National MLTSS Health Plan Association

Integrating IHSS into Managed Care - Considerations for California Health Plans

The Value of MLTSS

1. **Long-Term Services and Supports (LTSS)**
   LTSS refers to a broad range of day-to-day services and supports needed by people with long-term conditions, disabilities, or frailty. These services allow people to live safely and independently and can be delivered in institutional or home and community-based settings. Medicaid is the largest payer for LTSS in the United States, providing LTSS for almost 10 million Americans.[1] National Medicaid expenditures for LTSS were over $228 billion in 2023[2] - accounting for almost one-third of national Medicaid spending.[3]

2. **Managed Long-Term Services and Supports (MLTSS)**
   States are increasingly moving towards managed care models for their LTSS programs, known as MLTSS; today MLTSS programs are active in about half of US states. In MLTSS programs, states pay managed care organizations (MCOs) a capitated per-member per-month (PMPM) payment to provide LTSS, often along with acute care and other Medicaid benefits, depending on the state's program design. In states with comprehensive MLTSS programs, the MCO becomes the single point of accountability for their members' medical and LTSS needs. States can choose to implement MLTSS programs under a number of Medicaid authorities, including 1115 demonstrations, 1915(b) waivers, and/or 1915(c) or 1915(i) authorities.

3. **The Value of MLTSS**
   States choose to move to MLTSS because it offers more comprehensive care coordination, greater oversight and accountability, higher member satisfaction, and a greater ability to improve outcomes and the quality of life for LTSS beneficiaries. Care coordination is a central mechanism through which MLTSS improves both member outcomes and state fiscal sustainability. A study of Minnesota's MLTSS found that enrollees were 48% less likely to have a hospital stay and 6% less likely to visit an emergency department compared to similar individuals not in the integrated program.[4] In Kansas, the KanCare MLTSS program reported an 80% increase

[1] Trends in Users and Expenditures for Home and Community-Based Services as a Share of Total Medicaid Long-Term Services and Supports Users and Expenditures, 2023 | CMS
[2] Trends in Users and Expenditures for Home and Community-Based Services as a Share of Total Medicaid Long-Term Services and Supports Users and Expenditures, 2023 | CMS
[3] Medicaid Long-Term Services and Supports Data | University of Pennsylvania
[4] Minnesota Managed Care Longitudinal Data Analysis | Department of Health and Human Services

in primary care visits, a 29% decrease in costly hospital stays, and a 7% reduction in emergency department use after implementation.[5]

Better coordinated care as a result of MLTSS implementation can also have a positive impact on state budgets. Florida estimated that MLTSS-facilitated transitions from nursing facilities to community-based care avoided an estimated $284 million in Medicaid LTSS costs in 2014–2015 and $432 million in 2015–2016, while the state's per-member cost dropped 10% compared to the prior fee-for-service system.[6] Additionally, MLTSS has been shown to add value to state programs through rebalancing Medicaid LTSS spending from institutional to home and community-based care, reducing waiver waiting lists and increasing access to services, and providing cost predictability and stability for states.[7] These findings reflect a consistent pattern: by assigning dedicated care coordinators who bridge medical, social, and LTSS needs, MLTSS programs reduce high-cost acute utilization while enabling members to live in lower-cost, preferred community settings.

The California Context: IHSS Carve Out Creates Inefficiencies

1. **Current IHSS Operations in California**

   In-Home Supportive Services (IHSS) provide in-home services (as an alternative to institutional care) for eligible individuals in California who are aged, blind, or have a disability. Almost 900,000 Californians are projected to receive these essential services in fiscal year 2026-2027.[8]

   Currently, IHSS operates outside of the state Medicaid agency. Instead, IHSS are administered by the California Department of Social Services (CDSS), County Social Service Agencies, and county public authorities, with the non-federal costs of the program split between the state and individual counties. IHSS also operates outside of the authority of MLTSS plans operating in the state, leaving plans without responsibility for IHSS service authorization, care planning integration, or provider relationships.

   Today, each of California's 58 counties conducts their own IHSS eligibility assessments and approvals, each with their own standards, authorization practices and data collection procedures that are not consistent across counties. In parallel, MLTSS plans operating in the state are responsible for coordinating care for their members, many of whom also receive IHSS. This fragmented system creates duplicative oversight systems for individuals' care, limits data

[5] Demonstrating the Value of Medicaid MLTSS Programs (2017) | Center for Healthcare Strategies
[6] Leveraging Opportunities in Medicaid Managed Long-Term Services and Supports (MLTSS) | Institute for Medicaid Innovation
[7] Demonstrating the Value of Medicaid MLTSS Programs (2021) | ADvancing States
[8] Medi-Cal Bold Idea — In-Home Supportive Services Integration into Managed Care | California Healthcare Foundation

sharing, and prevents effective utilization of IHSS to prevent or delay institutional care. Because of the lack of transparency into IHSS service authorization and delivery, managed care plans may authorize home health services or durable medical equipment (DME) that are duplicative with the IHSS an individual is receiving – or should be receiving. This fragmentation is even more pronounced for dually eligible Californians, who must navigate different systems to access IHSS, services through their Medicaid managed care plan, and their Medicare services.

2. **How Integration Could Improve the System**

Integrating IHSS into California's MLTSS program could rectify many of the inefficiencies caused by the current system and provide aged, blind, and disabled Californians with better and more cost-effective care. By carving IHSS into managed care, MLTSS plans would have oversight into IHSS authorization, utilization, and spending. This visibility would allow plans to identify and eliminate redundant services across IHSS and plan-covered benefits, as well as to ensure that individuals are receiving the services they need. MLTSS plan care managers would be able to coordinate care across the full spectrum of an individual's care, including medical, behavioral health, IHSS, and other covered benefits.

Integrating IHSS into California's MLTSS program would also help to align the state with CMS' vision for LTSS. Recent updates to the LTSS Quality Measure Set emphasize the importance of comprehensive assessments and person-centered planning processes, as well as reassessments during care transitions.[9] California's carve-out of IHSS make performing these essential care management functions more difficult and ultimately take California further from the unified and coordinated LTSS programs CMS envisions.

Ultimately, with IHSS carved into MLTSS, individuals with LTSS needs in California would receive more wholistic, data-driven, and coordinated care, with MLTSS health plans accountable for the full spectrum of Medicaid services delivered to their members.

State Case Studies

1. **New Jersey**

On July 1st, 2014, the state launched their MLTSS program, consolidating four separate HCBS waiver programs - Global Options for LTC; AIDS Community Care Alternatives Program; Community Resources for People with Disabilities; and TBI Waiver - into one managed care structure. This consolidation eliminated the fragmented, siloed delivery system that previously required members to navigate multiple programs, and extended access by eliminating waiting lists entirely: prior to MLTSS, the underlying waiver programs operated with enrollment caps;

[9] Long-Term Services and Supports (LTSS) Quality Measures Technical Specifications and Resource Manual | Center for Medicare & Medicaid Services

under MLTSS, any individual who meets functional and financial eligibility criteria receives services immediately, with no waitlist.

Critically, New Jersey's MLTSS model carves in behavioral health alongside acute care and LTSS under a single capitated MCO contract, enabling whole-person care coordination for the first time. Each MLTSS member is assigned a dedicated care manager responsible for coordinating physical health, behavioral health, and long-term care which eliminates the handoffs and gaps that characterized the prior fragmented system.

The results have been significant. When MLTSS launched in July 2014, just 28.9% of New Jersey's Medicaid long-term care enrollees were receiving services in home and community-based settings. By June 2017, that figure had risen to nearly 45%. Over that same period, New Jersey's nursing facility population decreased by approximately 1,000 individuals, reflecting the program's success in diverting members to less restrictive, lower-cost community settings.[10,11]

2. **Arizona**

Arizona has the longest-running MLTSS program in the country. When CMS approved its Section 1115 demonstration waiver in 1989, Arizona became the first state to deliver long-term care through a fully capitated managed care model. Unlike most states that built HCBS access through separate waiver programs with enrollment caps and waiting lists, Arizona's ALTCS program was designed from the outset as an entitlement: any individual who meets functional and financial eligibility criteria is enrolled immediately, with no waitlist.

In Arizona's ALTCS program - acute care, behavioral health, long-term care, and case management are all delivered through a single capitated MCO contract. This means ALTCS members have a unified care team responsible for coordinating across every dimension of their care which eliminates the fragmentation that characterize states where HCBS, medical, and behavioral health services are siloed across separate delivery systems.

Arizona has seen positive outcomes from this integrated, entitlement-based model. In 2021, Arizona reported that 86% of MLTSS consumers are in community settings and 68% are living in their own homes which is a rebalancing outcome unmatched by virtually any other state.[12] As Arizona's own program officials have noted, MLTSS has been "an important tool to support rebalancing of institutional and HCBS spending, and, in turn, provide greater access to HCBS options."[13]

[10] New Jersey Comprehensive Waiver Demonstration Section 1115 Annual Report | State of New Jersey
[11] Demonstrating the Value of Medicaid MLTSS Programs (2017) | Center for Healthcare Strategies
[12] Demonstrating the Value of Medicaid MLTSS Programs (2021) | ADvancing States
[13] Demonstrating the Value of Medicaid MLTSS Programs (2021) | ADvancing States

3. **Minnesota**

   Minnesota operates one of the most mature MLTSS programs in the country – the state moved to MLTSS in 1997 and expanded to include HCBS in 2005.

   Minnesota thoughtfully designed their Minnesota Senior Health Options (MSHO) to eliminate the fragmentation that characterizes most states' approach to LTSS. The goals of the project included reducing administrative duplication and complexity; creating a seamless point of access for beneficiaries and participating providers; and creating a single point of accountability for total costs and outcomes of care for the population served.[14] To achieve these goals, the state made the decision to include all Medicaid state plan and HCBS waiver services within the MSHO program, and later the MSC+ program also operating in the state.

   Minnesota's capitation rate structure reinforces this integration with direct financial incentives. In Minnesota, all MLTSS plans receive a "basic care" rate for members who reside in institutional settings, and this rate is lower than that for individuals who reside in the community. This structure provides a strong incentive for MLTSS health plans to prevent individuals from moving to nursing homes and to invest in initiatives to assist individuals in transitioning from a nursing home to living in the community.[15]

   Ultimately, Minnesota's program has shown exceptional results – the state has been consistently ranked as the #1 state in the nation for their LTSS program by the AARP LTSS Scorecard,[16] and over 90% of LTSS recipients in the state utilize HCBS.[17]

4. **Tennessee**

   The Tennessee CHOICES program began in 2010; prior to Tennessee CHOICES, LTSS were carved out of the states Medicaid managed care program and were delivered via FFS. Under Tennessee CHOICES, MLTSS plans are responsible for coordinating and delivering an individual's medical, behavioral health, and LTSS care needs, including HCBS, creating a more integrated model of care.

   Under the Tennessee CHOICES program, care management responsibilities moved from independent case management agencies to be the responsibility of the managed care

[14] How Have Long-Term Services and Supports Providers Fared in the Transition to Medicaid Managed Care | U.S. Department of Health and Human Services
[15] Community Living Policy Center | Brandeis University
[16] LTSS State Scorecard: Minnesota | AARP
[17] Long-term services and supports (LTSS) demographic dashboard | Minnesota Department of Human Services

organization, further supporting the MLTSS plans' ability to manage all aspects of their members' care.

The impacts of Tennessee's MLTSS model are seen in the fiscal and rebalancing results since implementation. In 2009, before the program began, 84% of Tennessee's LTSS enrollees were in nursing facility settings and just 16% received HCBS. By April 2021, the split had shifted to 53% facility-based and 47% HCBS.[18] The fiscal impact of this change is seen in the cost differential between institutional and home-based care. TennCare spends an average of $60,000 per year per member in nursing facility care, compared to $17,000 per year for the same individual receiving HCBS, and just $8,000 annually for individuals at risk of needing nursing home care who can be stabilized in the community through HCBS.[19]

Where California Can Go From Here

The experiences of New Jersey, Arizona, Minnesota, and Tennessee show that when states move LTSS, including HCBS, into managed care, the results are better outcomes for beneficiaries, more efficient use of Medicaid dollars, and a meaningful shift away from costly institutional care. As California considers carving IHSS and other LTSS into its MLTSS framework, these states' experiences can inform key design choices, such as:

- **A single care coordinator** responsible for both LTSS (including IHSS) and medical and behavioral health needs.
- **A capitation rate structure** that creates meaningful financial incentives for plans to invest in community-based alternatives to institutional care.
- **Strong consumer protections and participant direction**, including preserving and expanding self-direction options for IHSS recipients.
- **Robust state oversight and MCO accountability**, including quality performance requirements tied specifically to LTSS outcomes.
- **Entitlement design** that eliminates waitlists and ensures eligible members can access IHSS and other HCBS without delay.

States that have moved their most complex, highest-need populations into well-designed MLTSS programs have consistently achieved better health outcomes, higher member satisfaction, reduced institutional utilization, and more sustainable Medicaid expenditures. California has the opportunity to build on this evidence to create a model of whole-person, community-centered care.

[18] Tennessee's Strong MLTSS Program | The VBP Blog
[19] What Are TennCare Long-Term Services and Supports? | The Sycamore Institute