LTSS CHOICES

The Role of Medicaid Managed Long-Term Services and Supports during the COVID-19 Pandemic

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About this Series

This Spotlight is part of the AARP Public Policy Institute's LTSS Choices initiative. This initiative includes a series of reports, blogs, videos, podcasts, and virtual convenings that seeks to spark ideas for immediate, intermediate, and long-term options for transforming long-term services and supports (LTSS). We will explore a growing list of innovative models and evidence-based solutions—at both the national and international levels—to achieve system-wide LTSS reform.

We recognize the importance of collaborating and partnering with others across the array of sectors, disciplines, and diverse populations to truly transform and modernize the LTSS system. We invite new ideas and look forward to opportunities for collaboration.

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For Americans with limited income and savings, the primary way to access long-term services and supports (LTSS) is to enroll in Medicaid, a public program that is run at the state level but combines federal and state funding. Medicaid accounted for 52 percent of all LTSS expenditures in the U.S. in 2018.[1,2] Historically, state Medicaid programs reimbursed LTSS providers using a fee-for-service model; however, increasingly states are shifting to a different financing and delivery system to manage and provide these services for Medicaid beneficiaries: contracting with Medicaid managed care organizations (MCOs).

The growing reliance on MCOs to finance and deliver Medicaid services posed unique challenges and prompted innovative responses as states responded to the COVID-19 pandemic. MCOs providing Medicaid managed LTSS (MLTSS) had to address many care and coordination issues, including the availability and use of telehealth, food distribution, paying family caregivers, data tracking, addressing workforce needs, and backup planning.

[1]Molly O'Malley Watts, MaryBeth Musumeci, and Priya Chidambaram, "Medicaid Home and Community-Based Services Enrollment and Spending," Issue Brief, (San Fransisco: Kaiser Family Foundation, February 2020).

[2]These percentages do not include the significant contribution made by informal caregivers, whose economic value is estimated at approximately $470 billion. See Susan C. Reinhard, Lynn Friss Feinberg, Ari Houser, Rita Choula, and Molly Evans, "Valuing the Invaluable 2019 Update: Charting a Path Forward," Insight on the Issues, (Washington, DC: AARP, November 2019).

The COVID pandemic severely tested the ability of states and their MLTSS plans to meet Medicaid program requirements, but the pandemic response also prompted some potential improvements to care. Some approaches and practices that states and their MLTSS plans put into place in both institutional and home- and community-based settings (HCBS) during the pandemic are examples for how MLTSS can enhance care as well as help address future public health emergencies.

This *Spotlight* examines the role played by MCOs delivering MLTSS during the pandemic, shining a light on the efforts to meet the needs of individuals receiving LTSS in nursing homes and in their own homes. As the disproportionate number of COVID-related deaths in nursing homes makes clear, individuals receiving LTSS services are particularly vulnerable to the virus. This *Spotlight* presents some of the "on-the-ground" experiences of MCOs and other stakeholders as the crisis unfolded. We explore the challenges states and MCOs faced, efforts to meet the needs of recipients of MLTSS, and lessons learned.

Methodology

The following information and insights are based on interviews with more than 25 individuals, including state Medicaid directors or their leads on LTSS in 6 states (Arizona, Florida, Pennsylvania, Tennessee, Virginia, and Wisconsin), a cross-section of representatives from both national and local Medicaid MLTSS plans, national association representatives, LTSS thought leaders, and consumer advocates. A standard list of questions, modified according to on the organization represented by the individual, guided the interviews. This analysis does not represent a comprehensive inventory of initiatives implemented to address the pandemic nationally, nor is it a scientific sampling representative of all state Medicaid programs; however, the intentional cross-section of states and MCOs offers important insights into what happened as the pandemic unfolded.

The Growth of Medicaid MLTSS

Many states are shifting to managed care as the delivery system for individuals who use Medicaid LTSS. Historically, states operated Medicaid LTSS programs using a fee-for-service model, in which states paid providers directly for services provided to Medicaid beneficiaries. Under managed care, states contract with MCOs to provide care coordination and services to Medicaid beneficiaries through a capitated per-member-per-month payment.

Currently, 25 states operate MLTSS programs, which is up dramatically from 8 states in 2004. Ten states, including Pennsylvania and Virginia, have added MLTSS programs since 2012.[3] Spending on MLTSS increased more than six fold from $6.7 billion in 2008 to $43.6 billion in 2016.[4] In 2017, the year for which the most recent data are available, approximately 1.8 million Americans were enrolled in an MLTSS plan.[5] Today's estimates suggest well over 2 million Americans are enrolled in a Medicaid MLTSS plan, which accounts for recent expansions (such as those in Pennsylvania). Figure 1 presents the states with at least one Medicaid MLTSS program.

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[3]Elizabeth Lewis et al., "The Growth of Managed Long Term Services and Support Programs: 2017 Update," (Washington, DC: Truven Health Analytics for Centers for Medicare & Medicaid Services, January 2018).

Caitlin Murray et al., "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018," *Mathematica*, January 7, 2021.

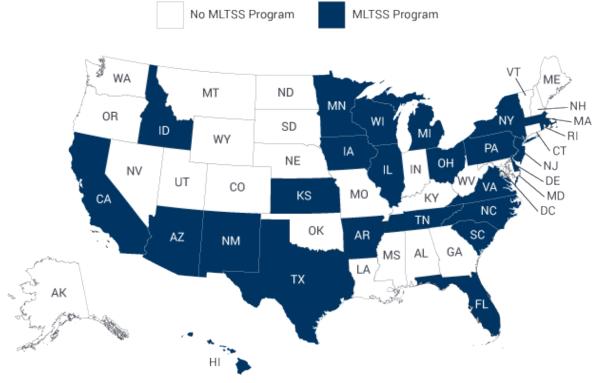[5]Ibid.; Lewis et al., "Growth of Managed."

FIGURE 1: STATES WITH MEDICAID MLTSS PROGRAMS

Source: MACPAC, 2020, analysis of ADvancing States data, 2020.

Differences in Medicaid MLTSS Contracts

MLTSS programs vary significantly from state to state, differing in populations served, benefits covered, and geographic reach, among other distinguishing characteristics. Some have mandatory enrollment, while others are voluntary. Programs can also vary within a state, as some Medicaid agencies have contracted for more than one MLTSS model depending on the population served and services delivered. Most MLTSS programs serve older adults and people with physical disabilities, often excluding individuals with an intellectual or developmental disability. The structure of each program affects the services an MCO is responsible for providing, potentially narrowing or expanding the scope of benefits available.

Generally, state MLTSS programs fall into one of three categories:

■ *Medicaid LTSS-only* plans provide Medicaid LTSS benefits only (not medical services), usually including both institutional and HCBS services, although some are limited to managing only HCBS with limited financial risk for institutional beneficiaries.

■ *Comprehensive Medicaid MLTSS* plans deliver both LTSS and non-LTSS medical services. States may limit enrollment only to beneficiaries of LTSS services or include all members of a population (e.g., all individuals over age 65

regardless of whether they require LTSS). Most states (21) employ this type of plan, according to a recent survey of state Medicaid directors[6]

■ *Integrated Medicaid and Medicare* plans cover both Medicare and Medicaid benefits, including LTSS, for individuals who are enrolled in both programs.

State Medicaid agencies contract with MCOs in administering their MLTSS program. The contracts ensure that state and federal requirements are met, including parameters related to appropriate care coordination, individualized assessment of need, and person-centered planning. Although all contracts must include these core requirements, the specifics of the contract language differ, introducing another element of variability among programs.

In assessing the role played by MLTSS plans during the COVID pandemic, it is important to consider the core areas for which a plan is responsible as well as the variability among MLTSS programs across states. Depending on a state's MLTSS program structure, the services for which an MLTSS plan is responsible vary significantly, ranging from an MLTSS-only health plan to a comprehensive Medicare and Medicaid plan offering the full gamut of health care services. Even among MLTSS-only plans, there are wide variances in services, as some plans limit coverage by carving out all or a portion of institutional services.[7]

Challenges States and MCOs Faced during COVID-19

Care coordination, real-time data, communication, access, and equipment all posed challenges as state Medicaid agencies and MCOs sought to quickly respond to COVID. Establishing clear roles and accountability for care in nursing homes was particularly important as the disproportionate death toll on nursing home residents became clear. Since the beginning of the pandemic, roughly 184,000 residents and staff of nursing homes and other long-term care facilities have died of COVID,[8] accounting for nearly one-third of deaths attributable to the pandemic in the United States.[9]

Clearly establishing the responsibilities of state Medicaid agencies in addressing beneficiary needs versus that of the MLTSS plan was a necessary first step. Although all states took the lead role, the approaches in working with MLTSS plans differed. Some state agencies played a more central part in directing the activities of MLTSS plans, while other states focused on removing barriers, providing flexibilities, and addressing issues that would otherwise inhibit the ability of MLTSS plans to respond to beneficiaries' needs and meet plan contract requirements.

Despite their contractual relationship with nursing homes, MLTSS plans struggled to gain access to nursing home residents, making it difficult to perform care coordination responsibilities. As nursing homes facilities were locked down, care managers were unable to gain entry to the buildings. Not only were plans unable to gain entry, they also found it difficult to reach appropriate personnel inside. Further, the lack of direct observations that would otherwise have occurred during in-person assessments became a problem: MLTSS plans did not have the technology in place–sometimes not

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[6]Kathy Gifford et al., "A View from the States: Key Medicaid Policy Changes, Results from a 50 state Medicaid Budget Survey for State Fiscal Years 2019 and 2020," Kaiser Family Foundation, San Francisco, October 2019.

[7]Ibid.; Lewis et al., "Growth of Managed." As an example, New York State received approval in December 2019 from the Centers for Medicare & Medicaid Services to limit the nursing home benefit included in the partially capitated MLTSS plans to three months for enrollees who require long-term stays in nursing homes, moving reimbursement to fee for service.

[8]AARP Nursing Home COVID-19 Dashboard, Public Policy Institute, online at: https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html, accessed after update May 13, 2021.

[9]Percentage calculation used data from Centers for Disease Control and Prevention Covid Tracker online at: https://covid.cdc.gov/covid-data-tracker/#datatracker-home, accessed on May 15, 2021.

even telephones were available for individual residents–to conduct virtual visits with beneficiaries, particularly at the outset of the pandemic. This inability to reach members also impacted efforts to transition people out of nursing homes.

Other factors compounded the challenges plans faced. Amid the public health emergency and major staffing challenges, nursing homes had to respond to multiple plan representatives/case managers seeking assistance. Nursing home workers were often overwhelmed with an already severely strained staff that didn't have the spare resources necessary to facilitate plan and member interaction. Although most individuals in nursing homes receive coverage through Medicaid, the number of members in any one MLTSS plan in a particular facility can be relatively small depending on the number of MLTSS plans under contract with a state. In addition, many residents were not covered by any Medicaid MLTSS plans, instead receiving coverage through traditional Medicare or Medicare Advantage plans, or through private pay. Thus, individual MLTSS plans often had only a small percentage of residents who were members in any one facility.

The lack of reliable, real-time data to better manage the pandemic as it was unfolding was a fundamental challenge. In the early days of the pandemic, states struggled to gather data on clusters of COVID cases in nursing homes. Tennessee was the first state to mandate that its nursing facilities report COVID case data, taking this step even before the Centers for Medicare & Medicaid Services (CMS) required it. The lack of timely encounter data from the MLTSS plans sometimes made it difficult to make urgent decisions in terms of redirecting resources. Without data-sharing, states were unable to assess the pandemic's impact on reimbursements to certain providers, such as those of adult day services, that were suspended by COVID lockdowns. In addition, the lack of data and coordination regarding the distribution of federal dollars and other resources, such as personal protective equipment, made it more difficult for states to find gaps and respond quickly.

Efforts to Meet the Needs of Beneficiaries

Several themes emerged in meeting these challenges.

Clear, frequent communication was essential.

State Medicaid agencies took the lead in providing guidance and directing MLTSS plan efforts during the pandemic, although how states played that role varied. States held regular meetings with MLTSS plans on an individual and group basis as the pandemic unfolded, with many meetings daily, particularly at the onset. Through regular communication, states shared the latest federal guidance from the Centers for Disease Control and Prevention and other agencies, updates on pandemic-related developments at the state and local levels, and state direction on priority MLTSS activities, including regulatory flexibilities to address most pressing needs.

The frequent and clear communication allowed for refinement and improvement as states and MLTSS plans handled concerns as they arose. States sought and responded to input from MLTSS plans. The meetings also provided a forum for MLTSS plans to share what they saw happening on the ground. MLTSS plans often gave advice from the vantage point of their clinical expertise. One plan with roots in an academic health center had expertise on quarantining and telehealth. National plans shared advanced intelligence on what they were seeing in other markets hit hard earlier on in the pandemic. This iterative process evolved over time as states passed through the stages of the pandemic. For example, Virginia's health plans became increasingly proactive over time in recommending initiatives to better meet the needs of members, such as additional meals for beneficiaries and certain medical supplies (e.g., diapers) for patients returning from hospitals.

Plans supported nursing homes, responding to real-time needs.

The MLTSS plans identified several ways to address the barriers nursing homes faced. First and foremost, at the early stage of the pandemic, there was a need for personal protective equipment (PPE), and most of the plans surveyed detailed their efforts to make PPE available to nursing homes and other providers. For example, one plan deployed unused stock of PPE from the medical facilities it owned to distribute PPE to providers in its managed care markets.

Besides locating PPE, MLTSS plans implemented strategies to reach their members virtually, but there was a particular awareness for not overwhelming an already incredibly strained nursing home staff. State departments of health or state survey and certification agencies responsible for Medicare and Medicaid facility oversight and licensing took direct responsibility for health and safety issues related to nursing homes as the pandemic unfolded. In some instances, the responsible agency was outside the department overseeing Medicaid programs.[10] Given the continual communication and direction from these oversight agencies, and the ongoing pandemic pressures, state Medicaid agencies advised plans not to overload nursing homes with unnecessary demands.

In Pennsylvania, MLTSS plans coordinated efforts by standardizing a schedule and a virtual process for engagement to avoid overburdening nursing home staff. Several plans provided technology for care managers to interact with beneficiaries in nursing homes. One plan sought to leverage the Federal Lifeline program, a Federal Communications Commission program that provides discounts to low-income consumers on monthly telephone and broadband Internet service, and supplemented these resources where necessary to provide devices and WiFi for its nursing home residents. In addition to giving tablets to nursing home beneficiaries in 11 states, another plan worked with nursing homes in one state to tie into their electronic medical record system to assist in coordinating health care for members. Other plans noted similar efforts to integrate with nursing homes' clinical record systems to enhance care management.

Convening a task force of nursing homes and other LTSS stakeholders, Arizona developed a plan for prioritizing access by key oversight personnel (e.g., long-term care ombudsmen) to ensure entry during the lockdown periods. It also made grant funding available to nursing homes to purchase IT equipment, such as iPads, to support telehealth visits for care managers and family members.

MCOs also contributed clinical support to nursing homes. Clinical staff for one plan volunteered to assist nursing homes in several states. Wisconsin engaged its MCOs to provide technical assistance on behavioral health issues to surge facilities set up during the pandemic, as these facilities lacked the expertise to care for individuals with behavioral health needs. MCOs in Tennessee collaborated with a vendor to develop protocols for COVID units in nursing facilities and provided incentive payments to nursing home units that met these protocols. These efforts by MLTSS plans to provide clinical and other supports to nursing homes, and efforts to use IT solutions to assist with care management, represent practices that could serve as blueprints in future health emergencies; they could also enhance care more generally for MLTSS nursing home beneficiaries.

Plans were asked to focus on home and community-based services.

While states expected MLTSS plans to meet contract requirements and provide care management and services for all beneficiaries, states asked plans to place particular focus on the needs of people receiving HCBS during the pandemic. The Medicaid agency and its contracted MLTSS plans had the

[10]For example, in Pennsylvania, the Department of Health is a separate agency from the Department of Human Services, which houses the Medicaid program; in Florida, the state's survey and certification agency is part of the Agency for Health Care Administration, an umbrella agency that also includes the state's Medicaid program.

primary responsibility for the health and safety of vulnerable individuals in HCBS settings–and the direct care workforce on which they relied.

The top priority for MLTSS plans at the onset of the pandemic was helping to secure PPE for the direct care workforce and other HCBS providers; however the HCBS workforce was not designated "essential" in the federal distribution of PPE. Instead, MLTSS plans relied on their existing supply chains for PPE and other necessary items, such as cleaning products.

Plans also faced issues interacting with members receiving HCBS: They needed to ensure that their care managers did not further spread the infection, and beneficiaries were often reluctant to have outside people enter their homes. Plans also faced reticence among staff in conducting in-home assessments and care coordination, particularly during the initial stages of the outbreak.

To address this barrier to in-person meetings, MLTSS plans conducted immediate phone or virtual outreach to members in HCBS to identify needs, reconfigure services as necessary, check availability of staffing, test backup plans, and provide additional supports to members. For example, plans called members to confirm they had necessities, like food and medicine, and arranged home delivery as needed, and continued to make calls depending on the ongoing support needs identified. Plans saw the required person-centered service plan, particularly the emergency backup plans, as key to identifying the needs of consumers and addressing gaps in care during the pandemic.

Predictive analytical tools allowed several plans to monitor care and triage services for those most in need. A Massachusetts plan leveraged its data and analytics to focus on two variables: the changing needs of individuals and challenges in the provider network (e.g., monitoring closures and PPE needs). By developing a dashboard that pulled from claims, electronic medical records, and social data, the plan distributed information to 400 care managers three times a day to help manage the care of 40,000 members, including roughly 12,000 who were identified as top priority.

Plans gave significant attention to organizing and educating their workforces, especially as care managers moved to conducting virtual visits. For example, one plan purchased ZOOM/DocuSign for all care managers and conducted comprehensive training on person-centered virtual care management. Likewise, because their personnel were on the front lines of interacting with consumers, MLTSS plans continually updated staff about COVID-related protocols, including guidance safety protocols and how to enter homes.

CMS emergency waiver flexibilities were critical.

The declaration of a Public Health Emergency in January of 2020 due to COVID allowed CMS to grant waiver flexibilities, which greatly aided states and their MLTSS plans in providing HCBS services during the pandemic. The waiver flexibilities included so-called Appendix K amendments to 1915(c) HCBS waivers and 1115 demonstrations, and section 1135 waivers. Under these various authorities, states gained administrative relief, made temporary modifications to Medicaid eligibility and benefit requirements, relaxed rules to serve individuals with disabilities and older adults in their homes, modified payment rules to support health care providers, and provided wider access to Medicaid-covered services furnished via telehealth.[11] The Public Health Emergency is likely to remain in place through the end of 2021,[12] thereby extending availability of the various flexibilities.

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[11]CMS, "State Health Officials Letter 20-004 RE: Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency," CMS, Baltimore, December 22, 2020.

[12]Letter to Governors from Norris Cochran, Acting Secretary of Health and Human Services, January 22, 2021.

The telehealth flexibilities given to states and their MLTSS plans, particularly the ability to use telephone and/or video conferencing to conduct assessments and coordinate care, represented one of the top flexibilities noted by almost every plan and the state representatives interviewed. Although not a substitute for face-to-face interactions, telehealth offered efficient access to beneficiaries who otherwise might have been hard to reach during the pandemic. This was true despite several challenges and constraints, including member access to devices and data, the lack of broadband in rural areas, and technology platforms that are not always disability-friendly or easy for people with limited prior exposure to navigate. Several plans noted initiatives to fill in gaps for beneficiaries lacking a device, although most beneficiaries or their caregivers had access to a phone for assessment and care coordination purposes. In Tennessee, plans used tablets that they provided to members as part of their electronic visit verification (EVV) program for monitoring direct care workers, to provide care coordination, and support members and family caregivers.

Other key waiver flexibilities included the following:

- **Increased use of paid family caregivers.** To ensure a sufficient workforce, states paid certain family members, often spouses, to provide services during the COVID pandemic. Based on an analysis by CMS, more than two-thirds of states were granted the authority to expand the workforce in this way,[13] and the states and plans interviewed echoed the importance of adding this flexibility to meet the needs of individual, person-centered plans.

- **Modifications to existing services or addition of new services.** States often requested exceeding the existing service limits included in a waiver or adding a new HCBS service during the pandemic. For example, one critical need was the availability of food for beneficiaries isolated in their homes. Some states increased the number of meals an individual could receive each day, or added home-delivered meals to the HCBS service package for the first time. CMS reported that other services added to waivers included remote support services, live-in caregiver, medical respite, assistive technology, wellness monitoring, and companion and homemaker services, among others.[14]

- **Services provided in expanded settings.** As COVID lockdowns impacted providers, such as adult day programs, states sought alternative ways to provide services included in an individual's person-centered services plans. This workaround entailed providing actual services in a different setting or using remote technology to bring services into the home or other venues. Several of the plans interviewed administered adult day care services virtually, using existing network providers to lead, over a technology platform, physical, cognitive, and social activities normally provided onsite at an adult day facility. This was a way to fill gaps in an individual's service plan and help maintain the provider network. A Wisconsin plan initiated several pilot programs to explore deploying technology for community-supported living, daily living skills, and other wraparound services to people in their homes.

- **Temporary, or one-time, direct rate enhancements.** These helped defray the added costs incurred during the pandemic and provided additional pay to the direct care workforce. To help keep providers afloat, states also made retainer payments to providers, including adult day and other HCBS providers, that experienced significant drops in patient volume due to the pandemic. Because many providers rely on Medicaid as their primary source of revenue, suspension of services severely impacted their revenues and potentially put their businesses in jeopardy of permanent closure. Retainer payments helped preserve these provider networks. States handled the enhanced

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[13]Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, "Innovations in Medicaid: State Home and Community Based Services (HCBS) Pandemic Response and Unwinding COVID-Related Waivers" (presentation, ADvancing States Conference, Washington, DC, December 8, 2020).

[14]Ibid.

payments differently. Tennessee gave temporary targeted rate increases for home care workers, a specific rate adjustment of $5 per hour for hazard pay for personal assistants supporting COVID patients, and retainer payments for adult day providers. Virginia also provided hazard pay for personal attendants, and Florida offered retainer payments for adult day providers. Arizona directed additional payments to nursing homes, assisted living facilities, and HCBS providers. For the most part, MLTSS plans either served as conduits for the provision of these directed payments or absorbed these costs as part of their capitation payment (with the expectation that these costs would be factored in during the actuarial rate-setting process).

Waiver flexibilities proved to be an extremely important tool for MLTSS plans in fulfilling their core responsibilities and, by most accounts, the plans adapted quickly to the changes allowed by the waivers. For example, with telehealth, MLTSS plans ramped up almost overnight to incorporate virtual visits into their practice. Over time, the plans also employed remote technology for the delivery of services (such as adult day), to deliver support to family caregivers, and to address social isolation of beneficiaries. Likewise, MLTSS plans utilized the backup service plans to integrate family caregivers into an individual's plan of care and tap existing provider networks to add services (e.g., additional meals) to meet the special needs of beneficiaries during the pandemic in a timely fashion.

Some MLTSS plans engaged in initiatives beyond contractual requirements.

In some cases, MLTSS plans tackled well-known existing gaps in LTSS that became particularly acute during the public health emergency. These effort in some cases went beyond basic contract requirements to address issues like the workforce shortages plaguing nursing homes and HCBS. One plan partnered with ADvancing States, the organization representing the nation's 56 state and territorial agencies on aging and disabilities and LTSS, to develop an IT infrastructure for the job registry Connect to Care Jobs, which matched individuals to long-term care positions. In Wisconsin, MCOs and local providers developed an online resource that matched providers experiencing shortages of workers with those that were reducing staff (e.g., day programs) to help fill vacant positions.[15]

MLTSS plans also addressed areas of social determinants of health such as housing and food needs experienced by HCBS beneficiaries. Food became a priority as vulnerable individuals isolated in their homes. As noted above, states responded by adding or increasing the number of home-delivered meals provided to HCBS beneficiaries. National MLTSS plans leveraged contracts with national grocers to supply food to members in need. A Massachusetts plan provided cash to its HCBS beneficiaries to buy necessities such as food and household products; this plan also collaborated with the Massachusetts state government to temporarily house COVID-positive, marginally housed individuals in six hotels across the state.

Lessons Learned: Replicating Successes and Making Improvements

These experiences shed light on needed improvements as MLTSS plans and states prepare for future public health emergencies. At the same time, some interventions initiated in the height of the crisis can strengthen the LTSS system, representing clear improvements that states and MLTSS plans should consider adopting permanently.

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[15] Wisconsin supplemented its efforts at the state level with a quadrant structure that teamed MCOs and fiscal intermediaries with local providers and other LTSS stakeholders in four areas of the state. The goal of this structure was to help MCOs and other stakeholders respond more rapidly to specific challenges at the local level given diverse needs of the urban southeast versus those of the more rural areas of Wisconsin. In addition to job matching, the state reported that this framework helped to quickly identify local sources of PPE either from the MCO or local providers and allocate this supply to providers with PPE shortages.

The innovations plans made to connect with members and provide care management are among the practices that could be replicated in future health emergencies. These successes, especially the expanded use of telehealth, should also be embraced as permanent solutions for enhancing ongoing care coordination for MLTSS beneficiaries. Other improvements that could have long-term benefits include stronger protocols for accessing nursing home residents and integration with an institution's medical record to better manage overall care. Medical record integration is a particular asset for plans managing the full range of both Medicaid and Medicare benefits.

MLTSS plans saw themselves as an important resource and partner to states in managing the health care crisis. Particularly in serving vulnerable beneficiaries through HCBS, the plans were a relatively nimble resource that states could deploy to meet the ever-changing needs presented by the pandemic. These supports included provision of PPE, guidance on the ground as the pandemic unfolded, rapid transition to virtual assessments and care management, and implementation of other flexibilities to serve HCBS beneficiaries. Plans introduced new technological tools to assist in the provision of services, and tapped into additional resources–going beyond the basic contract requirements.

The following are among the other important takeaways that deserve attention as states, MCOs and public health experts evaluate the pandemic response with a view toward lessons learned.

Clearly Defined Roles

There is a need to assess the proper role of state public health officials and Medicaid programs in overseeing the safety and health of residents in nursing homes and other institutional facilities. In states with MLTSS plans, the assessment should include the appropriate role of MLTSS plans in serving beneficiaries in these institutions. New Jersey is already tackling this issue. There, legislators established the Task Force on Long-Term Care Quality and Safety to address improvements in nursing home resident and staff safety, quality of care and services, person-centered care, and workforce engagement and sustainability, among other issues. The task force is also charged with exploring reforms to increase the use of Medicaid managed care to drive improvements in quality and oversight of nursing homes.[16]

Enhanced Clinical Support

MLTSS plans also have significant clinical expertise to share; as previously noted, there are examples of MCOs providing crucial on-the-ground support to states as the crisis unfolded in nursing homes. Pennsylvania established the Regional Response Health Collaborative, a partnership between state government agencies and 10 health care systems. This collaborative provided clinical and operational supports, and an educational platform for long-term care providers such as nursing homes, assisted living and personal care homes, as they responded to the COVID-19 pandemic.[17] Although this effort did not involve MLTSS plans, this and other models for potential engagement of clinical expertise and personnel in support of long-term care providers should be explored.

Strengthening Provider Contracting

In the aftermath of the pandemic, strengthening the provider contracting provisions could enhance the quality of care on an ongoing basis and in the event of another public health emergency. MLTSS plans

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[16]NJ A 4481, State Legislation, "Establishes New Jersey Task Force on Long Term Care Quality and Safety." Enacted September 2020, https://www.njleg.state.nj.us/bills/BillView.asp?BillNumber=A4481.

[17]"Regional Response Health Collaborative," Department of Human Services, accessed May 18, 2021, https://www.dhs.pa.gov/coronavirus/Pages/RRHCP.aspx#:~:text=The%20Regional%20Response%20Health%20Collaborative,Pennsylvania%20and%20the%20Jewish%20Healthcare

can use their financial leverage to incentivize nursing home care improvement and preparedness. This may include incentives to nursing homes that have implemented best practice protocols for infection control, or other pay-for-performance metrics related to resident safety and quality. Ultimately, plans may wish to explore limiting their networks to exclude nursing homes that do not meet minimum standards of care.

Embracing Telehealth

For beneficiaries receiving HCBS services, states and their MLTSS plans introduced numerous interventions and policy changes to address the significant barriers posed by the pandemic. None was more important than the major acceleration in the use of telehealth. Telehealth successfully supported assessments and care coordination and introduced potentially new models of delivering services virtually. Many MLTSS plans used telehealth and IT software to provide real-time support to family caregivers and help case managers identify and assist individuals at risk of mental and physical health decline due to social isolation.

There is no doubt that many of these telehealth innovations are here to stay. Still, states and MLTSS plans must evaluate the cost-effectiveness of these tools in providing high-value services to beneficiaries. While electronic devices can provide a mechanism for staying in contact with individuals, there is no substitute for a face-to-face visit. Assessing the right balance between standard in-person care and using telehealth should be ongoing and a focus once the pandemic has subsided.

Evaluation of Waiver Flexibilities

States will have to decide if some of the waiver flexibilities that proved successful during the pandemic should be adopted as ongoing policy. The increased use of paid family caregivers was a particularly important resource for MLTSS plans as they worked to fill gaps in an individual's person-centered service plan. Considering the potential to continue this policy should be part of the evaluations in which states engage post-pandemic. Similarly expanded services, such as home-delivered meals, may warrant continuation. CMS will also need to decide what it will allow once the public health emergency has officially ended.

Data Tracking

The importance of data to track the spread of COVID cannot be overemphasized. Data tracking was critical for states and their MLTSS plans to make informed and quick decisions to keep services functioning and protect the health and safety of staff and LTSS recipients. CMS released its first tranche of data on nursing home deaths several months into the pandemic,[18] but many states moved earlier in compiling their own information. Similarly, managed care claims and encounter data helped identify gaps in service delivery and providers at risk of shuttering due to declining patient volumes.

Gaps in data, however, hindered responses. Once PPE and emergency funds started to flow to individual providers within a state, there was no mechanism to track these resources and determine unmet needs. An assessment is required to identify the critical gaps in data experienced during the COVID pandemic, to ensure the infrastructure and functionality are in place to better manage future public health emergencies.

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[18]CMS, "Nursing Home COVID-19 Data and Inspection Results Available on Nursing Home Compare," News Release, CMS, Baltimore, June 4, 2020, https://www.cms.gov/newsroom/press-releases/nursing-home-covid-19-data-and-inspections-results-available-nursing-home-compare

Emergency Backup Plans

The pandemic also reinforced the importance of having a detailed emergency backup plan to continue to support operations during crises. Florida Medicaid officials noted that contract amendments implemented just prior to the pandemic strengthened requirements on implementing an emergency management plan. These amendments were instituted in response to hurricanes and other emergencies Florida has experienced in recent years, but the state felt they were helpful in responding to the COVID pandemic. An MLTSS plan in Texas said it felt better prepared to deal with COVID given its experience dealing with prior emergencies and the critical actions required to focus on the needs of beneficiaries. That said, the COVID pandemic was a unique phenomenon that challenged everyone's preparations for emergencies. One plan noted that, although it had an emergency service plan, some time had passed since it had been activated, and the plan did not prepare workers for the COVID pandemic. One of the first actions states and MLTSS plans should take is to review these emergency backup plans and update them based on lessons learned.

Designating the HCBS Workforce As "Essential"

As the pandemic unfolded, public officials and the media paid a significant amount of attention to the plight of individuals residing in nursing homes and other congregate settings–and the need to provide these institutions with PPE and other financial resources. This focus was appropriate given that these individuals were at significant health risk and the facilities in which they were housed were often understaffed and overwhelmed. While the millions of Americans who rely on Medicaid HCBS services, including those served through MLTSS plans, are also an extremely vulnerable population, they did not receive the same initial attention. The HCBS direct care workforce charged with caring for these individuals is often exceedingly fragile, but these workers were not always deemed as "essential" when federal resources, such as PPE, were distributed.

Fortunately, state Medicaid programs, with assistance from MLTSS plans, did place significant emphasis on assisting these beneficiaries and supporting the workforce upon which they depend. If faced with future public health emergencies, HCBS beneficiaries and their workforce must be recognized as an important part of the overall federal response. The additional resources for Medicaid HCBS services contained in the recently approved American Rescue Plan[19] indicate that this is a lesson already learned from the COVID pandemic.

Conclusion

The COVID-19 pandemic posed tremendous challenges for MLTSS plans, as it did for the entire health care system, particularly with respect to beneficiaries residing in nursing homes. MLTSS plans were unable to enter these institutions when they were under lockdown–despite contractual relationships and the need to be accountable for the care their members received. However, several plans reported some successes in working around these constraints. MLTSS plans also played a key role in reaching HCBS beneficiaries, partnering with states to implement several Medicaid flexibilities permitted by CMS during the pandemic.

Overall, the state survey respondents said the MLTSS plans were a valuable partner during this challenging time and were a resource that assisted in responding quickly to challenges on the ground.

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[19] CMS, "State Medicaid Director Letter, SMD# 21-003 RE: Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency," CMS, Baltimore, May 13, 2021.

But there is room for improvement; an ongoing analysis of the pandemic response could not only strengthen readiness for future public health crises but also identify pandemic-driven responses that should remain as improvements to the LTSS system.

Clearly, the experience in nursing homes during the pandemic calls for an assessment of what can be done to ensure the health and safety of residents in similar health emergencies going forward. This assessment should examine the roles and responsibilities of federal and state governments, nursing homes, and MLTSS plans and include an analysis of how the federal COVID relief dollars provided by Congress were spent. Specifically, understanding how those dollars flowed, how they were used, and to what effect is fundamental to future policies. Likewise, the use of data, telehealth, supports for the direct care workforce, emergency backup plans, and such CMS waiver flexibilities as paying family caregivers are among the issues that should be assessed. Such a review would not only help prepare the long-term care system for future emergencies but also pave the way for an improved system of care for those individuals relying on Medicaid and MLTSS.

About the Authors

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Acknowledgments

Appendix. Experts Interviewed, 2021, Alphabetically by Organization

- ADvancing States - Camille Dobson, Deputy Executive Director
- Altarum - Michael Monson, CEO and President
- AmeriHealth Caritas - Sharon Alexander, President, LTSS Solutions
- Anthem - Rachel Turner Chinetti, Senior Director, Specialized Populations & Programs
- Arizona Health Care Cost Containment System - Jami Snyder, Director
- Association for Community Affiliated Plans - Christine Aguiar Lynch, Vice President of Medicare and MLTSS
- ATI Advisory - Allison Rizer, Principal
- ATI Advisory - Anne Tumlinson, CEO
- Bureau of TennCare - Patti Killingsworth, Chief of LTSS Division
- Centene Corporation - Jennifer Burnett, Senior Director, PA Health and Wellness
- Centene Corporation - Laura Finkelstein Chaise, Vice President, Long-Term Services and Supports and Medicare-Medicaid Plans
- Center for Health Care Strategies - Alexandra Kruse, Associate Director, Integrated Care, State Programs
- Center for Health Care Strategies - Nancy Archibald, Associate Director, Integrated Care, Federal Programs
- Commonwealth Care Alliance - Christopher D. Palmieri, President & CEO
- Commonwealth Care Alliance - Michelle Herman Soper, Vice President of Policy Development (Former Vice President of Integrated Care, Center for Health Care Strategies)
- Disabled and Elderly Health Programs Group, Center for CHIP and Medicaid Services at CMS - Barbara Edwards, Former Director
- Florida Agency for Health Care Operations - Eunice Medina, Former Bureau Chief, Medicaid Plan Management Operations
- Inclusa Inc. - Kris Kubnick, Chief Member Experience Officer
- Independent Care Health Plan - Margaret Kristan, Vice President, Long-Term Care and Community Inclusion
- Inland Empire Health Plan (IEHP) - Ben Jáuregui, Behavioral Health & Care Management Support Services Manager
- Inland Empire Health Plan (IEHP) - Shelly LaMaster, Director of Integrated Care
- Long Term Quality Alliance - Mary Kaschak, Executive Director
- Molina Health Care Plan - Michelle Bentzien-Purrington, Vice President, MLTSS and SDOH Innovation
- Pennsylvania Health Law Project - Laval Miller-Wilson, Executive Director
- Pennsylvania Office of Long-Term Living - Kevin Hancock, Principal, Health Management Associates, Former Deputy
- Speire Health Care Strategies - Tom Betlach, Partner
- United Healthcare Community & State - Michelle Martin, Senior Policy Director, Long Term Services and Supports
- United Healthcare Community& State - Jillian Hamblin, Vice President, Long Term Care Programs
- UnitedHealthcare Community & State - Kate Paris, Vice President, Policy & Influence
- UnitedHealthcare Community Plan Tennessee - John Madondo, Executive Director, LTSS and Complex Care
- UPMC Health Plan - Brendan Harris, Vice President, Community HealthChoices
- Virginia Department of Medical Assistance - Tammy Whitlock, Deputy Director for Complex Care
- Virginia Department of Medical Assistance Services - Karen Kimsey, Director
- Wisconsin Department of Health Services - Kiva Graves, Director, Bureau of Quality and Oversight, Division of Medicaid Services

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