January 2022

Managed Long-Term Services and Supports

Improving outcomes & empowering individuals with complex needs

United Healthcare

Managed Long-Term Services and Supports

What are LTSS?

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

The need for LTSS affects individuals of all ages and is generally measured by limitations in one's ability to perform activities of daily living such as eating, bathing, dressing or walking, and activities that allow individuals to live independently in the community, including shopping, housework and meal preparation.

Services typically covered include:

Personal care
(e.g., clothing, bathing)

Home-delivered
meals

Transportation

Home health
aide services

Supported
employment

LTSS are delivered in a variety of settings, including institutional (e.g., intermediate care facilities for people with intellectual and developmental disabilities and nursing homes) and home- and community-based settings (e.g., adult day services and personal care/homemaker services).

It's predicted that the demand for LTSS will increase dramatically in the coming years due to an aging population and individuals continuing to live longer.

5M

In 2013, more than 5 million individuals received LTSS, with Medicaid serving as the largest payer of those services and supports.[1]

$167B

In fiscal year 2016 (the most recent year for which comprehensive data is available), more than $167 billion in Medicaid funding was spent by the federal government and states on LTSS — an increase of almost 5% from the previous year.[2]

$470B

A substantial amount of LTSS is provided by family members and other informal caregivers. In fact, by one estimate, approximately $470 billion in care was provided by "informal" or family caregivers in 2016.[3]

44%

Of the people who use LTSS, 44% are under the age of 65.[4]

The total expenditures associated with LTSS are considered to be underestimated. Unfortunately, the availability of family caregivers for those who are aging is shrinking, which will only increase the need for and costs associated with "formal" LTSS benefits.

How can LTSS be delivered?

LTSS services can either be delivered through a fee-for-service (FFS) arrangement or through a managed care arrangement. There are important differences in these two arrangements.

Managed care is a capitated rate, meaning that the health plan gets a fixed amount of funding from the state per person, per month. The plan then manages all of a person's care and services with that amount of monthly funding.

In fee-for-service (FFS), a health plan is not involved in managing the cost of a person's care. Instead, states pay claims individually as providers deliver and bill for services and care.

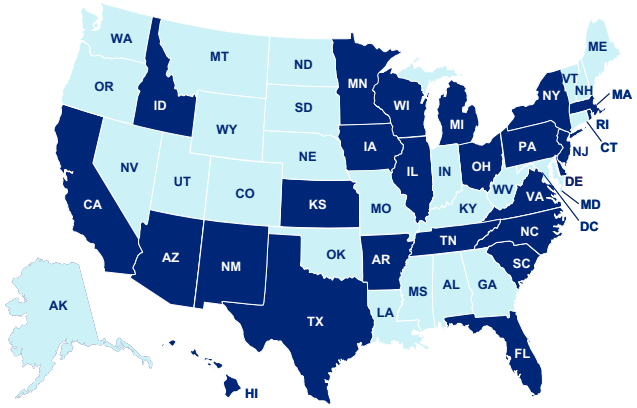
What are the benefits of MLTSS?

An aging American population and increasing longevity among people with developmental and physical disabilities has caused an increasing need for LTSS. With Medicaid as the primary payer, the increased demand will put increasing pressure on state Medicaid budgets.

Through Managed Long-Term Services and Supports (MLTSS), states have an opportunity to improve the sustainability of their Medicaid programs and improve the health care experience for enrollees and caregivers.

MLTSS programs provide a cost-efficient and sustainable solution to help states meet the needs of individuals with complex care needs while affording them greater flexibility and control over their lives. By shifting LTSS from fee-for-service (FFS) to managed care, states can also anticipate better care coordination and more efficient use of home- and community-based services (HCBS).

The high cost of caring for people in need of LTSS presents a growing challenge for states given competing budget priorities. These costs are generally driven by the cost of nursing home care, which is many times greater than the cost of care in the community. As a result, an increasing number of states are providing LTSS through managed care organizations (MCOs) — referred to as Managed Long-Term Services and Supports (MLTSS).



25 states As of November 2020, 25 states operated MLTSS programs, serving more than **2.7 million individuals.**

Benefits of MLTSS programs:

1 Reduce costs

a) Transition individuals out of nursing homes when appropriate

b) Reduce the administrative burden on states and providers by reducing duplication in care coordination

2 Improve health outcomes

a) Reduce nursing home placement through identification and coordination of benefits and health services for individuals with complex health issues

b) Improve health equity by identifying barriers that prevent people from receiving care — and partnering to solve them

3 Better member experiences

a) Support individuals living in their desired setting and help them achieve their goals through coordinating care and services

6% Less than 6% of the Medicaid population uses LTSS, but they account for 31% of total costs.[5]

2X Specialized nursing home care costs twice as much as custodial care in a community-based setting.[6]

3:1 Medicaid dollars can support roughly three people with HCBS for every person in an institution.[7]

90% Nearly 90% of people age 65+ want to stay in their residence.[8]

70% Someone turning 65 today has a 70% chance of needing LTSS in the future.[9]

MLTSS programs help improve enrollees' physical health, and states with MLTSS show fewer hospitalizations.[10] Ongoing care navigation and support reduces the need for acute emergent care and costly inpatient admissions and hospital stays.

State snapshots:

Arizona Long-Term Care System

Since 1989, Arizona Long-Term Care System (ALTCS) has served members in Arizona who are eligible for nursing home placement. According to the most recent data, Arizona has been able to steadily reduce the number of individuals being placed in nursing homes from 95% to 29% by providing the care they need at home and in the community.[11]

Florida MLTSS Program

Since implementing MLTSS, 60% of surveyed beneficiaries in Florida reported improved health. Average inpatient hospital stays have reduced by ~2 days, and the program has reduced potentially avoidable hospitalizations to 4.5 per 1,000 members per month.[12]

Hawaii QUEST Integration

Formerly QUEST Expanded Access, QUEST Integration has increased the percentage of nursing home level of care individuals receiving HCBS from 40% in 2008 to 77% in 2018.[13]

Massachusetts Senior Care Options

Enrollees in the Massachusetts Senior Care Options (MASCO) program had a 16% lower risk of long-stay nursing facility admission.[14]

Minnesota Integrated Care

Since implementing integrated care, dually eligible individuals in Minnesota were 48% less likely to have a hospital stay and 6% less likely to have emergency room visits than enrollees in the state's non-integrated MLTSS program.[15]

Tennessee CHOICES

At the time that Tennessee added LTSS benefits to the TennCare program, more than 80% of eligible individuals were served in nursing homes with very limited investment in and access to HCBS. Based on the most recent data, the number of nursing home-eligible individuals accessing HCBS and living in community settings is now at 44%.[16]

LTSS member journey comparison - FFS vs Managed Care

Fee-for-service versus managed care

LTSS member journey in a fee-for-service arrangement

1 Upon enrolling
- Targeted case management for those who qualify and enroll

2 Yearly
- Annual assessment for service planning purposes, predominately focused on just HCBS

3 Upon hospitalization
- Burden is on providers and member/family to manage progress and needs
- Upon discharge, provider (hospital staff) tries to facilitate return to home, provides contact phone numbers to member/caregiver to arrange durable medical equipment (DME) and any follow-up services
- Often difficult to facilitate all the necessary pieces to return home and instead is discharged to skilled nursing facility (SNF)

4 Upon move to SNF
- Beneficiary receives necessary services
- Beneficiary/caregiver have to advocate for return to home; financial incentive for SNF is to retain member in facility
- If beneficiary exceeds Medicare stay, cost transfers to Medicaid

LTSS member journey in a managed care arrangement

1 Upon enrolling
- Complete assessment and risk stratification
- Develop person-centered care plan
- Set up services/service plan
- Regularly assess caregiver
- Regularly assess member and adjust services and programs as needed
- Monitor gaps in care
- Monitor medication adherence/prescription management
- Assess connection of medical needs and behavioral health
- Identify social determinants of health (SDOH)
- Long-term plan and existing supports are known (outside of eminent risk of institutional placement)

2 Upon hospitalization
- Prior authorization/review inpatient admission
- Regular reviews of inpatient progress, concurrent reviews of inpatient stay
- Start planning for discharge — focus is on going home but recognize SNF is sometimes necessary

3

Upon discharge to SNF
- Prior authorization for SNF with preferred provider
- Regular reviews of progress
- Plan for discharge to home if member desires and is able to (may need only short-term or step-down level of care)

OR

Upon discharge to home
- Arrange for home health
- Arrange DME
- Arrange any other needs for member and caregiver
- Re-assess member status/needs
- Adjust care plan as necessary

At its core, MLTSS provides **improved coordination** of benefits and services (ensuring high-quality, effective care), **increased program sustainability** (managing costs while serving more individuals), and a **strong, positive experience** for enrollees and caregivers.

A new study has shown that MLTSS enrollees rate their quality of life and experience of care as higher than those who live in FFS arrangements.[17]

What are program design considerations in MLTSS?

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

Broad populations — Eligible populations include individuals who meet nursing home eligibility, including aged, blind and disabled (ABD) individuals. MLTSS programs can reach dually eligible individuals and special populations.

This approach:

- Ensures early detection of risk in individuals to prevent future decline
- Eases the administrative burden for the state by creating a single program versus maintaining multiple programs
- Increases a state's ability to effectively rebalance institutional services through early identification and alignment of less costly HCBS

Eligibility standards — States may also consider creating tiered eligibility to encourage the use of HCBS for individuals who meet nursing home level of care, in addition to those at risk of nursing home placement.

Increasing access to LTSS earlier + Minimizing barriers to waiver participation = Supporting the overall program goal of rebalancing.

Benefit design — MTLSS programs will encourage a holistic, person-centered approach inclusive of a broad array of services that include:

- Medical
- Pharmacy
- Behavioral
- Social Services

This reduces fragmentation that can lead to:

- Cost shifting
- Increased program costs
- Program inefficiencies
- Decreased quality

Medicare/Dual Special Needs Plans Alignment — MLTSS programs serve a high proportion of individuals dually eligible for both Medicaid and Medicare.

States should leverage Dual Special Needs Plans (DSNPs) to:

- Better integrate and coordinate care
- Align the delivery of LTSS services

Mandatory enrollment — Auto-enrollment algorithms that balance enrollment among MCOs support continuing investment and program improvements. As programs mature, states may consider adopting quality-based, auto-enrollment algorithms as incentives to MCOs delivering high-quality results.

90 Days — Individuals can change enrollment plans

12 Months — Plan lock-in period

This enrollment process:

- Ensures program viability
- Achieves optimal savings
- Improves quality and budget predictability

Health plan engagement — Limiting the number of MCOs serving LTSS-eligible individuals:

- Simplifies state administration of the program and oversight of MCOs
- Reduces the administrative burden on a provider community that may lack organizational and technical resources

Clinical model — Clinical models that enable optimal program effectiveness to include the following key elements:

1. Flexibility in the timing of assessments. For example, one best practice is to assess individuals with the highest risk and/or needs first and then use a more extended timeframe for assessing individuals with lower risk and/or needs.
2. Appropriate utilization and care plan development by enabling MCOs to align care management resources and coordinate the most effective, comprehensive array of services for each individual.
3. The use of evidence-based assessments that have been shown to effectively identify functional status and service need.
4. Sufficient incentives to encourage repatriation and nursing home avoidance using payment terms and quality monitoring that place real incentives on MCOs to decrease and avoid the need for nursing home placements.

Other elements — Following a decision to implement an MLTSS program, states:

- Establish actuarially sound rates
- Utilize rate cells that adequately reflect the needs of the population
- Support provider and individual transitions
- Achieve network adequacy
- Develop quality measures

How do states implement a managed LTSS program?

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

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

States should also ensure continuous engagement of all stakeholders, including:

- Beneficiaries
- Providers
- Advocacy groups
- Community-based organizations
- State legislature

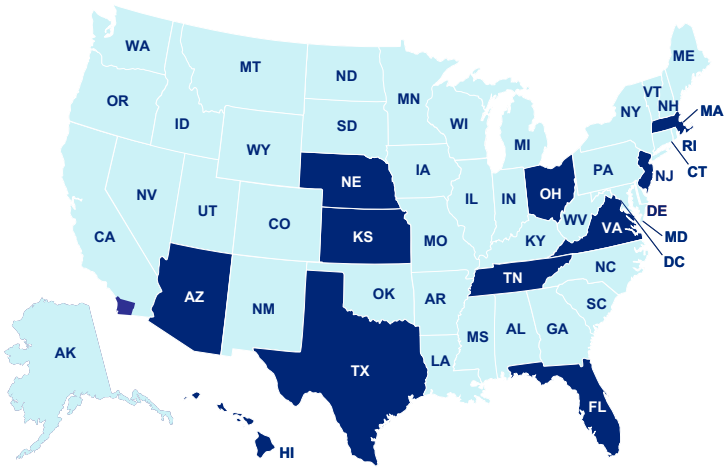
Working together, stakeholders can shape MLTSS programs to ensure that quality, holistic care will be delivered and that community resources are aligned to meet beneficiary needs. Open dialogue continues to be critical as the program becomes operational, as stakeholders can help identify early problems or concerns and assist with the transition process to managed care.

To ease the transition to managed care and to stay consistent with CMS guidance, states must develop a communication plan to involve stakeholders throughout implementation using various strategies, such as:

- Regular standing community partner meetings
- Advisory committees
- Workgroups
- Beneficiary interviews and surveys
- Websites
- Social media

UnitedHealthcare's experience

UnitedHealthcare has extensive experience helping states successfully transition from FFS to more fully managed LTSS programs. Since the late 1980s, we have been at the forefront of supporting states as they develop and implement acute and LTSS programs that help improve quality, contain costs and give members more choice to make health care decisions that support their personal health goals and preferences. We understand and uphold the principles of person-centered care, and we work with individuals and families collaboratively in care planning to ensure that we support what is most important to the person receiving services. **Today, we serve over 300,000 individuals covered by a variety of LTSS programs across the country.**



Sources:

[1] https://aspe.hhs.gov/reports/overview-long-term-services-supports-medicaid-final-report-0#figure1

[2] https://content.govdelivery.com/accounts/USCMSMEDICAID/bulletins/1f51e83#:~:text=Federal%20and%20state%20spending%20on,%24159%20billion%20in%20FY%202015

[3] https://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html

[4] https://www.govinfo.gov/content/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf

[5] https://www.everycrsreport.com/files/20170228_R43328_5834413c5243a128f3e91f6ed70e7e0f074bca6c.pdf

[6] https://www.aplaceformom.com/caregiver-resources/articles/elder-care-costs

[7] https://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html

[8] https://assets.aarp.org/rgcenter/general/home-community-services-10.pdf

[9] https://www.americanprogress.org/issues/healthcare/reports/2019/04/10/468290/state-options-making-wise-investments-direct-care-workforce/

[10] https://www.mathematica.org/news/better-care-experiences-and-quality-of-life-new-evidence-from-mathematica-favors-managed-care

[11] https://medicaiddirectors.org/wp-content/uploads/2015/08/trends_in_medicaid_long_term_services_and_supports.pdf

[12] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mltss-summeval-rep.pdf

[13] https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/ATT_B_-_Interim_Eval_Report.pdf

[14] MASCO Stat (TBD)

[15] https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf

[16] https://www.chcs.org/media/FINAL-Demonstrating-the-Value-of-MLTSS-5-12-17.pdf

[17] https://www.mathematica.org/news/better-care-experiences-and-quality-of-life-new-evidence-from-mathematica-favors-managed-care?utm_source=acoustic&utm_medium=email&utm_campaign=covid-19&utm_content=MLTSS%20032421%20(1)

UHCCommunityandState.com

100-CST28818 1/22

United Healthcare