Arizona for Better Medicaid

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Growth in MLTSS and Impacts on Community-Based Care

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Growth in MLTSS and Impacts on Community-Based Care

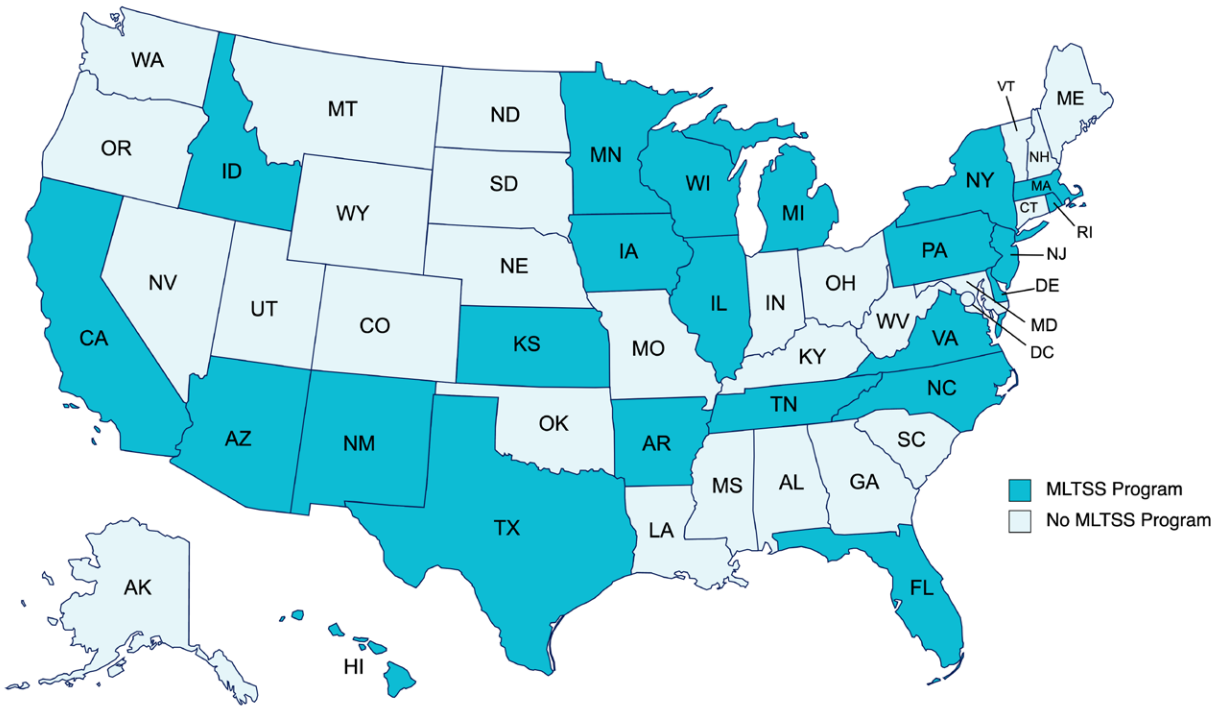
States are increasingly pursuing managed long-term services and supports (MLTSS) programs to improve accountability for high-quality, integrated, cost-effective care.

Given the complex care needs of LTSS populations, states are increasingly looking to MLTSS programs to offer a predictable and sustainable solution to provide comprehensive care coordination and high-quality cost-effective care. **Individuals receiving LTSS make up about 6% of the Medicaid population and yet account for nearly 34% of all Medicaid expenditures.**[1]

LTSS refers to a **broad range of health and health-related services and supports** needed by individuals with challenges for self-care due to a physical, cognitive, or mental condition. These range from personal care activities through congregate care in settings such as assisted living, nursing homes, and intermediate care facilities.

Currently, **23 states operate MLTSS programs**, in which state Medicaid agencies contract with managed care plans to deliver LTSS, up from 8 states in 2004.[2] This includes states that utilize approaches such as Medicaid managed care organizations and prepaid health plans but not states that only have a financial alignment demonstration.

State Adoption of Managed Long-Term Services and Supports Programs, April 2021[3]



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This increase in programs led to a corresponding **increase in enrollment of 125% to 1.8 million people in 2017**.[4]

Demographic trends continue to exert additional pressure on LTSS systems and state Medicaid budgets. According to recent estimates, the cost of **paid LTSS services across all payers was approximately $409 billion in 2018**.[5] That figure represents almost one-third of what was spent in total between Medicare and Medicaid in 2018. Projections from one study indicate that costs could rise over 40% between 2018 and 2030 bringing the total cost to more than $575 billion by 2030.[6]

Practically all demographic changes in the United States point to significant increases in demand for LTSS going forward.

More than 50% of adults aged 65 and older in 2015 are projected to develop significant disabilities and require LTSS.[7] An average person who turned 65 in 2015 can expect to live almost another 21 years and incur approximately $138,000 in LTSS costs.[8]

Although older adults and people with physical disabilities are important users of LTSS, they are not the only groups with disabilities. In 2013, **estimates of the number of Americans with intellectual and/or developmental disabilities (I/DD) were as high as 6.2 million people and expected to grow considerably over time.**[9] LTSS utilization is high in this segment of the population with more than 1.1 million people receiving LTSS through the I/DD system in 2013.[10]

States commonly use MLTSS to serve older adults and people with physical disabilities. In 2012, nine states with MLTSS programs targeted both older adults and adults with physical disabilities. That number grew to 22 by 2020.[11]

The number of MLTSS programs serving adults with I/DD **grew from eight states and nine programs in 2012 to 18 states and 25 programs in 2019.** Ten states covered home and community-based services (HCBS) for individuals with I/DD and seven states included intermediate care facilities for individuals with intellectual disabilities (ICF/IID) services within their MLTSS programs. Michigan, Rhode Island, and Tennessee covered HCBS, but not ICF/IID, in MLTSS.[12]

Presently ten states use MLTSS to deliver services to children with disabilities.

In the most recent CMS report, which does not contain data from five states, Medicaid LTSS spending was $124 billion in 2017, increasing to $129 billion in 2018. Since 2008, overall Medicaid LTSS expenditures have grown by about 2 percentage points each year when adjusted for inflation. **Spending growth is driven by an increase in HCBS expenditures**, which have increased by about 5 to 10 percentage points each year, while institutional LTSS expenditures have decreased by about 2 to 4 percentage points.[13]

MLTSS State of Play

>50%

of adults aged 65 and older in 2015 are projected to develop significant disabilities and require LTSS.

6.2M

Americans live with intellectual and/or developmental disabilities (I/DD)

$129B

spent on Medicaid LTSS in 2018, an increase of $5 billion from 2017

Populations Included in MLTSS Programs by State[14]

State	Older Adults and/or Adults with Physical Disabilities	Adults with Intellectual or Developmental Disabilities	Children with Disabilities
Arizona	●	●	●
Arkansas		●	
California	●	●	
Delaware	●	●	●
Florida	●		
Hawaii	●	●	●
Idaho	●		
Illinois	●	●	
Iowa	●	●	●
Kansas	●	●	●
Massachusetts	●	●	
Michigan		●	●
Minnesota	●		
New Jersey	●		
New Mexico	●	●	●
New York	●	●	
North Carolina		●	●
Pennsylvania		●	
Rhode Island	●	●	
Tennessee	●	●	
Texas	●	●	●
Virginia	●		
Wisconsin	●	●	

States with MLTSS programs have demonstrated progress toward rebalancing spending towards HCBS, improving quality of life and satisfaction for participants, reducing waiver waitlists, and increasing budget predictability.[15]

Over the last decade, state Medicaid programs have sought to "rebalance" Medicaid LTSS to support the delivery of HCBS rather than care in institutional settings. States with MLTSS programs report that these programs have promoted rebalancing the LTSS delivery system and reduced waiting lists for HCBS services.[16] Examples of success include:

- **Tennessee** began its MLTSS program, TennCare CHOICES, with only 17% of Medicaid consumers receiving services in community settings. As of August 2017, 46% are living in community settings.[17] In its first five years, the program increased the number of beneficiaries with physical disabilities and older adults receiving HCBS by 170%, increasing from 4,861 in 2010 to 13,240 in 2015.[18] TennCare CHOICES has also eliminated waiting lists for beneficiaries who qualify for a nursing home level of care.
    - The **TennCare Employment and Community First CHOICES** program for individuals with I/DD integrated I/DD services into the existing managed care program and demonstrated:[19]
        - Enrollment of more individuals with I/DD in HCBS within 20 months of the program than in the previous 6 years.
        - Over 20% of working-age individuals with I/DD working in competitive integrated employment **(7% higher than the national average)**.
- With MLTSS (the Arizona Long Term Care System has been in place since 1989), **Arizona** reported that 88% of its MLTSS consumers are in community settings and 70% are living in their own homes.[20]
- **New Mexico** by 2015 had reduced the percentage of Medicaid consumers residing in nursing facilities from nearly 19% to 14%.[21]
- Since its MLTSS program was implemented, **Florida** has had a 12% decrease in the number of Medicaid consumers receiving care in nursing facilities.[22]

State MLTSS Successes

>20%

of working-age individuals with I/DD in TennCare CHOICES are working in competitive integrated employment

88%

of Arizona MLTSS consumers are in community settings and 70% are living in their own homes

12%

decrease in the number of Medicaid consumers receiving care in Florida nursing facilities

Several states have reduced or eliminated HCBS waiting lists after moving to MLTSS.

- States reported that they reinvested savings achieved through MLTSS implementation to reduce the size of waiting lists. **Florida invested $12.6 million to enroll wait-listed individuals with the most critical needs into its MLTSS program.**[23]
- Strategies to reduce waiting lists include:
  - Increased wage rates for direct care workers to better recruit and retain an adequately sized workforce to provide more HCBS,[24]
  - Increased benefit flexibility under managed care with MLTSS plans to provide value-added services not otherwise available or providing cost-effective alternatives on a case by case basis,
  - A blended capitation rate for nursing homes and HCBS that incentivizes care in the least restrictive setting and provides resources for MLTSS plans to offer more people HCBS, and
  - Early identification of needs allowing for timelier intervention and prevention of more intensive LTSS needs.[25]
- According to a CMS evaluation, **of 7 states that had waiting lists for HCBS waivers before the start of the MLTSS program, 2 states eliminated the wait for services and 4 states decreased the number of people on their waiting lists after the MLTSS programs began.**[26]
- **Illinois increased the capacity of its Persons with Disabilities waiver to serve an additional 4,300 individuals** with a transition to MLTSS alongside a combination of federal programs to rebalance LTSS towards HCBS.[27]
- **For New Jersey, the transition to MLTSS represented the greatest programmatic change and was identified by the state as a contributing factor in its rebalancing efforts** in a recent evaluation. Through their program, LTSS spending on HCBS for people with I/DD grew from 51% in 2012 to 73% in 2016.[28]
- However, states need to ensure they allocate sufficient resources to allow MLTSS programs to enroll beneficiaries into programs. **Stakeholders in Kansas and Tennessee pointed to state budget obstacles as causes of missing the goals of moving people from waitlists to MLTSS services.**

Waitlist Statistics

$12.6M

invested by Florida to enroll wait-listed individuals with the most critical needs into its MLTSS program

4,300

additional individuals eligible to receive a Persons with Disabilities waiver slot in Illinois with an MLTSS transition

4

states decreased the number of people on their waiting lists for HCBS waivers after MLTSS programs began

Endnotes

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