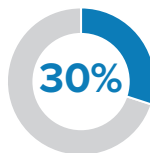# Building Better Care

The Role of Medicaid Managed Care in Long Term Services and Supports

30%

Medicaid long term services and supports (LTSS) expenditures are a significant part of the annual Medicaid budget. **In 2016, LTSS expenditures accounted for 30% of the total Medicaid budget.**

Since 2013, Medicaid expenditures for home and community-based services (HCBS) have exceeded expenditures for facility-based care. **Nationally the average now is approximately 60%.**

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Half of states use managed care organizations to deliver LTSS. Currently more than 1.7 million people receive LTSS through Medicaid managed care organizations (MCO).[1]

Key federal and state actions in the area of HCBS include: HCBS Quality Measurement and Improvement, the HCBS Settings rule, and Electronic Visit Verification (EVV).

Challenges facing HCBS programs include: workforce capacity, funding, the impact of COVID-19 on the post-acute delivery system including nursing homes, home health, and HCBS providers.

1   https://www.kff.org/other/state-indicator/total-medicaid-enrollment-in-managed-long-term-services-and-supports/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Introduction

In Medicaid, long term services and supports (LTSS) refers to the services and supports enrollees of all ages receive to help them with functional limitations and/or chronic illnesses. LTSS also provides enrollees with assistance with performing activities of daily living (ADL) like bathing, grooming, dressing, meal preparation, eating, and medication assistance.[2] Services can be provided in a range of settings, including nursing homes, assisted living facilities, convalescent homes, and home and community-based settings.

In 2016, combined federal and state Medicaid expenditures for LTSS were $167 billion – approximately 30% of total Medicaid spending. Over $95 billion (57%) of total LTSS expenditures were spent on home and community-based services (HCBS).[3] Each year, millions of Medicaid enrollees of all ages use the full spectrum of LTSS, from nursing home care to home-based services. However, medical care and LTSS are very different. LTSS is not curative care; it is a combination of supports and services that help people carry out their daily activities.

Background

When Medicare and Medicaid were created in 1965, state Medicaid programs provided services in nursing homes, convalescent hospitals, and other institutions for older adults and people with disabilities. These services, generally known as "long term care," were provided in facilities staffed by an array of medical and non-medical professionals who provided basic medical care and ADL supportive services. Medicaid was only required to pay for long term care in institutions and not in a person's home. This created an institutional bias in the program that encouraged placement of people with care needs into nursing facilities. However, over the past 40 years, policy and legal changes have altered the landscape of long-term care, in favor of providing care in a person's home and community rather than institutions.

While facility-based care is still a mandatory Medicaid benefit in every state, many states now choose to cover HCBS as an optional benefit for some or all Medicaid enrollees. States have made significant efforts to rebalance the proportion of care provided in individual's homes and community settings compared with care provided in nursing homes. In fact, 2013 marked the first year that total U.S. Medicaid expenditures for HCBS exceeded expenditures for facility-based care.[4]

Who Uses LTSS?

People who use LTSS are elderly and non-elderly individuals with functional impairments, a physical disability, developmental disability, behavioral health diagnosis, or a combination of disabilities.[5] Many states offer services through special programs for people with spinal cord or traumatic brain injuries, as well as chronic conditions that result in significant disabilities. Eligibility requirements for receiving LTSS can be complicated and vary from state to state.[6] Generally, individuals must require assistance with their ADLs and meet the Medicaid income requirements set by the state.

How Do States Implement LTSS Programs?

Because the majority of LTSS are optional benefits, states add the services to their Medicaid program through State Plan Amendments (SPA)[7] or through waivers. The most common way states add additional LTSS is through a 1915(c) waiver. Also known as the "Home and Community Based Services" or "HCBS" waiver, the 1915(c) waiver allows individuals to receive a variety of services, including personal care, case management, adult day services, and habilitation while residing in their homes instead of in institutional settings. States can have more than one 1915(c) waiver; in fact, there are more than 300 1915(c) waivers currently in effect serving more than 4.6 million people across the United States. States typically create individual waiver categories based on a population (e.g., over 65) or a condition (e.g., traumatic brain injury).

LTSS and Managed Care

States contract with Medicaid managed care organizations (MCO) to provide some or all their Medicaid benefits. Today, 24 states use managed care to provide some or all the LTSS benefits. This is a dramatic increase from 2004 when just 8 states used managed care for LTSS.[8] Under managed long term services and supports (MLTSS), MCOs receive a capitation payment (a pre-determined amount paid per member, per month) from the state to cover the

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2   https://www.hilltopinstitute.org/wp-content/uploads/publications/LTSSChallengesandOpportunitiesforStatesindifficultBudgetTimes-December2011.pdf
3   https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf
4   https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/
5   Ibid.
6   https://fas.org/sgp/crs/misc/R43506.pdf
7   Each state has a State Plan that documents details of its Medicaid program for the federal government. State plans are often amended by a State Plan Amendment (SPA) to add to or change elements of the program. SPAs are different than waivers.
8   https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/

costs of all the services specified under the contract. States choose MLTSS for a variety of reasons, including improved care management, community inclusion, and quality of care. MCOs work with LTSS enrollees and their care teams to ensure that enrollees receive all the care and services they need in a timely manner. Currently more than 1.7 million people receive LTSS through Medicaid MCOs.[9]

Nearly half of all states have adopted MLTSS for some part of their LTSS-utilizing population. Because MLTSS are provided through a variety of waivers, states can include the individual waivers in the state Medicaid contract. While a state may have several waivers, most states move some of the waivers into managed care while the others remain in fee for service (FFS). For the waivers remaining in FFS, the state continues to manage the LTSS services while a health insurance provider covers medical care. This separation of services creates challenges for health insurance providers who are trying to effectively manage care and provide care coordination.

LTSS v HCBS—What's the Difference?

There can be confusion over the difference between LTSS, HCBS, and MLTSS. LTSS refers to a broad set of services that can be provided at various levels of skill and in various settings, while HCBS are a type of LTSS that are provided in home or community settings. HCBS are a crucial part of the LTSS system as the majority of people prefer to receive services at home.[10] When states utilize managed care for some or all of their LTSS benefits, known as MLTSS, a state's HCBS are often included in the services provided through managed care. The right to receive care at home and in the community is a pillar of the disability rights movement and is a key element of the Americans with Disabilities Act (ADA). In July 2020, the ADA celebrated its 30th anniversary.

Federal and State Actions in MLTSS

Medicaid is a partnership between the federal government and the individual states. To receive federal funding, the government requires that certain benefits be provided

by every state.[11] As previously mentioned, states provide some LTSS and all HCBS by asking the federal government to waive certain Medicaid requirements (e.g., state-wideness, comparability of services, or eligibility requirements) to allow the state to provide more services to certain populations. The federal government regularly approves state waiver requests but continues to provide broad oversight. In recent years, federal action related to HCBS has included:

- **HCBS Settings Rule ("Settings Rule")**: Centers for Medicare & Medicaid Services (CMS) created the Settings Rule, which supports enhanced quality in HCBS programs and adds protections for individuals receiving services. The Settings Rule also reflects the intent of CMS to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting.[12] The Settings Rule is scheduled to take effect on March 17, 2022.[13]

- **Electronic Visit Verification (EVV)**: The 21st Century Cures Act requires states to implement EVV for all Medicaid personal care services (PCS) provided through a waiver and home health services (HHCS) that require an in-home visit by a provider.[14] The number of indictments and convictions for fraud committed by personal care service providers and attendants grew by 56% and 33%, respectively, from 2012 and 2015. Given the increased use of HCBS, the goal of EVV is to reduce opportunities for fraud and improper payments.[15]

- **Measuring and Improving Quality**: CMS and states are consistently working together to advance quality measurement in HCBS. Following 2004 recommendations from the Government Accountability Office (GAO), CMS began a structured and transparent quality oversight process with states related to section 1915(c) waiver programs.[16] Since that time, CMS has continued to refine the quality oversight process and state reporting requirements.[17] While CMS provides process and structure, states individually choose how to meet the CMS requirements. In LTSS, people

9   https://www.kff.org/other/state-indicator/total-medicaid-enrollment-in-managed-long-term-services-and-supports/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

10   http://longtermscorecard.org/~/media/Microsite/Files/2014/Reinhard_LTSS_Scorecard_web_619v2_rev_04152016.pdf

11   https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html

12   https://www.medicaid.gov/sites/default/files/2019-12/final-rule-fact-sheet.pdf

13   https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html

14   https://www.medicaid.gov/medicaid/home-community-based-services/guidance/electronic-visit-verification-evv/index.html

15   https://www.macpac.gov/wp-content/uploads/2019/02/Electronic-Visit-Verification-for-Personal-Care-Services-Status-of-State-Implementation.pdf

16   https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/measuring-and-improving-quality-home-and-community-based-services-hcbs/index.html

17   https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/measuring-and-improving-quality-home-and-community-based-services-hcbs/index.html

require services for years or even a lifetime. A positive result, for example, can be when a person's health status does not decline and hospitalizations or other institutional stays are avoided. Measuring quality in MLTSS depends on the existence of quality measures in LTSS that are currently focused on processes such as confirming provider qualifications or whether an individual's personal goals were included in the care plan.[18] LTSS and MLTSS are further complicated by the unique nature of each state's programs, the various tools used for measurement, the differences in populations involved, and the wide variety in services provided. Health insurance providers currently struggle to demonstrate efficacy in MLTSS because measures are convoluted and inconsistent, but there are several efforts underway to create more meaningful and complex quality measures related to HCBS and MLTSS that will serve to measure quality consistently across states and MCOs.

As with all aspects of Medicaid, the federal government provides a framework of requirements to states for HCBS. Operating within that framework, states have discretion to implement and execute their Medicaid program and approved waivers.

Challenges

Workforce Capacity: There are approximately 3 million workers employed in individual homes and other residential settings. Due to an aging generation, another 1.1 million home care jobs will be added between 2018 and 2028.[19] The labor force is not growing fast enough to keep up with the need for home care workers. This leaves health insurance providers with a growing challenge of ensuring safe and appropriate care for all individuals who require LTSS.

Social Determinants of Health (SDOH): Over the last several years, SDOH has become a primary topic in health care. A patient's health can be influenced by many non-medical factors, including a lack of stable housing, food insecurity, and transportation limits. Medicaid patients receiving LTSS are some of the most vulnerable individuals due to increased medical as well as non-medical need. User-friendly transportation options are limited (wheelchair friendly, driver trained to assist someone with cognitive deficits), food security is difficult (uncontrolled diabetes plus physically disabled or cognitive deficits that limit understanding of managing diabetes), safe, affordable and

stable housing is in limited supply and even more so for individuals who require ramps or wheelchair accessible buildings. While SDOH impact all Medicaid enrollees, individuals with LTSS needs are at higher risk and the options for services are more limited.

Rates: Setting actuarially sound rates in Medicaid can be a challenging process due to the mix of people served, variations in access to services across states, and the types of services provided. In MLTSS, the mix of services, the wide range of health needs of patients who utilize LTSS, and the operational complexity of LTSS combine for added challenges in rate setting.[20] Within the capitated rate, health insurance providers are often required to maintain services and providers without modification as well as conduct assessments, provide care coordination, and continually monitor care plans for service gaps.

Impact of COVID-19 on the Post-Acute Delivery System: Nursing homes, home health and HCBS providers have all experienced significant challenges as a result of the COVID-19 crisis. More than 50,000 nursing home residents have died from COVID-19, according to CMS, and safely housing residents and isolating them when necessary continues to pose a problem. Nursing homes have also experienced a decline in residents due to COVID-19.[21] Similar challenges have affected home health and HCBS providers, with patients needing but refusing care out of concern over potential exposure to COVID-19. Nursing homes, home health, and HCBS providers all experienced a lack of sufficient personal protective equipment (PPE), which created significant risk for providers and patients. A decline in revenues coupled with increased costs for wages and PPE have created financial strains, especially in nursing homes.

Policy Recommendations

Improve Workforce Opportunity May Increase Capacity

Individuals who take on the job of direct care are tasked with providing some of the most important care needed by patients with complex medical needs. Direct caregivers assist patients with bathing, toileting, meal preparation, eating, and a variety of other services that are highly personal and essential to a patient's well-being. Despite the importance of the work, compensation for these workers is low. From 2008 to 2018, these workers

18   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
19   https://phinational.org/policy-research/key-facts-faq/
20   https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/
21   https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

experienced little to no pay increases.[22] Workers often receive few of the benefits that other employers offer, such as paid leave. Lack of training, lack of opportunity, and low wages leads to low job satisfaction, high rates of caregiver burnout, and high rates of turnover. Many in the workforce cite lack of professional development and growth as a reason for exiting the direct care workforce. Studies have shown a decrease in departures among workers who are offered training and a career ladder.[23] Policymakers and health insurance providers must champion efforts to create training opportunities and develop pathways to promotion.

Increase Use of Managed Care

Across the country, capitated managed care is the leading Medicaid service delivery model. In total, 39 states plus the District of Columbia contract with MCOs to provide some or all Medicaid benefits.[24] Only 24 states, however, use a managed care model to deliver services to those who utilize LTSS. States choose to contract with Medicaid MCOs for a variety of reasons including budgetary certainty and the opportunity to provide all services through a single organization, which allows for improved quality monitoring. Most importantly, the use of MCOs allows high need, complex populations to receive all services through one entity. This ensures a streamlined and person-centered approach to services patients require—medical as well as LTSS. Removing the patient's burden of coordinating care and offering states budgetary certainty makes managed care a positive choice that should be more widely expanded to include all Medicaid populations.

Quality Measures

Measuring quality in LTSS can be challenging given the programmatic differences between states and the varying needs of the populations served. Measuring quality is further complicated by states adopting different methodologies. MCOs welcome the opportunity to demonstrate quality in LTSS and are participating in current efforts to define measures that go beyond process and include patient satisfaction and the value of services delivered. MCOs encourage policymakers to complete a comprehensive review of existing quality measures currently used by individual states, including the quality assessment tools currently available, the patient burden, and the intended goal of any new quality measures before implementing requirements. While MCOs are eager to demonstrate value, it is essential that any new measurement requirements be mindful of the patient's time and the goals of the measurements.

Examples of Health Plan Efforts

AmeriHealth Caritas

AmeriHealth Caritas Delaware has paired two critical services for eligible members of their Medicaid population: LTSS and housing supports. Like many communities across the country, the high cost of rent makes stable housing unaffordable for many and places a significant strain on Medicaid enrollees who require LTSS. Between rent, security deposits, and utility payments, the cost of stable housing is unaffordable for many people, particularly elderly and disabled individuals who live on limited and fixed incomes. In effort to best support their members, AmeriHealth Caritas Delaware uses a housing coordinator as part of its interdisciplinary care services that are available to individuals who need LTSS.

In AmeriHealth Caritas' Delaware membership, approximately 3,000 individuals are eligible to receive LTSS services. The members who receive LTSS are assigned a case manager to evaluate their needs, including an assessment of social determinant of health needs completed by the case manager, development of a care plan, and arrangements for the services to fulfill the care plan. Individuals with housing needs are identified during interdisciplinary care team rounds, weekly meetings with the largest local hospital systems, and routine care monitoring meetings with nursing facilities.

When an individual is found to need housing assistance, the case manager enlists the help of the housing coordinator to join the member's care team. Key to AmeriHealth Caritas Delaware's efforts is the holistic approach to providing services. Instead of a person receiving LTSS and housing help in separate silos, the housing coordinator becomes a part of the team to insure streamlined care and assistance.

Once the housing coordinator is involved in a member's care plan, multiple efforts are undertaken to provide person-centered care. The housing coordinator has cultivated important local relationships with the Delaware Housing Alliance, who manages intake for homeless shelters throughout the state, and is the point of contact with the Delaware State Housing Authority to stay informed of housing options and opportunities for assistance. The housing coordinator also assists with housing applications, locates income based subsidies, searches for housing in areas specific to the member's choice, and connects the member to community based organizations that can provide financial assistance with

22   https://phinational.org/policy-research/workforce-data-center/#tab=National+Data&natvar=Wage+Trends
23   https://www.leadingage.org/sites/default/files/Direct%20Care%20Workers%20Report%20%20FINAL%20%282%29.pdf
24   https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

things like security deposits, rent, and utility assistance. Once a member is safely in stable housing, the housing coordinator serves as a resource to the member and the property manager to help address issues of health, safety, and other supports in an effort to avoid eviction.

AmeriHealth Caritas Delaware's' approach to integrated housing coordination working exclusively with the population utilizing LTSS has proven to be very beneficial to its members. In 2019, the AmeriHealth Caritas Delaware's' housing coordinator worked with over 140 housing referrals to solve a range of housing related matters, assisting members in achieving their goal of remaining independent in a community-based setting.

While the number of individuals needing stable housing severely outpaces the availability of affordable housing, AmeriHealth Caritas Delaware continues to collaborate with a cross section of local health and housing partners to help advance stable and affordable housing solutions for the LTSS population served.

Anthem

Anthem launched an initiative in the fall of 2017 to build its capacity and bench strength as a Person- Centered Organization (PCO). This strategy originated within Anthem's national Specialized Programs and Populations team that is comprised of subject matter experts in LTSS and IDD from across the country, including former state developmental disability directors, state agency leaders, service providers, HCBS waiver administrators and disability advocates. In developing care management strategies for Anthem's specialty programs and collaborating with Anthem's Disability Policy Engagement leaders, this team recognized the need to embed Person Centered Thinking© (PCT) throughout program elements across populations and products. Anthem engaged with a leading organization in an agreement that spanned several years to develop a comprehensive program that incorporates the nationally recognized foundational concepts and approaches of the Learning Community for Person Centered Practices. This model goes beyond person centered planning; it facilitates an approach that is responsive and meaningful to each person to improve health, well-being, and the attainment of personal goals.

PCT involves changing perspectives from solely caring for people to working in partnership, through supporting opportunities for people to establish their own goals and actively participate in making decisions that impact their overall health and quality of life. Each person, and often their loved ones, determine what is most important to them for their happiness, health, and safety. Being a PCO means continuously learning and striking a balance between these two goals while aligning priorities and resources to achieve desired, optimal outcomes.

Anthem has worked collaboratively with Support Development Associates (SDA) to establish internal training programs to certify health plan associates and business leaders as PCT trainers and coaches over the last several years. The credentialing process, recognized by the International Learning Community for Person Centered Practices (ILCPCP), must be completed under the instruction of an approved mentor. Trainers and coaches supported the fidelity of PCT skill practices in the day-to-day work of our associates. Additionally, SDA provides technical assistance and works in collaboration with Anthem's key leaders and managers on how to infuse person centered practices into materials, policies and processes to create a learning culture that drives a successful PCO.

This approach is multi-faceted. Anthem initially built internal capacity through certified trainers and coaches as well as ambassadors at all levels of the organization who attended the two-day PCT training and are committed to Anthem's Community of Practice. As of July 2020, Anthem has 18 certified trainers with over 2,000 associates having completed the two-day training. Anthem is also on track to certify two mentors in 2020 who will support ongoing efforts to train and certify Anthem PCT trainers. Our strategy includes in-person learning, virtual learning, and topical webinars as well as ongoing review of our documents, policies and procedures with SDA as Anthem scales the person-centered practice.

Over the last 2 years, Anthem received successful feedback from our annual member and provider HCBS surveys as a direct result of this initiative. Member satisfaction with their service coordinator is over 85% and provider satisfaction with Anthem is up 4% from the prior year to 74%. In addition, 87.8% of our LTSS members report that they feel more comfortable managing their care since becoming Anthem members. In addition, our Anthem LTSS health plans are obtaining LTSS Distinction status from NCQA in Tennessee, New Jersey and Texas, with two additional plans under review for 2020.

BlueCare Tennessee

BlueCare Tennessee (BlueCare), BlueCross BlueShield of Tennessee's (BCBST) Medicaid subsidiary has participated in Tennessee's Medicaid program, TennCare, for more than 25 years. Over the years, BlueCare has seen many changes to TennCare and most recently added the Employment and Community First (ECF) CHOICES program to their Medicaid contract. TennCare developed

the CHOICES program for individuals over the age of 65 and individuals living with disabilities. In 2016, TennCare took the next step by creating ECF CHOICES, a program designed to help individuals with intellectual and developmental disabilities (I/DD) develop employment skills and find meaningful, competitive employment opportunities.

When an individual is eligible for ECF CHOICES, the BlueCare support coordinator meets with the member to create a person-centered support plan (PCSP) within 10 days of enrollment in BlueCare. The person-centered support plan establishes the member's physical health, behavioral health and social supports needs as well as the member's interests and personal goals. When a member expresses interest in finding a job, the member and the support coordinator work together to identify the employment benefits that will lead to successfully achieving the member's goals. The support coordinator works with the member to explore interests and what sort of job opportunities align with those interests. Once some options are enumerated, BlueCare secures a provider who works with the member to find appropriate job opportunities and identify any job training or vocational rehabilitation services that may be necessary before starting work. When a member successfully starts a job that is aligned with his/her interests, it is with the support of the employment specialist and on-the-job support from a job coach, peer support or direct service professional who can help the member successfully move to and maintain full employment.

BlueCare has experienced great success with their employment program. The national average for employment among the I/DD population is around 13%, and in Tennessee the average is 18%. Within BlueCare, nearly 27% of eligible members are working in a variety of settings from retail to school districts to public utilities. BlueCare excels for a few reasons. The first is that BlueCare holds an expectation that all members should work, with or without a disability. The second is that BlueCare strongly believes that every member is capable of integrated, competitive employment with the correct placement, and supports if needed. BlueCare invests heavily across the state in helping providers shift the paradigm to these values, along with fully member-centered practices. This is accomplished by offering in-person regional and provider specific trainings by the employment specialist, which can be modified to meet the specific needs of the participants. The final key to BlueCare's success is the employment specialist, who has a background in employment supports for the I/DD population and works with employers to break down barriers to show how a person with I/DD can be a

wonderful addition to their organization. The employment specialist remains close to employed members, helping them realize their goals and offering assistance when hurdles come up. For one member who had to relocate after his mother passed away, BlueCare supported the member's move, the journey through grief, and finding a new fulfilling job opportunity in his new town. BlueCare and the support coordinator helped another member realize his goals of getting a promotion at work, learning how to drive, and live on his own. [Click to hear Ryan talk about his incredible journey.](#)

The future is bright for Tennesseans living with I/DD. In addition to its commitment to the growing ECF CHOICES program, BCBST has signed on to serve as a partner to individuals with I/DD by becoming a host company for Project SEARCH. Project SEARCH offers internship opportunities that allow students with I/DD in their last year of high school to gain real-world experience and build valuable skills with an eye to finding job opportunities that align with a student's interests. The students spend a year going to school part time and interning part time in different areas of the host company. In its first year as a corporate business partner, BCBST enjoyed a pool of 6 interns who rotated through various departments every 9 weeks. At the end of the year-long internship, BCBST hired one of the graduates into a full-time position. In its second year, the program grew to 10 interns, two of whom have since been hired at BCBST.

Centene

In 2012, Centene Corporation developed the Centene National Disability Advisory Council (CNDAC). CNDAC members include leaders from national disability organizations representing and serving people with disabilities of all ages, including people who are blind or visually impaired, people who are deaf or hard of hearing, people with physical disabilities, people with intellectual disabilities, developmental disabilities and people with multiple disabilities. The Council meets quarterly with Centene's CEO and provides advice to senior executive teams at Centene about the development and implementation of Centene's diversity and inclusion initiatives for members and employees with disabilities. In addition to the CNDAC, Centene has consumer-led Member Advisory Committees in all 13 LTSS states. The state-focused committees provide state-specific guidance designed to help Centene develop actionable solutions that are appropriate at the local level, and are responsive to the needs, preferences, and values of plan members.

In 2017, the CNDAC recommended that Centene launch a Provider Accessibility Initiative (PAI) to increase disability access in Centene's provider offices. The goal of the PAI is

to provide equal access to quality health care and services that are physically and programmatically accessible for members with disabilities and their companions with disabilities by increasing the percentage of Centene providers that meet minimum federal and state disability access standards by:

1. Improving the accuracy, completeness, and transparency of provider disability access data in provider directories by:

   a. Asking all providers to self-report standardized disability access data; and
   b. Verifying the accuracy of that self-reported data through on-site Accessibility Site Reviews (ASR) conducted by local Centers for Independent Living (CIL).

2. Partnering with the National Council on Independent Living (NCIL) to offer Centene providers competitive access to a national Barrier Removal Fund (BRF) that includes:

   a. Funding to remediate priority disability access barriers; and
   b. Technical assistance from the NCIL, local CILs, and Centene's local health plans.

Since 2018, the Centene PAI has received 379 BRF applications from providers in Illinois, Texas, Ohio, Kansas, Florida, New Mexico, California, Indiana, and Pennsylvania. In the same time period, CIL onsite ASRs of providers have been conducted in over 2,600 offices. Centene has provided over 100 grants to doctors across the country to make disability access improvements. Funds provided through the PAI have been used to purchase accessible medical/diagnostic equipment, such as accessible exam tables/chairs, Hoyer lifts, and accessible weight scales. Funds have also been used to renovate parking lots, install automatic door openers, improve restrooms, and build or repair ramps. Providers have made interior improvements, such as widening doorways and installation of vinyl flooring, and purchased programmatic accessibility items, such as noise cancelling headphones, assistive listening devices, weighted blankets and stuffed animals, circadian lighting, and sound proofing walls. In 2020 as part of the PAI, NCIL and Centene developed a series of short videos and tip sheets for providers with timely recommendations from experts with disabilities on how to deliver disability-competent care during the COVID-19 epidemic.

Centene remains committed to the PAI and will continue to award disability access grants to providers through 2024. Efforts are also underway to study the impact of the PAI on providers and members. What has made the PAI successful is the increased access to care, not only for Centene's members with disabilities, but for the community as a whole. This initiative reflects Centene's responsibility as a provider of healthcare services to the populations most in need, and the incredible change that can occur when health plans partner with, and listen to the people they serve through national and local advisory councils. Each component of the PAI, whether removing physical barriers, assessing physical structures, providing programmatic improvements, or updating disability access information in provider directories, demonstrates that commitment.

HCSC

In Illinois, the transition to managed long term services and supports has taken a varied approach. Illinois initially began moving Medicaid LTSS-receiving populations into managed care starting in 2013. The state then received approval to jointly implement the Medicare-Medicaid Alignment Initiative (MMAI) in 2013. The project began providing coordinated care to Medicare-Medicaid enrollees in the Chicagoland area and Central Illinois beginning in March of 2014. With the start of the MMAI, long term services and supports for dual eligible members were also delivered through managed care. Blue Cross and Blue Shield of Illinois (BCBSIL) recognized a need to ensure prompt and appropriate delivery of service to members at the same time as maintaining a robust provider network and developed the LTSS Support Center. In a state with a relatively young MLTSS program, the Support Center works to smoothly operationalize all MLTSS benefits for members and providers while adhering to the requirements included in BCBSIL's contract with the state.

The BCBSIL LTSS Support Center was started on January 1, 2018 in response to the many administrative and operational responsibilities required to establish and maintain a successful LTSS program within the managed care environment. Given the level of LTSS utilization validation monitoring, provider communication and member access to timely care, this team works behind the scenes on requirements allowing the field care coordinators to fully focus on member care needs through maximizing clinical expertise. As an example, through the implementation of the service validation process, BCBSIL has demonstrated improvement of over 35% from the 2018 baseline performance of services prescribed to actual services rendered.

The LTSS Support Center is comprised of twenty-five non-clinical roles providing operational support to 32,000 members in home and community-based services and long term care (LTC) to meet LTSS regulatory requirements and member needs, including critical actions with prescribed timelines. This team conducts initial member outreach and engagement to welcome members to BCBSIL, review

benefits, validate HCBS services and satisfaction, and conduct initial health risk screenings, when needed. On an ongoing basis they support HCBS utilization management functions, investigate and resolve eligibility discrepancies, perform ongoing HCBS service validation with members and providers, and provide other operational functions.

The LTSS Support Center has proven very successful since its implementation. The team has increased email communications, including correspondence with other MCOs, providers, and state agencies, to a total of approximately 4,500 emails each month. The team handles approximately 500 calls per month from members and providers. Enrollees have maintained continuity of care thanks to 15,000 HCBS authorizations that have been generated or updated, 2,400 successful transitions of care, and 5,000 claims validations. In total, the BCBSIL LTSS Support Center has allowed providers and patients to experience a streamlined approached to MLTSS that ensures prompt care delivery while adhering to state contracting requirements.

Conclusion

Medicaid is the nation's essential safety net, taking care of Americans when they need it. Providing that care helps enrollees with functional limitations and chronic illnesses manage their day-to-day lives, preserving their dignity. From bathing, to meal prep, to medication assistance, LTSS programs are lifesaving and life-sustaining.

The programs have made great strides over the last 20 years, and as managed care organizations increasingly take over, continued advancements are guaranteed. In 2004 only 8 states contracted with Medicaid MCOs for LTSS. That number is now up to 24. Unlike traditional Medicaid, Medicaid MCOs ensure a streamlined, patient-centered approach to care. Medicaid MCOs provide LTSS to more than 1.7 million Americans, helping them maintain their independence and quality of life and acting as responsible stewards of taxpayer dollars.