A State Legislator's Guide to Strengthening Medicaid Long-Term Services and Supports

Developed by Manatt Health Strategies and the Center for Health Care Strategies

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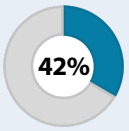
Long-term services and supports (LTSS) comprise a major and growing portion of state and federal Medicaid budgets. Testing new strategies to improve LTSS systems is an increasingly critical issue for states to tackle since Medicaid is the largest payer for LTSS in the United States.

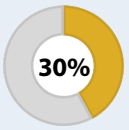
Long-term services and supports (LTSS)[1] include a broad range of services that enable more than 12 million people[2] in the United States—including older adults and adults and children with intellectual and developmental disabilities (I/DD), physical disabilities, and mental health conditions—to meet their daily self-care needs and live with independence in a variety of community and institutional settings. LTSS provide assistance to individuals with their personal care needs (e.g., eating, bathing, and dressing) and daily living needs (e.g., housework, meal preparation, and grocery shopping). Examples include nursing facility care, adult day health programs, home health aide services, personal care services, transportation, and supported employment as well as assistance provided by a family caregiver.

State legislators should understand options for effective, high-quality LTSS policies and programs that serve vulnerable individuals in their state given the large number of people who use LTSS, and the growing demand and considerable costs of these services. This brief summarizes information from ***Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States***, which provides actionable strategies for Medicaid agencies on developing LTSS reforms that improve the quality of care for beneficiaries and help contain program costs. Legislators can refer to the toolkit for full details on advancing these reforms.

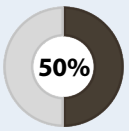
Key Drivers of State LTSS Reform



In 2016, state Medicaid programs paid for 42 percent ($154 billion) of LTSS expenditures in the United States.[3]



During that same time, LTSS comprised 30 percent of total federal and state Medicaid spending.[4]



Due to an anticipated 50 percent increase in individuals age 65 and older by 2030,[5] demand for and spending on LTSS will continue to grow among high-cost LTSS users, particularly those with intellectual/developmental disabilities.[6]

State Strategies

States have made progress on LTSS reforms in recent years, but given the growing demand, and high costs and needs of this population, LTSS programs remain a high priority for states. Recent state LTSS reforms focus on:

- **Rebalancing**, or devoting a greater proportion of LTSS spending to home- and community-based services (HCBS) instead of institutional care. In 2016, 57 percent of Medicaid LTSS spending was for community-based services, up from 18 percent in 1995.[7]
- **Integration**, or providing LTSS in a coordinated, comprehensive, person-centered arrangement focused on meeting beneficiaries' full health and social needs. Nearly half of states use managed care to deliver LTSS within an integrated system.[8]

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Rebalancing Medicaid-Financed LTSS

What are states doing to promote rebalancing of HCBS and nursing facility services?

State efforts to shift service spending and utilization to community-based settings have been largely driven by: (1) individual and family preferences; (2) federal requirements to provide care in the least restrictive setting; and (3) the relative cost-effectiveness of providing community-based rather than institutional services.[9] Strategies include:

- **Developing LTSS System Infrastructure**. States are enhancing system capacity to improve access to services in many areas, including: (a) simplifying ways to apply to and access information about LTSS programs; and (b) building workforce capacity for direct care workers and family caregivers.
- **Helping Nursing Facility Residents Return to and Remain in Their Communities.** Most states have invested in services to transition individuals in need of LTSS from institutional to community settings, such as assisting with housing searches, paying for rental security deposits, and making home modifications.
- **Expanding Access to HCBS to Prevent or Delay Medicaid Nursing Facility Utilization**. A few states have expanded access to a limited set of HCBS for people who would not otherwise qualify for Medicaid or LTSS to slow future needs for more expensive Medicaid services, including institutional care.

How can state legislators promote rebalancing of HCBS and nursing facility services?

- **Target LTSS infrastructure investments effectively**. Analyses of LTSS infrastructure, including identifying major system gaps and opportunities for return on investment, can help inform decisions about program investments.
- **Enact programs to bolster the LTSS workforce.** To recruit and retain the direct care workforce, many states have implemented minimum wage standards or higher payment rates; established career path training programs; and made changes to nursing delegation laws to expand home-care delivery options. States also are providing new supports to unpaid family caregivers.
- **Seek input from diverse stakeholders**. State legislators have close connections to various LTSS stakeholder groups and constituents, and can work closely with Medicaid officials while encouraging important collaboration across often siloed state agencies (e.g., Medicaid and other health and human service agencies such as Aging, Developmental Disabilities, Housing, Behavioral Health, etc.), as well as beneficiary, family, and provider groups.
- **Consider longer-term investments in expanded HCBS access**. Reliance on Medicaid for LTSS by a rapidly aging population will increase Medicaid costs as individuals deplete their savings following health crises and become eligible for full Medicaid benefits (e.g., medical, behavioral health, dental, etc.). Legislators could explore the potential economic and quality-of-life benefits from expanding services to at-risk populations.

Advancing Integration of LTSS with Physical and Behavioral Health Services

What are states doing to integrate LTSS with other services?

States are advancing integrated care delivery to reduce care fragmentation, deliver person-centered and community-based care while improving health outcomes, and potentially reduce program costs. Strategies include:

- **Integrating Comprehensive Care under Capitated Managed Care**. Nearly half of states now include LTSS populations in Medicaid managed care programs. In most cases, health plans assume financial risk for providing medical, behavioral health services, and LTSS to Medicaid LTSS populations.
- **Integrating Medicare-Medicaid Benefits for Dually Eligible Beneficiaries**. Nearly 12 million individuals—many of whom are LTSS users—are dually eligible for both Medicaid and Medicare. This disproportionately high-need, high-cost population must navigate these two distinct, fragmented programs.[10] States are focused on developing care models that align the programs and streamline access to services, provider networks, and administrative processes.*
- **Enrolling I/DD Populations in Managed Care**. A few states have developed health plan or provider-led managed programs for individuals with I/DD focused on enhancing community living, maintaining employment, and better coordinating the complex array of medical and social services that Medicaid typically provides for this population.
- **Integrating LTSS through Provider-Based Initiatives.** Other states are seeking to increase coordination for LTSS services through providers, either as an alternative to or in addition to Medicaid managed LTSS (MLTSS) programs. Models seek to hold providers directly accountable for care coordination for multiple services and health outcomes.

How can state legislators help advance LTSS integration?

- **Require Medicaid programs to incorporate stakeholder feedback into integrated programs.** Legislators can require programs to collect ongoing feedback from beneficiaries and providers to: (1) address program concerns; (2) improve beneficiary understanding of new program options; and (3) build critical support among providers.
- **Build state capacity for program oversight**. Legislators can work with Medicaid officials to designate sufficient resources are available to: (1) build state capacity to transition LTSS populations into new managed care or provider-led models; (2) bring together siloed programs and services; and (3) develop information technology and data infrastructure to oversee these new systems of care.
- **Understand financing considerations for states and plans.** Nearly 70 percent of Medicaid enrollees who use LTSS are dually eligible for Medicare and Medicaid.[11] Studies in Minnesota[12] and Arizona[13] demonstrate that fully integrated Medicare-Medicaid programs have decreased rates of hospitalizations and emergency department use, and increased use of HCBS and primary care services. However, savings are often achieved from Medicaid LTSS and behavioral health interventions that help delay or prevent services covered by Medicare. As new opportunities arise to share in Medicare savings through integrated programs, states should consider ways to both achieve savings and improve care.

* Some states operate demonstrations under the Financial Alignment Initiative, which tests new approaches to integrate Medicare and Medicaid. Other states align MLTSS health plans with Medicare Advantage Dual Eligible Special Needs Plans, or D-SNPs, to create an option to enroll in the same plan for different services.

About the Authors

The **Center for Health Care Strategies (CHCS)** is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve beneficiaries of publicly financed care, especially those with complex, high-cost needs. To learn more, visit www.chcs.org.

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