mhpa
Medicaid Health Plans of America

Issue Brief

Managed Long-Term Services and Supports

Background

Managed long-term services and supports (MLTSS) refers to the delivery of long-term services and supports through capitated Medicaid managed care programs. MLTSS offers States a broad and flexible set of program design options intended to support a sustainable, person-centered, long-term support system in which people with disabilities, older persons, and those with certain conditions have choice, control, and access to a full array of services and supports that assure optimal care and outcomes, such as independence, health, and quality of life. MLTSS include all home and community-based services (HCBS) such as personal care, social engagement, work supports, adult day care, home-delivered meals, and transportation services, as well as institutional services, such as care received through nursing homes.

MHPA Policy Position

MHPA's support for MLTSS is grounded in the belief that managed long-term services and supports are valued health care options for Medicaid beneficiaries that can make a meaningful difference in their lives, health outcomes, and quality of care.

MHPA is committed to ensuring that the delivery of managed long-term services and supports are built on the foundation of six (6) pillars:

1. **STAKEHOLDER ENGAGEMENT.** Stakeholders, including beneficiaries, providers, and advocacy groups of all impacted LTSS populations, should provide significant insight into the planning, implementation, and ongoing oversight of MLTSS programs.
2. **APPROPRIATE ACCESS.** Beneficiaries should have timely access to services and supports that are appropriate, improve quality of life, and that best meet the needs and goals of the individual. MLTSS beneficiaries should receive services: (a) at the appropriate level; (b) in the appropriate amount; (c) at the appropriate time; and (d) in the appropriate place. Access in an MLTSS program, however, can sometimes be driven by the availability of certain types of providers to serve the need for such services and supports.
3. **QUALITY CARE THROUGH QUALITY DRIVEN SERVICES AND SUPPORTS.** Beneficiaries should have access to a combination of needed services and supports that are high-quality, person-centered, comprehensive, and cost effective, and support the goal of community integration. Performance-based incentives tied to beneficiary outcome measures are effective tools to achieve that goal in MLTSS.
4. **PERSON-CENTERED.** Beneficiaries should be treated with dignity and respect; they should be included and engaged across the care continuum; and they should be empowered with the freedom, control, and responsibility to make informed choices that include, but are not limited to, goal setting and the planning for and receiving of their needs-based MLTSS. Care plans should reflect the needs, goals, and preferences of the beneficiary and have assurances of appropriate supports to meet them.
5. **CARE COORDINATION.** Beneficiaries should receive benefits that are coordinated across all providers and products, including medical, acute, behavioral, social, LTSS, and with caregivers to drive the improvement of their health outcomes and experience.
6. **FINANCIAL SUSTAINABILITY & INNOVATION.** Payment rates to health plans should be actuarially sound, take into consideration beneficiary functional status, and be adjusted based on actual needs and service utilization patterns to provide for the financial stability of health plans that support the delivery of high quality and appropriate MLTSS. This should allow for and foster future innovations in the delivery of these services.

Medicaid MCOs are uniquely positioned to serve these populations through the delivery of MLTSS given our focus on and experience with:

- Person-centered care (including self-directed care)
- Improved care management and coordination of care
- Creating efficiencies by assisting with the navigation of a fragmented and complex health care system
- Caregiver support
- Making community connections that create and build on existing relationships
- Information systems (e.g., electronic visit verification systems)
- A holistic approach that addresses the needs of the whole person
- Community resources and services that address social determinants of health
- Support for services that address social determinants of health;
- Ensuring quality
- Accountability for outcomes

MHPA supports efforts to increase community integration and access to home and community based services (HCBS), when appropriate; to improve quality of life and health outcomes; to build increasing social capital for beneficiaries; and to enable meaningful choice for older adults and those with disabilities of all ages.

MHPA supports efforts to ensure access to MLTSS through adequate infrastructure and resourcing of the range of caregiving delivery roles, *including personal attendants, family caregivers, and natural supports. The shortage of personal attendants can act as barrier to care for MLTSS beneficiaries. MHPA supports efforts to ensure sufficient wages, benefits, educational and workforce training opportunities to enable the delivery of high-quality care in the most integrated setting.*

- ***Family caregivers and natural supports.*** Resources should be made available to support individuals in these roles that could include caregiver assessments and the provision of information, training, and respite care, when and where appropriate.
- ***Personal attendants.*** Resources should be tailored to meet specific needs that could include educational and workforce training opportunities and to ensure the adequacy of wages and benefits.

The delivery of MLTSS through managed care aligns with State interests to continually improve quality care and outcomes, rebalance state spending toward community based care, and ensure cost effectiveness. *Managed care contracting provides budget predictability and establishes greater accountability through enhanced quality performance measurement and data analytics.*

Dually Eligible individuals are beneficiaries eligible for both Medicare and Medicaid with considerable medical and non-medical needs and accountability for their care split between two programs and often multiple payers. ***Dually eligible individuals experience high rates of chronic illness, with many having multiple chronic conditions and/or social risk factors, and about half use long-term services and supports. MHPA supports the delivery of a coordinated, integrated, and aligned plans for dually eligible individuals*** *that facilitates the delivery of quality care, better outcomes, and increased value to the health care system through reduced spending and elimination of silos that create care fragmentation.*

About Medicaid Health Plans of America (MHPA)

Founded in 1995, the **Medicaid Health Plans of America (MHPA)** represents the interests of the Medicaid managed care industry through advocacy and research to support innovative policy solutions that enhance the delivery of comprehensive, cost-effective, and quality health care for Medicaid enrollees. MHPA works on behalf of its 94-member health plans, known as managed care organizations (MCOs), which serve approximately 23 million Medicaid enrollees in 37 states and the District of Columbia, or about one-third of all Medicaid beneficiaries in states with managed care delivery systems. MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market.