National
MLTSS
Health Plan Association

July 2026: MLTSS Association Key Issue Areas and Recent Publications

Introduction

The National MLTSS Health Plan Association (MLTSS Association) is the leading organization in Washington, DC promoting Medicaid managed long-term services and supports (MLTSS) and integrated care. The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid. Our members assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible.

Our members also offer integrated care options, including Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs). We cover a significant number of enrollees in MLTSS plans and integrated plans, including large national plans and regional and community-based plans.

Below, we outline some of the MLTSS Association's key areas of interest as Congress considers the future of long-term care in the United States.

LTSS Workforce

LTSS encompass a broad range of medical and non-medical services and supports that assist individuals with chronic illnesses, disabilities, or functional limitations with daily activities and ongoing health-related needs over an extended period. As the US population ages, the need for LTSS is growing more quickly than the current workforce can support. It is estimated that the number of adults age 85 and older will triple by 2060, while the population of adults age 18 – 64 will remain relatively stable.[1] Addressing the LTSS workforce shortage will require policy changes that strengthen the existing workforce and embrace the use of enabling technology to support hands-on care.

Direct Care Workforce: The direct care workforce includes more than 5.4 million home care workers, personal care aides, nursing assistants, and other professionals who provide essential day-to-day support to older adults and people with disabilities. These workers help individuals live safely and with dignity, yet low wages, limited benefits, demanding working conditions, and few opportunities for advancement contribute to persistent shortages and high turnover. Developed through a 2023 MLTSS Association work group, our report provides recommendations for policymakers to address the direct care workforce shortage, including specific recommendations for Congress and the federal government.

Enabling Technology: Enabling technology includes high- and low-tech tools that help older adults and people with disabilities live more safely and independently at home and in their communities. These range from simple devices, such as medication organizers and adapted kitchen equipment, to more

[1] https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2025/

advanced technologies like emergency response devices and smart-home features. When used effectively, these tools can reduce safety risks, ease daily tasks, support caregivers, and help delay the need for more intensive services. The MLTSS Association led a workgroup comprised of our health plans members as well as representatives from companies on the cutting edge of these technologies to develop a report that includes examples of successful deployments of enabling technology in MLTSS, best practices from states and LTSS health plans, and recommendations for policymakers to expand and support the use of this technology in LTSS.

Integrated Care

Dually eligible individuals qualify for both Medicare and Medicaid based on their age, disability status, and income/assets. Of these individuals, only about 10 percent are enrolled in fully integrated managed care, which coordinates benefits and services across the two programs. The remaining dually eligible individuals must navigate a complex system of overlapping coverage and disconnected services. Integrated care seeks to reduce this fragmentation by coordinating benefits and services across both programs and creating a more connected, person-centered experience.

Dual Eligible Special Needs Plans, or D-SNPs, are Medicare Advantage plans specifically designed for people enrolled in both Medicare and Medicaid. The resources below highlight the Association's work to strengthen the D-SNP framework and expand access to coordinated, person-centered care.

Integrated Care Policy Proposals: The Association's policy proposals identify statutory and regulatory changes that Congress and federal agencies could make to strengthen D-SNPs and improve coordination between Medicare and Medicaid. These proposals draw on the experience of D-SNPs and MLTSS plans that have developed specialized approaches to serving people with complex needs.

Auto-Enrollment: One of our policy proposals to advance integrated care is focused on auto-enrollment, which allows eligible individuals to be enrolled in an integrated coverage option automatically rather than requiring them to complete a separate enrollment process on their own. This brief reviews the history of auto-enrollment and lessons learned from Medicare-Medicaid Plans (MMPs), a federal demonstration that tested new approaches to coordinating Medicare and Medicaid benefits. The Association's letter to the administration explains how carefully designed expansions of auto-enrollment could make it easier for eligible individuals to access integrated, person-centered care.

Comparison of Integrated Care Options: Several models are used to coordinate Medicare and Medicaid benefits, but they differ in how coverage is administered, how plans and states work together, and how accountability is structured. This educational resource compares the major integrated care models across nine key domains, helping readers understand their structures, strengths, and limitations. It also explains why the Association views D-SNPs as the most scalable pathway for expanding integrated care nationwide.

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MLTSS Rate Setting

Rate setting is the process by which states determine the capitation payments (a fixed monthly per-member per-month amount) that MCOs receive to cover the cost of care for their MLTSS members. Actuarily sound rates are critical to both plan sustainability and member access to services. In May 2026, the MLTSS Association sent a letter to CMS that outlines key themes and recommendations to improve the MLTSS rate-setting process.

Value-Based Contracting

Value-based contracting (VBC) ties payment to quality and outcomes rather than the volume of services and has the potential to reshape how LTSS is delivered and paid for. VBC arrangements between MCOs and LTSS providers can improve care coordination, incentivize better outcomes, and reduce unnecessary utilization but, adoption in MLTSS has lagged behind other parts of Medicaid. This report from the Association's VBC Workgroup offers recommendations to accelerate the adoption of VBC in MLTSS.

Program Integrity

Home and Community-Based Services (HCBS) are Medicaid-funded services, such as personal care, respite care, and home health aides, that allow people to receive long-term care in their own home or community instead of in a nursing facility or other institution. Program integrity efforts are designed to ensure Medicaid HCBS dollars are spent appropriately, protecting both taxpayer resources and the beneficiaries who rely on these services from fraud, waste, and abuse.

Role of Medicaid Managed Care in Safeguarding HCBS: Medicaid MCOs invest substantially in detecting and preventing fraud, waste, and abuse, using tools like credentialing, authorization guardrails, and Electronic Visit Verification. This brief, developed in collaboration with Medicaid Health Plans of America (MHPA), highlights the essential role Medicaid managed care plays in ensuring HCBS are delivered appropriately to the right people, in the right settings, and at the right time.

Recommendations to Support Program Integrity in Medicaid HCBS: Structural barriers, including inconsistent state policies, limited data-sharing authority, and gaps in federal guidance, constrain how much plans can accomplish on their own to combat fraud, waste, and abuse. This letter to CMS outlines recommendations to strengthen program integrity in Medicaid HCBS.