these alternatives may provide a strong path forward.

Figure 1: LTSS Medicaid Program



**Asterisked states also have an FAI program; MA FFS model operates through ACOs*

***Blended states offer FFS in some counties or to some populations, and MLTSS to others*

****Operates a state-led MFFS model or the state operates as the managed care entity*

Model	States	Description
Standard FFS	19 states	All Medicaid LTSS benefits and populations remain in FFS.
ACO/PCCM/Other	4 states	Leverages a Medicaid ACO or a Primary Care Case Management program that includes LTSS, or a program that includes formal coordination between LTSS providers and managed care entities (without LTSS carved-in). Also includes state-led MFFS model.
Blend of FAI and FFS**	3 states	Operates either a MFFS or capitated FAD for some LTSS benefits and populations with the remainder being delivered through FFS.
Blend of Partial MLTSS (non-acute care) and FFS	2 states	Operates a partial MLTSS program (LTSS only; no acute services), such as a PAHP, typically for a subset of LTSS recipients.
Blend of Comp. MLTSS and FFS	9 states + DC	Operates at least one comprehensive MLTSS program for a cohort of beneficiaries but either does not cover all geographies or all LTSS eligible populations; some substantial portion of beneficiaries remain in FFS.
Comp. MLTSS (includes acute care)	13 states	Operates a statewide MLTSS program for the majority of LTSS beneficiaries and services, inclusive of LTSS and acute care services.

Background and Context

While considerable research has been completed on MLTSS programs, less has been written about the impacts and outcomes generated by MLTSS alternatives. ATI Advisory undertook this study to assess attributes of MLTSS alternatives and quantify their ability to help states rebalance LTSS to community settings. We identified five model types across seven states.

Primary Care Case Management (PCCM) programs:

In PCCM models, contracted entities perform coordinated care management and intensive supports for individuals with high levels of need. These services typically include high-touch care coordination, beneficiary education, utilization management,performance measurement, and coordination of behavioral health and LTSS. As of 2020, 12 states leverage PCCM models.

Formal collaborations between MCOs and LTSS providers:

States with Medicaid managed care for acute and medical care services can require Medicaid MCOs to coordinate through a formal relationship with LTSS providers. This coordination supports the full scope of members' needs without paying MCOs a capitation payment for LTSS. Oregon is one example of a state that employs this method by requiring formal Memorandums of Understanding (MOUs) be signed between its Coordinated Care Organizations (term used for MCOs in the state), Area Agencies on Aging (AAAs) and local Aging and People with Disabilities districts (APDs).

Managed Fee-for-Service:

Managed fee-for-service (MFFS) models vary in their design, but at the core is an entity responsible for coordination of services without financial risk. States can develop MFFS models within their own state agencies by developing robust internal infrastructure to manage and coordinate LTSS for beneficiaries. States may also employ the Affordable Care Act Section 2703 health home State Plan Option to provide a comprehensive system of care coordination for Medicaid enrollees with complex needs. In these models, health home providers integrate and coordinate all primary, acute, behavioral health and LTSS to treat the "whole-person."

Accountable Care Organizations (ACOs):

States implement Medicaid ACOs to align provider and payer incentives to focus on value over volume with the goal of promoting health and managing costs. Depending on the design, these provider-led organizations may partner with MCOs for certain functions, and they may take on partial or full risk, or share savings and losses with a Medicaid agency or with MCOs.

MCO models with provider ownership:

States interested in MLTSS seeking to keep providers at the core of the delivery system approach can require that providers maintain a majority ownership of contracted MCOs. The Arkansas PASSE model began as a PCCM model but evolved into a provider led MLTSS program. Other states, such as Florida and North Carolina, similarly leverage provider led MCOs.

The states that operate these alternative models have differing degrees of success with rebalancing services toward community-based care, managing costs and utilization, and beneficiary satisfaction. This success is influenced by factors beyond model and program design (e.g., system capacity, federal funding efforts); however, our research provides important insights for states and policymakers to consider as they design programs to administer LTSS outside the traditional MLTSS approach, with a focus on LTSS providers as key to program management. Across the programs we reviewed, we identified the following themes:

- Meaningfully engaging LTSS providers can improve stakeholder buy-in and ultimately, outcomes;
- coordination and integration of services across providers can be achieved through strong contract requirements and payment policies without full capitation of all services;
- offering providers supports to evolve with the changing delivery systems can improve model success and
- Medicare coordination and/or integration should be considered for all models managing LTSS, including MLTSS and alternative models.

— Methods

We assessed Medicaid LTSS program design in states using alternatives to MLTSS. This included a review of publicly available literature (e.g., state reports, program manuals, white papers, policy briefs) as well as quantitative data (e.g., year-over-year trends in HCBS balance, defined as the ratio of LTSS spending and the ratio of LTSS users receiving care in HCBS settings). In addition to key programmatic components, we sought detail on the roles and relationships of community and facility-based providers, facility experiences with acute care utilization, and beneficiary experiences including program satisfaction and access to care. We supplemented our review with structured interviews with state Medicaid officials, provider representatives and operators, and subject matter experts.

State Selection

States were included if they used a FFS delivery system to manage and coordinate LTSS. We then prioritized state programs that identified rebalancing spending between institutional and home and community-based LTSS as a goal, were provider-led, and/or incorporated payment or financial risk for the lead entities to coordinate LTSS. Selected state programs vary in total LTSS spending on, and users served in, home and community-based settings (as opposed to nursing facilities, NFs), the use of home- and community-based services (HCBS) state plan and waiver options, care management approach (e.g., PCCM, health homes), risk arrangements, and other key components. Seven states ultimately were included for further analysis: Alabama, Arkansas, Connecticut, Georgia, Massachusetts, Oregon, and Washington.

CMS Key Elements of LTSS Delivery Systems

1. Adequate Planning
2. Stakeholder Engagement
3. Enhanced Provision of Home and Community Based Services
4. Alignment of Payment Structures and Goals
5. Support for Beneficiaries
6. Person Centered Processes
7. Comprehensive, Integrated Service Package
8. Qualified Providers
9. Participant Protections
10. Quality

— MLTSS Alternative Models and Attributes

The seven states included in this analysis vary in their payment approaches (e.g., level of risk shifted to a provider entity), care management approaches, roles for providers and MCOs, and LTSS population served (Table 1). We identified five model types among the states:

Primary Care Case Management

Formal collaboration between MCOs and LTSS providers

Managed Fee-for-Service

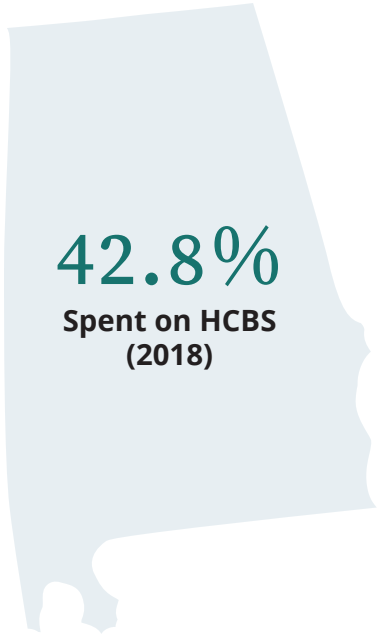
Accountable Care Organizations (ACOs) that include LTSS

MCO models with provider ownership

Table 1. Summary of MLTSS Alternative Models

State	LTSS Model Summary	Year Implemented	Population Served	% Spent on HCBS[3] (2018)
Alabama	• The Integrated Care Network (ICN) is a PCCM model • One entity is selected by competitive bid every 2-5 years • Statewide	2018	• Aged, Blind, and Disabled • Excludes those in nursing facilities for >60 days • Excludes Individuals with Intellectual / Developmental Disabilities (I/DD)	42.8%
Arkansas	• Provider-led MCO model • 4 entities as of 2021 • Statewide	2017 (PCCM) 2019 (MCO)	• Individuals with behavioral health needs and individuals with I/DD	51.9%
Connecticut	• MFFS model for LTSS • Statewide	2012	• Aged, Blind, and Disabled; Individuals with I/DD; Expansion Population	55.5%
Georgia	• SOURCE Program • Case Management • Statewide	1997	• Aged, Blind, and Disabled	48.5%
Massachu-setts	• Community Partner Program • ACOs that include LTSS	2018	• Individuals under 65 with LTSS needs who are not dually eligible for Medicare	71.1%
Oregon	• Collaboration between MCOs and AAAs or other LTSS providers • Statewide	2012	• Aged, Blind, and Disabled	83.4%
Washington	• MFFS with a health homes infrastructure • Statewide	2013	• Individuals with Chronic Conditions	70%

Case Study: Alabama



42.8%
Spent on HCBS (2018)

Integrated Care Network

Alabama's statewide Integrated Care Network (ICN) uses a PCCM model to coordinate care and promote rebalancing of LTSS. The approach, which launched in 2018, involves collaboration between nursing facilities and local AAAs to coordinate care for both institutional and HCBS Medicaid LTSS users across the state. Alabama implemented the ICN to improve Medicaid fiscal stability and coordinate LTSS beneficiaries' care across settings. The state's Long Term Care reform workgroup reviewed case studies of MLTSS states[4] and considered the impacts of MLTSS in their state. Alabama determined that a full-risk, capitated model would be more expensive than the current Medicaid program.[5]

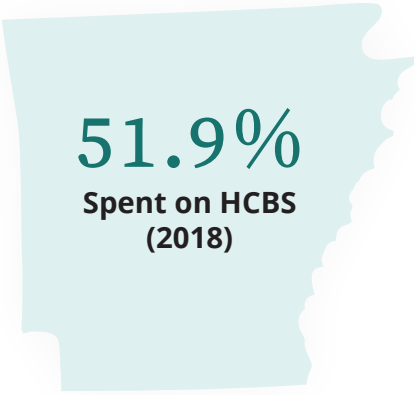
Alabama's alternative managed approach to LTSS leverages local agencies and providers. In a 2018 white paper, Alabama Medicaid representatives announced that the ICN will provide the State's LTSS system with "more managed care elements, as the ICN will take on some financial risk and accountability for improving the HCBS mix."[6]

> ***Nursing facilities, which played a central role in the provision of LTSS at the time of the ICN launch, wanted to "be a part of the change instead of having change happen to them."*** – Alabama interviewee

The ICN is competitively procured and must serve beneficiaries statewide. Alabama Select Network, the current ICN, is owned and governed by a large network of nursing facilities. The state requires that 60% of ICN board members represent ICN owners, and half of those members must be providers. The ICN contracts with state agencies and AAAs responsible for aging services and behavioral health, nursing facilities, and community providers.

The subcontracted AAAs provide case management, receiving monthly per-member-per-month (PMPM) payments through the ICN. The ICN is accountable for reaching the State's LTSS rebalancing goals or the State withholds 10% of its total payments for that year.[7]

The ICN also provides staff training and develops processes for assessment and care coordination. Separate from its board, the ICN uses an advisory committee to advise the ICN on ways it may be more efficient in providing quality care. The committee comprises the AARP, other statewide civic organizations, beneficiaries, and non-owner providers.[8] Similar to MCO requirements in MLTSS programs, the ICN must maintain adequate financial reserves and undertake quality improvement efforts.



PASSE

The Provider-led Arkansas Shared Savings Entity (PASSE) model targets and mandatorily enrolls high-cost beneficiaries with behavioral health needs and/or with intellectual/developmental disabilities (I/DD). The PASSE model initially launched as PCCM in 2017, but transitioned in 2019 to a provider-led MCO.

Each PASSE must be majority-owned by providers, including acute care, LTSS, hospice, and other provider types. MCOs constitute minority owners in the PASSE and offer administrative as well as financial resources. PASSEs act as a "bridge" between local providers and nationwide managed care companies that have administrative expertise to help alleviate high costs.[9]

As a provider-led MCO, the PASSE has full financial risk through a capitated PMPM. As a result, provider-owners of the PASSE *only* benefit if the state's goals are met – that is, only if the provider-led entity effectively manages utilization and reduces spending across settings. Similar to a traditional MCO, the PASSE performs care coordination, administers Medicaid benefits, and performs functions including eligibility determination, claims processing, prior authorization, utilization management, case management, and network contracting. The PASSE is subject to additional quality incentives and must operate continuous quality improvement and reporting programs.[10]

PASSEs act as a "bridge" between local providers and nationwide managed care companies that have administrative expertise to help alleviate high costs.

Case Study: Connecticut

55.5%
Spent on HCBS (2018)

State-Managed FFS

Until 2011, Connecticut leveraged a managed care program design. That year, the state shifted away from managed care in response to a number of issues including inconsistency among MCOs in their provider requirements, confusion for beneficiaries and providers, and state difficulty monitoring the program due to incomplete and inaccurate encounter data.[11] Compounding these issues, several MCOs in Connecticut dropped out of the program with the remaining MCOs requesting higher fees. A mystery shopper survey conducted during the managed care program found that only about 25 percent of callers reached a provider that had appointment availability. Legal disputes related to utilization management, and concerns around MCO transparency and network adequacy further exacerbated the challenges the state experienced. Connecticut replaced the managed care with a state-managed FFS model in 2011, and has since managed LTSS as a state agency.

State LTSS policies and programs are guided by an LTSS Steering Committee as well as a public Strategic Rebalancing Plan (Plan), issued by the governor in 2013 with input from providers and other stakeholders. The Committee involves policymakers and officials across the Administration and is informed by subcommittees that include providers and nursing facility operators with on-the-ground experience.[12]

The state manages a unified case management system for LTSS users that is accessible real-time by HCBS providers. The state also analyzes comprehensive LTSS claims to quantify rebalancing and develop predictive models to support utilization management and care management.

The Plan identifies short-term action steps to achieve long-term rebalancing while sustaining LTSS availability in the state. The Plan has two goals:

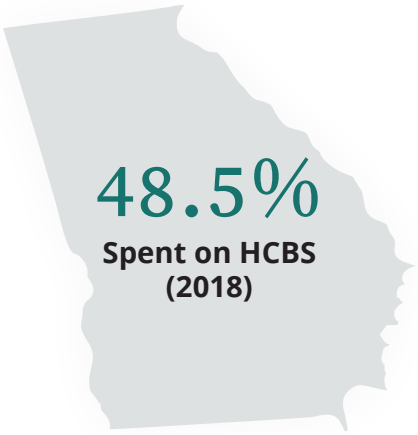
1. Remove barriers that prevent choice in where people receive LTSS at a state policy and systems level; and
2. Partner with nursing facilities, communities, and existing community providers to implement change at a local level.

The Plan outlines technical assistance to institutional providers interested in diversifying their business beyond facility care. While initially delayed due to COVID-19, nursing facility operators can receive support from state staff in 2022 to learn how to set up HCBS business lines and work with Medicaid as an HCBS provider. This will enable them to continue to provide reimbursable services to former residents after transitioning them to the community under the state's Money Follows the Person program.[13]

A Look at the Efficiency of Connecticut's Medicaid Program

Connecticut has the lowest Medicaid expense as a percentage of total state budget of any state in the region other than New Jersey, and is below the national average. In 2020, Connecticut reported it had a 3.5% administrative cost across its Medicaid operations, compared to the MCOs' administrative costs typically in excess of 11%.

Case Study: Georgia



SOURCE

Georgia established the Service Options Using Resources in a Community Environment (SOURCE) program in 1997, with goals to rebalance LTSS to the community, manage disability among the chronically ill, eliminate system fragmentation, and improve financial predictability through decreased medical utilization.

> ***The program was designed to serve older adults and people with disabilities needing nursing facility level of care. It provides HCBS, primary care, personal care, respite services, and case management under an enhanced primary care case management (EPCCM) approach.[14]***

The initial SOURCE program centralized around partnerships ("sites") with three local hospital systems, but over time the program has expanded to include a formal relationship between AAAs, Medicaid HCBS providers, institutional providers, and other local service groups.[15] Several nursing facility operators have established SOURCE sites.[16]

The SOURCE site coordinates primary care and community-based services, operationally and financially. While community and physician services for SOURCE clients are paid through Medicaid FFS, utilization is authorized by SOURCE sites, and sites receive a PMPM to provide enhanced case management.[17]

A SOURCE site must authorize HCBS for its clients through care planning; managed services range from Personal Support Services and Adult Day to Home-Delivered Meals. Notably, SOURCE sites authorize Medicaid-reimbursed services for its clients through a detailed needs assessment and standardized care plan process. Sites must provide 24/7 on-call services, medical consultation, and service authorization.[18]

For individuals dually eligible for Medicare and Medicaid, SOURCE Case Management providers also are expected to coordinate services delivered under Medicare. To support community living, SOURCE sites must gain funding to "bridge gaps in coverage" from Medicaid or Medicare sources and provide in-need SOURCE clients with non-reimbursed services like pest control, nutritional supplements, or moving expenses.[19]

71.1%
Spent on HCBS (2018)

Provider-Led ACOs that include LTSS Providers

In 2018, Massachusetts began a 5-year investment in delivery system reform.[20] Medicaid ACOs and community-based healthcare/human services organizations (referred to as Community Partners/Community Service Agencies) were central to this system reform, and key to promoting integration, care coordination, and provider accountability for quality and total cost of care.

Massachusetts' Medicaid ACOs are provider-led with the option to include MCOs.[21] The ACOs are contractually required to collaborate with Community Partners, which are community-based entities (e.g., AAAs), providing behavioral health, LTSS, or both.[22] ACOs and Community Partners co-develop care plans for aligned beneficiaries to ensure coordinated care across settings and providers. (See Table 2 for a summary of high-level supports offered by LTSS Community Partners.)

ACOs now help refer beneficiaries to LTSS providers and help in care planning.

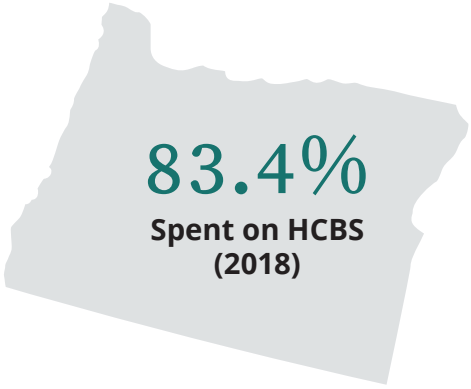
Eligibility for the ACO is limited to individuals with LTSS needs under 65 who are community-dwelling and not dually eligible for Medicare. The Medicaid ACO operates alongside two notable integrated care programs serving dually eligible individuals in Massachusetts: the Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP)-based Senior Care Options for those over the age of 65 and the OneCare Financial Alignment Demonstration for those under 65.

Table 2. Overview of Massachusetts' LTSS Community Partner Supports

	LTSS Community Partner
Outreach and engagement	x
Supports for transitions of care	x
Connection to social services and community resources	x
Health and wellness coaching	x
LTSS care planning including providing informed choice of services and providers	x
LTSS care coordination	x

ACO Snapshot

ACOs are designed to align provider and payer incentives, with a focus on shifting away from volume to value. Providers are held accountable for the outcomes of the beneficiaries they serve through value-based payments coupled with quality improvement activities and data analysis. These value-based payments may be upside only (shared savings) or risk based including global capitation.



Collaboration between MCOs (CCOs) and LTSS Providers

In 2012, Oregon launched its Coordinated Care Organizations (CCO)[i] program as part of the state's broader Health System Transformation Demonstration.[23] CCOs are community-based MCOs that operate through risk-based contracts with the state and are accountable for the provision of integrated and coordinated health care.[24] At the start, CCOs were provider-led.

The same year, a state organized study group of stakeholders examined the viability of Oregon implementing a traditional MLTSS approach. After concerns from LTSS beneficiary advocates and LTSS providers about potential fragmentation and quality implications under MLTSS as well as the limits of CCOs to coordinate LTSS,[25] LTSS was excluded from the CCO program. The state chose to pay LTSS providers on a FFS basis, coordinated principally by local agencies.[26] The study group highlighted strategies without MLTSS to administer LTSS under a shared public accountability model. Stakeholders expressed a strong desire for transparency and quality under the state's publicly administered LTSS.[27]

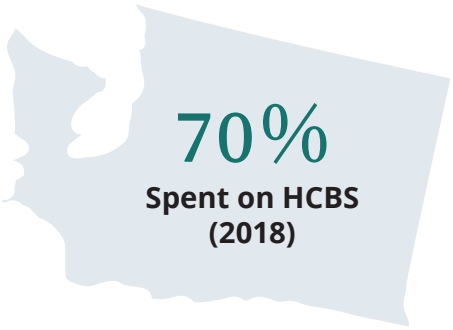
Under the shared accountability model, CCOs are responsible for referring their members who need or use LTSS (institutional or HCBS) to regional or county agencies.

The state delegates responsibility for managing and monitoring most LTSS to local Aging and People with Disabilities districts (APDs)/AAAs. CCOs are required to develop a Memorandum of Understanding (MOU) with APDs/AAAs to guide coordination and alignment between LTSS local offices and CCOs. At minimum, LTSS/CCO MOUs must address interdisciplinary care coordination (between CCO, primary care, LTSS, and APD/AAA representatives), transitional care practices, and member engagement. (Table 3 provides additional examples of requirements.)

i Oregon's Coordinated Care Organization (CCO) program is a regional Medicaid managed care program leveraging strengths of local providers and communities with the aims of improving quality of care for its population and controlling cost growth. CCOs have global budgets, receiving payments based on projected spending for physical, behavioral, and oral health services. See here for Oregon's most recently approved extension of the CCO model.

Table 3. FY2020-2024 Required Domains, CCO-APD/AAA Shared Accountability28

Required Domains	Examples of CCO Expectations/ Responsibilities	Examples of APD/AAA Expectations/ Responsibilities
Domain 1: Prioritization of high needs members	Risk assessment and screening for all members receiving Medicaid funded LTSS.	Share with CCOs key health-related information & individualized LTSS care plans.
Domain 2: Interdisciplinary care teams (IDT)	Support care teams through regular IDT meetings for prioritized members; work with APD/AAA to confirm which members are receiving LTSS; include LTC providers and APD/AAA case managers in IDT approach.	Ensure that CCO providers/care teams are notified of which CCO members are receiving LTSS services, as well as relevant contacts (e.g., APD/AAA office contact, LTSS provider).
Domain 3: Development and sharing of individualized care plans	Consistent with members' individualized care plans, identify preventive approaches, screenings, and strategies to reduce unnecessary hospitalizations, ER visits and maintain or improve health of members with LTSS.	Define how key health-related information (e.g., risk assessments generated by LTSS providers) will be integrated into CCOs' care plans for members with ICC needs.
Domain 4: Transitional care practices	Ensure transition processes include evidence-based discharge planning, setting up and monitoring of follow-up appointments, ensuring transportation, medication reconciliation, durable medical equipment needs/orders, etc.	Work with CCOs, Oregon Health Authority and medical providers on durable medical equipment and environmental modifications needed for successful transitions.
Domain 5: Collaborative Communication tools and processes	Use hospital and SNF event notifications to support Care Coordination and/or population health efforts; participate in opportunities for joint discussions with SNF Collective and APD/AAA teams on SNF event notifications.	Share how APD/AAA office is using SNF information; participate as appropriate in discussions on APD/AAA use or monitoring of SNF information.



Managed Fee-for-Service

In July 2013, Washington State launched both a health homes model and a Managed FFS (MFFS) Financial Alignment Demonstration. The MFFS model leverages the health homes infrastructure as the foundation for the demonstration. Through these initiatives, the state sought to:

1. Improve quality and coordination of services.
2. Increase the HCBS balance and reduce nursing facility entry among clients at high entry risk.
3. Integrate LTSS use with behavioral and physical healthcare.
4. Achieve and share cost-savings across Medicare and Medicaid, between the state and CMS.

Washington State contracts with "lead entities" to serve as health homes statewide, which may include MCOs or certain types of community-based organizations (CBOs). The health home lead entities contract with care coordination providers, which include AAAs, social service agencies, community health centers, and behavioral health providers.

Health home entities coordinate physical health, behavioral health, LTSS, and social services, starting with a needs assessment and Health Action Plan. They also communicate and consult with providers of care, as well as ensure access to support groups and peer supports. Especially relevant to HCBS populations, they provide caregiver support and social connection to recipients who need it. Beyond these direct services, health homes must be able to refer the client to broad networks of related healthcare or LTSS providers and must assure 24/7 access to referrals for such services. Health homes receive a higher payment rate during the first month of an individual's enrollment, to encourage outreach and engagement, screening and assessment, and development of a Health Action Plan.

The MFFS model targets high-cost, high-need dual eligible individuals with one or more chronic condition (including behavioral health conditions) and a predictive risk score (Predictive Risk Intelligence System score[ii]) indicative of the person having 50% greater health care spending in the next month relative to the average Medicaid beneficiary with disabilities. While nursing facilities are not eligible to serve as health home entities, the model evaluates admissions into SNFs as a key quality measure used to evaluate the effectiveness of the program.

Medicaid health homes were established through the Affordable Care Act to coordinate care for individuals with chronic conditions and severe and persistent mental health condition. Health homes must coordinate all acute care, behavioral health, and LTSS.

ii The Predictive Risk Intelligence System (PRISM) score identifies patients who could benefit from comprehensive services with care coordination. The methodology for calculating a person's risk score can be found here: https://apps.leg.wa.gov/wac/default.aspx-?cite=182-557-0225.

— Program Experiences and Outcomes

States vary in their program design and their tenure coordinating LTSS, ranging from over two decades to only a few years in operation. Many of the programs included in this study have evolved from their original design, building upon initial structures and processes to better target state goals. For this reason, program experiences and outcomes should be considered in the context of each state's broader delivery system reforms, some of which may have a significant impact on the state-level data (Table 4).

Table 4. State Attributes Likely to Impact LTSS Outcomes

State	Overall Medicaid Enrollment by Delivery System[29,iii]	Medicare-Medicaid Integration Platforms[30]
Alabama	No Medicaid managed care. 97.2% of the Medicaid population is covered by PCCM, while 2.8% is covered by FFS/Other.	Alabama has D-SNPs[iv], PACE[v], and an approved Medicaid Health Home model.
Arkansas	4.7% of the Medicaid population is in a Medicaid MCO. 42.9% of the Medicaid population is in PCCM and 52.4% is in FFS/Other.	Arkansas has D-SNPs and PACE.
Connecticut	100% of Medicaid beneficiaries are in FFS/Other.	Connecticut has D-SNPs and an approved Medicaid Health Home model.
Georgia	75% of Medicaid beneficiaries are in an MCO and 25% are in FFS/Other.	Georgia has D-SNPs.
Massachusetts	53.4% of Medicaid beneficiaries are in an MCO, 38.4% are in PCCM, and 8.2% are in FFS/Other.[vi]	Massachusetts has a capitated Financial Alignment Demonstration, D-SNPs, and PACE. These models serve 28% of dually eligible beneficiaries.[31]
Oregon	92.2% of Medicaid beneficiaries are in an MCO and 7.8% are in FFS/Other.	Oregon has D-SNPs and PACE.
Washington	84% of Medicaid beneficiaries are in an MCO, 1% are in PCCM, and 15% are in FFS/Other.	Washington has a MFFS Financial Alignment Demonstration, D-SNPs, PACE, and an approved Medicaid Health Home model.

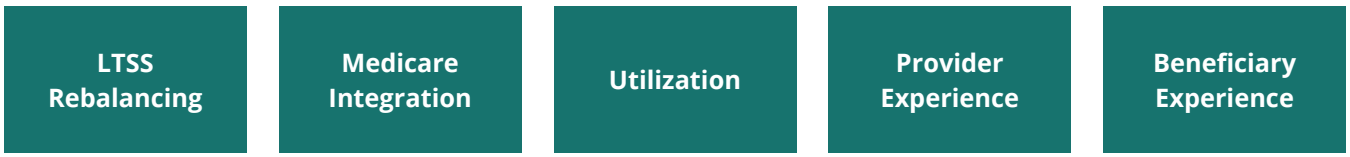
iii Overall Medicaid enrollment includes all Medicaid populations enrollment across Medicaid managed care, PCCM, or FFS/Other (capturing all beneficiaries not in managed care or PCCM) as of July 2021.

iv D-SNPs are Dual Eligible Special Needs Plans, a type of Medicare Advantage product specifically designed to coordinate care for dually eligible beneficiaries.

v PACE is the Program of All-Inclusive Care for the Elderly, a Medicare and Medicaid program that helps people over the age of 55 with nursing-home level of care meet their health care needs in the community.

vi Massachusetts' ACO enrollment is spread across MCO and FFS models.

We assessed each state's models on key outcomes important to MLTSS program success:[vii]



LTSS Rebalancing

Rebalancing LTSS to home and community-based settings is a primary goal of state LTSS reforms. Often, this is reported as the percent of Medicaid HCBS spending as a share of total LTSS spending for each distinct LTSS population – older adults and those with physical disability (A&D), individuals with I/DD, and individuals with serious mental illness (SMI). Spending balance can be artificially impacted by factors such as decreasing facility payment amounts or increasing HCBS payment amounts without increasing the number of individuals served in the community; however, it remains the standard measurement for balance given available data.

With these limitations in mind, we assessed YoY changes in LTSS spending balance for each LTSS population cohort, before and after implementation. Overall, total HCBS spending as a proportion of total LTSS spending generally increased year over year after program implementation, ranging from 4.2% to 9.7% (Table 5). Greatest changes in HCBS balance were seen across services for older adults and people with physical disabilities, ranging from 1.2% in Georgia to 24.2% in Oregon.

vii Note that interviewee experiences and anecdotes dominate where publicly available, model-specific reports and evaluations were limited or unavailable.

Table 5. LTSS Balance in Select Models Over Time[32]

State and Year Launched	% LTSS Spend for HCBS Pre-Launch		% LTSS Spend for HCBS Launch Year	Year 1	Year 2	Year 3	Total Change from Pre-Launch to Year 3
AL, 2018	**HCBS % of Total LTSS Spend**	43.5%	42.8%	NA	NA	NA	***Post-implementation data are not available.***
	Older Adults, Individuals with PD	14.5%	16.1%	NA	NA	NA	
AR, 2017	**HCBS % of Total LTSS Spend**	52.1%	52.0%	51.9%	NA	NA	***Post-implementation data are not available.***
	Individuals with I/DD	54.7%	54.0%	57.9%	NA	NA	
	Individuals with behavioral health	81.2%	80.7%	79.1%	NA	NA	
CT, 2012	**HCBS % of Total LTSS Spend**	43.6%	43.2%	45.1%	47.6%	50.7%	***7.1%***
	Older Adults, Individuals with PD	25.3%	25.8%	27.8%	30.2%	35.9%	***10.6%***
	Individuals with I/DD	73.5%	73.4%	73.7%	75.6%	77.0%	***3.5%***
GA, 1997	**HCBS % of Total LTSS Spend**	15.4%	24.0%	26.1%	26.1%	25.1%	***9.7%***
	Older Adults, Individuals with PD	13.0%	13.7%	15.0%	15.3%	14.2%	***1.2%***
MA, 2018	**HCBS % of Total LTSS Spend**	70.4%	71.1%	NA	NA	NA	***Limited data available.***
	Individuals with I/DD	–	–	NA	NA	NA	
	Individuals with behavioral health	–	–	NA	NA	NA	
OR, 2012	**HCBS % of Total LTSS Spend**	77.5%	78.2%	78.9%	79.4%	82.2%	***4.6%***
	Older Adults, Individuals with PD	56.9%	60.3%	64.1%	77.7%	81.1%	***24.2%***
	Individuals with I/DD*	100.0%	100.0%	100.0%	100.0%	100.0%	***0.0%***
	Individuals with behavioral health	86.8%	73.3%	71.6%	81.6%	80.0%	***-6.8%***
WA, 2013	**HCBS % of Total LTSS Spend**	64.2%	64.4%	65.8%	68.1%	68.5%	***4.2%***
	Older Adults, Individuals with PD	61.8%	62.0%	63.6%	66.5%	71.1%	***9.6%***

Notes: Eiken et. al. LTSS Expenditure reports primarily use CMS-64 reports and include Medicaid expenditures for all LTSS, including institutional services and HCBS, by service category and state. We report HCBS spending as a percent of total LTSS spending across states, as well as HCBS spending by subpopulation out of total HCBS spending. HCBS expenditures by subpopulation do not perfectly align with each model's specific populations and should be used as estimates rather than exact amounts. All Fiscal Year (FY) expenditure data comes from the most recently available report. In some cases, reported data for a given year may appear different in newer versions than in the original report. Data are presented based on state reporting, which may explain these discrepancies.

* = Data are presented as reported in the Eiken et. al. Medicaid LTSS Expenditure reports. Percentages calculate to greater than 100%, which may be explained by errors in state reporting. No further explanation of trends are available. – = Other, whereby data were not reported in Medicaid LTSS Annual Expenditure reports. HCBS = Home-and community-based services; I/DD = Intellectual/developmental disability; LTSS = Long-term services and supports; NA = Not applicable, whereby post-implementation expenditure data are not yet available or reported; PD = Physical disability.

Medicare Integration

Another key attribute of LTSS program design is the ability and approach to integrate LTSS with medical, acute-care services. For a large portion of Medicaid users, this requires system level integration between Medicaid (the LTSS payer) and Medicare (the medical care payer). Nearly half (49%) of individuals with both Medicare and Medicaid coverage (dually eligible beneficiaries) use Medicaid LTSS. States are increasingly integrating care for dually eligible beneficiaries through programs that enroll individuals in a single health plan for their LTSS and Medicare services. States without an MLTSS infrastructure can integrate with Medicare through alternate approaches that require coordination of care across payers.

Washington State's MFFS Financial Alignment Demonstration is the most targeted Medicare-Medicaid integration approach of the models studied for this report. The MFFS demonstration achieved $34.9M in Medicare savings for the first period of the demonstration with an additional $32.1M saved in the second demonstration period. In September of 2021, the state announced that it recently received $17.9M in shared savings from the sixth year of the demonstration with 38% of enrolled dually eligible beneficiaries engaged and actively participating. Evaluation results also indicate an increase of HCBS balance among targeted groups and beneficiary reported satisfaction with their health home, along with improvement in quality of life, access to services, and overall health.

While **Georgia SOURCE** providers are not responsible financially for Medicare covered services, they are expected to help members coordinate Medicare benefits. For instance, if an individual needs equipment, care coordinators are required to assist the member obtain the item whether it is covered through Medicaid or Medicare. SOURCE provider administrative and non-direct member care staff are also required to be trained in both Medicaid and Medicare benefits. At the time of this study, data were not available on program savings or experiences as a result of Medicare integration.

To support dually eligible beneficiaries navigate the disparate systems, **Connecticut** coordinates Medicare funded equipment and Medicare HCBS (home health) services for beneficiaries under 1915i, 1915c, and 1915k waivers."

The **Alabama ICN** model serves a largely dually eligible population and could benefit from greater emphasis on coordination of Medicare with ICN services for beneficiaries. This could be accomplished in a few ways, such as requiring the ICN to pursue a Medicare Advantage dual-eligible special needs plan (D-SNP). The state's 2018 solicitation for ICN proposals required that bidders "establish points of contact with Medicare Advantage plans to coordinate services for Enrollees who are also members of Medicare Advantage plans and establish mechanisms for sharing information to support Case Management activities," but did not go so far as to require contracting or the establishment of a D-SNP.

Oregon currently requires that its CCOs have an affiliate Medicare Advantage or Medicare Advantage D-SNP product. While the state allows for either model today, there is opportunity for reforming this approach to require that CCOs offer D-SNPs to further support integration and coordination efforts with Medicare.

The other models assessed for this study do not have intentional approaches to Medicare integration for individuals dually eligible for both programs. We view this as an opportunity for improvement. Provider-led MCOs in other markets have successfully managed Medicare Advantage products including D-SNPs and institutional SNPs (I-SNPs), which are targeted to Medicare beneficiaries with LTSS needs. (see Emergency Trends and Opportunities to Leverage Provider Organizations, p. 22)

Utilization

Acute care utilization is a key component for evaluating LTSS delivery systems. For community dwelling and short stay nursing facility residents with LTSS needs, lower acute care utilization is generally achieved through robust coordination across primary medical care, community services, and case management. Absent coordination and care management, many individuals experience greater unmet need, reflected in increased acute care utilization such as avoidable emergency department visits and admissions to institutional settings. For long-stay nursing facility residents, advancements in clinical care processes and information exchange have led to delivery of higher quality care and avoidance of unnecessary hospitalizations.

Trends in acute care utilization were not widely reported on or made publicly available for most models included in this report. Small cohort sizes and issues of programmatic attribution further limit rigorous evaluation. However,

evidence suggests that strong care management approaches can lead to favorable reductions in institutional stays and improve post-acute transitions to the home or community setting. **Washington's MFFS model**, for example, has seen year-over-year decreases in SNF admissions and long-stay nursing facility use, which may be explained by the model's focus on care coordination efforts to improve transitions from the hospital to home. Similarly, over the first eight years since **Connecticut's MFFS** model launched, the percent of hospital discharges to SNFs decreased from 48% to 34%. Complementing these reductions, the percent of hospital discharges to home and community settings during this same time (2012-2020) increased from 51% to 66%.

Anecdotally, representatives from Georgia's Health Care Association (GHCA) shared that member facilities operating in communities with effective SOURCE sites were seeing a shift in payer case mix and acuity level. According to GHCA interviewees and member facilities, SOURCE's case management approach helped lower-acuity members remain in the community longer and diverted nursing facility placement until higher acuity, skilled nursing services were needed.

The Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents demonstrated a 2.6% reduction in the probability of an all-cause hospitalization and a 21% probability of cost savings to Medicare. The Initiative leveraged Advanced Practice Registered Nurses and Registered Nurses to support nursing facility staff with clinical care assistance, education, introduction of INTERACT (Interventions to Reduce Acute Care Transfers) tools, end-of-life care planning, and medication management. These tools aimed to improve clinical care processes and information exchange to ultimately improve quality of care provided to residents and reduce unnecessary hospitalizations.

Provider Experience

Models featured in this report use providers as central to the design and delivery of LTSS programs. While programs vary in their mechanisms of provider engagement and responsibility, they align on their motivation for engaging providers: improve stakeholder buy-in and leverage providers' direct line of sight into patient care to help the state achieve its goals.

For example, Alabama, Connecticut, and Georgia engage nursing facility operators and HCBS providers in different, yet meaningful ways:

- In **Georgia** several nursing facility-owned entities have diversified their business models to include HCBS as a result of the SOURCE program. Speaking to nursing facilities' positive perception about SOURCE, Georgia Health Care Association representatives added that their member facilities, even those not participating as SOURCE sites see indirect financial benefit through shifting case mix by payer. SOURCE, in prolonging participants' ability to receive LTSS in the home or community, diverts Medicaid-long stay placement and in turn, nursing facilities can provide care to higher acuity patients under higher Medicare reimbursement.
- In **Arkansas**, the PASSE program, which originally launched as a PCCM model, has shifted into a provider owned MCO model. While the PASSE model now operates as an MLTSS program, the PASSE entities are primarily provider owned. Academic interviews led by the University of Arkansas in the fall of 2017 indicated that Arkansas Medicaid providers and beneficiaries alike preferred the provider-led approach in lieu of traditional MLTSS. Because county offices had previously conducted care planning for these populations, transitioning to this model relieved strain on those county offices. One official noted that the PASSEs have shown savings for the Medicaid agency, as well as continuous quality improvement. The official also noted that rather than solely focusing on financial aspects of managed care, the PASSE focuses on people in its efforts to involve providers, optimize care coordination, keep clients out of the emergency department, and help with discharge planning.

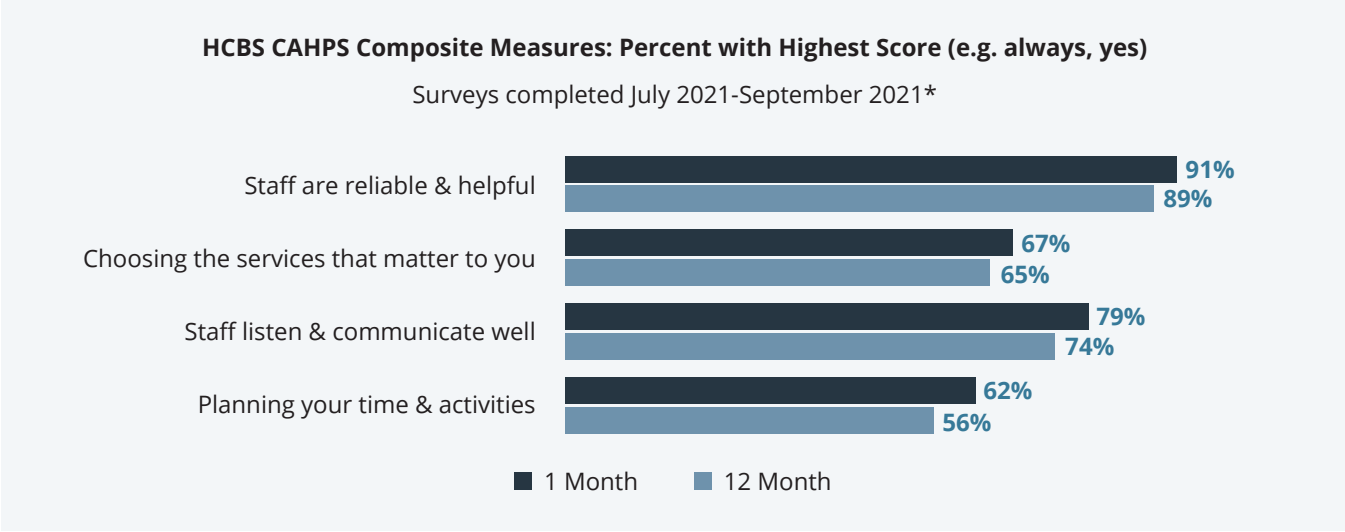
- **Massachusetts** integrates LTSS into its ACO model, with ACOs contracting with LTSS and behavioral health Community Partners. Operationally, interviewees reported challenges between LTSS and behavioral health providers and ACOs. Interviewees reported operational challenges around coordinating and securing ACO approval of personalized care plans authorizing LTSS. Despite early operational challenges, a recent report on Massachusetts's Medicaid ACO model indicated that stakeholders "overwhelmingly support" the program. Specifically, interviewees commend the model for facilitating and leveraging beneficial partnerships among ACOs, Community Partners, and Social Service Organizations. Through these partnerships, the model was better equipped to address social determinants of health and other community living needs that members may experience. Community Partners, for example, leverage existing community relationships and resources to provide direct services, such as care coordination or case management, as well as connect members to additional social services, such as access to registered dieticians in family health centers and diabetes educators to promote adequate nutrition.

Beneficiary Experience

Beneficiary satisfaction and experiences with the health care and LTSS delivery systems is an important indicator of the success of various models of care. Understanding if models meet the perceived needs and do so in beneficiary-friendly way is critical to fully evaluating programs. Limited data are publicly available on many of the models analyzed in this report. However, key data on LTSS user experience in Connecticut and Washington are positive:

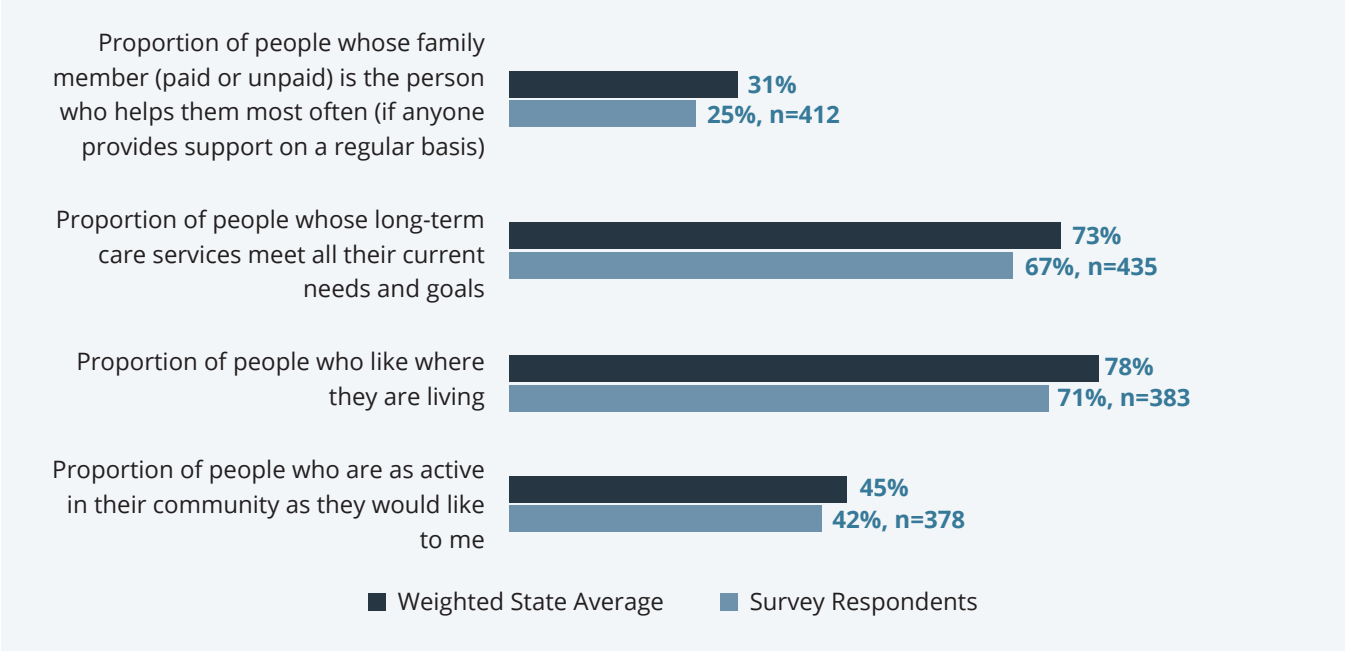
- **Connecticut's** HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys completed in 2021 as a part of the Money Follows the Person report indicate that these LTSS users have favorable experiences with LTSS staff and autonomy in choosing services that matter to them and how they spend their time (Figure 2).

Figure 2. Spotlight on LTSS User Experience in Connecticut



- **Washington** participates in the National Core Indicators Aging & Disabilities Adult Consumer Survey to evaluate beneficiary experience with LTSS. The most recent survey results indicate that beneficiaries in Washington are particularly satisfied with where they are living. A high proportion of people also indicate that their LTSS meet all their current needs and goals (Figure 3).

Figure 3. Spotlight on LTSS User Experience in Washington



Key Takeaways

There are a myriad of factors that influence state decisions regarding LTSS program design, and each program design has strengths and weaknesses. To be successful, a program must work for all stakeholders involved and consider individual experiences and outcomes alongside state savings opportunities. To date, much of the available research has focused on MLTSS as the primary approach to meeting state goals regarding LTSS balance to the community, coordinated care, and state financial predictability. However, MLTSS is not always practical or preferred in the context of local delivery systems or political environments and may not be the best fit for local consumers.

Our analysis illuminates alternative approaches to MLTSS that states might consider on their path toward rebalancing LTSS to home and community-based settings. These approaches demonstrate that LTSS and acute care utilization can be positively impacted, as well as provider and consumer experiences. Central to the majority of these is models is that the providers closest to beneficiaries' care are key decision makers and drivers of program design.

Key LTSS Program Design Elements

Regardless of the LTSS approach a state pursues, there are core elements states should consider. CMS has defined 10 MLTSS best practices that we also found across the MLTSS alternative programs evaluated for this study (Table 6). Additionally, because a considerable portion of Medicaid beneficiaries with LTSS needs are dually eligible beneficiaries, Medicare integration should be prioritized in any model created to serve LTSS beneficiaries. The transitions between a Medicare service (e.g., hospitalization) and Medicaid service (e.g., home care) can be critical in a person's outcomes and the costs to both Medicare and Medicaid. Five of the six models serving dually eligible beneficiaries in this current study have some degree of coordination with Medicare, similar to the portion of MLTSS programs that currently coordinate with Medicare.[33]

Table 6. CMS Key Elements of LTSS Delivery Systems

Elements	MLTSS Element Description	Example MLTSS Alternative Approach
Adequate Planning	Allow adequate time in advance of implementing new, expanded, or reconfigured MLTSS programs to allow for thoughtful planning and design, incorporation of stakeholder input, and implementation of safeguards to ensure a smooth transition to MLTSS.	Oregon undertook an extensive planning process to develop its shared accountability standards for CCOs and LTSS providers responsibilities as it relates to the coordination of LTSS. The process resulted in detailed standards that meaningfully incorporated stakeholder input.
Stakeholder Engagement	CMS expects states to have a formal process for the ongoing education of stakeholders prior to, during, and after implementation, and states must require their contractors to do the same.	Connecticut features a robust ongoing stakeholder engagement structure that drives state decision-making around LTSS policy and program design. As a result of this stakeholder engagement, the state has implemented technical assistance strategies to support nursing facilities evolve their business models to provide community-based care to encourage collaboration and recognize the importance of these entities in the LTSS landscape as the state moves to rebalance LTSS.
Enhanced Provision of Home and Community Based Services	MLTSS must be delivered in the most integrated fashion, in the most integrated setting that provides the greatest opportunities for active community and workforce participation.	MFFS models, administered by the state or via a health home infrastructure coordinate the totality of services a beneficiary requires. These models include a focus on social supports necessary to prevent unnecessary admissions and keep individuals in the community in alignment with their preferences and abilities.
Alignment of Payment Structures and Goals	Payment structures should support these essential elements of MLTSS and hold providers accountable through performance-based incentives and/or penalties.	Alabama leverages performance-based incentives in its ICN model. The ICN is accountable for LTSS rebalancing goals through quality withhold payments. Similar to requirements in MLTSS programs, the ICN must maintain adequate financial reserves and undertake quality improvement efforts.
Support for Beneficiaries	MLTSS participants must be offered conflict-free education, enrollment/disenrollment assistance, and advocacy in a manner that is accessible, ongoing, and consumer-friendly.	Arkansas offers a PASSE Ombudsman Office responsive for resolving issues or complaints from PASSE members.[34]
Person-Centered Processes	MLTSS programs must require and monitor implementation and use of person-centered needs assessment, service planning, and service coordination policies and protocols.	The Oregon CCO-LTSS provider MOU has extensive minimum expectations built in regarding provision of and support for developing and managing person-centered care plans, including a requirement that CCOs and LTSS providers share best practices, processes, and expectations for actively engaging beneficiaries and their families or representatives in the design and implementation of person-centered care plans.

Elements	MLTSS Element Description	Example MLTSS Alternative Approach
Comprehensive, Integrated Service Package	MCOs must provide and/or coordinate the provision of all physical and behavioral health services and LTSS (institutional and non-institutional) and ensure provision in the amount, duration, scope, and manner as identified through person-centered assessment and planning processes.	Health home models, such as the one in Washington, require that designated entities manage the full scope of beneficiary needs, including physical health, behavioral health, and LTSS.
Qualified Providers	States must ensure MCOs develop and maintain a network of qualified LTSS providers who meet state licensing, credentialing, or certification requirements and is sufficient to provide access to all services covered.	The Alabama ICN model requires that 60% of ICN governing board members must represent risk-bearing ICN participants, and half of the 60% must represent LTSS/medical providers that are risk-bearing participants. The ICN is also required to contract with a nursing facility network constituting at least half of nursing facility beds in the state.
Participant Protections	States must establish safeguards to prevent abuse, neglect, and exploitation; and fair hearing protections including the continuation of services during an appeal.	The Georgia SOURCE model includes requirements for the SOURCE case managers to take a variety of steps to ensure safeguards for beneficiaries including scenarios in which immediate notifications to authorities must be made.
Quality	States must develop and implement a comprehensive quality strategy that is integrated with existing state quality strategies.	Massachusetts Medicaid ACO model measures quality performance across process and administrative measures, clinical measures, and results from member experience surveys. Quality scores are used to adjust capitation rates, shared savings and losses, and other payments to ACOs to drive towards state goals.

States interested in implementing a coordinated model of LTSS should begin by engaging beneficiaries and providers to assess the viability of each approach within the landscape of state dynamics. Assessment of internal state infrastructure is also critical to determining if a state-led managed FFS program, for instance, would be viable as is in Connecticut, or if a model that leverages providers as central to coordination such as in Oregon or Alabama would be the best approach. Each state has different internal capacities, goals, and current program designs they most navigate.

It will be increasingly important as our nation ages and the number of individuals needing LTSS grows alongside this aging to ensure there are options nationwide to support beneficiaries to navigate across the health care and social support systems.

Emerging Trends and Opportunities Leveraging Provider Organizations

There are also emerging models and trends not detailed in this analysis that offer opportunities for states to leverage the providers serving Medicaid beneficiaries with LTSS needs. For example, the number of provider-led I-SNPs continues to increase year-over-year, with 64 of these programs in 2021 (representing 37% of all I-SNPs), up from five in 2015. I-SNPs are a type of Medicare Advantage product limited to Medicare beneficiaries with LTSS needs, many of whom are dually eligible for Medicaid and live in nursing or assisted living facilities. A provider-led I-SNP creates the potential for a single provider organization to have full financial risk (Medicare and Medicaid) for their residents and enrollees, allowing for integration of acute and LTSS. Several states are exploring the potential

role of I-SNPs in their broader Medicaid LTSS strategy as a way to move upstream in the LTSS continuum and also better serve individuals unlikely to transition out of nursing facilities.

Another growing trend is the use of provider-led organizations as an MLTSS plan. Several states' laws require or encourage the inclusion of provider-led organizations (e.g., Florida; North Carolina), and other states have explored this potential requirement along with increased contractual arrangements between MCOs and ACOs. Among states in this current study, Arkansas state law requires at least 51% of the MCO be owned by providers, at minimum comprising an IDD provider, behavioral health provider, hospital, physician, and pharmacist.

Additionally, in April 2019, CMS published a State Medicaid Director (SMD) letter inviting states to consider opportunities available through the Medicare-Medicaid Coordination Office (MMCO) to promote stronger integration between Medicare and Medicaid. One such opportunity is working with CMS to implement a MFFS program similar to the Washington model profiled in this report. CMS also invited states to propose new innovative approaches that build on the successes of programs like Washington. A key attribute of these MMCO-related opportunities is the ability for states to share in Medicare savings.

Moving Forward

It is increasingly important as our nation ages and the number of individuals needing LTSS grows to ensure there are options to support beneficiaries as they navigate the health care and social support systems. Program design necessarily is based on local needs, politics, and infrastructure, which vary across states. While a quarter of state Medicaid programs have chosen to pursue a mandatory, comprehensive MLTSS program, there are emerging alternatives to MLTSS that have shown successes in rebalancing, improving provider and beneficiary experiences, and creating a framework for integrating with Medicare. For Medicaid programs interested in improving their LTSS delivery and administration outside traditional MLTSS, there is considerable opportunity to build on these alternatives and work more closely with the provider community in the state.

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