



Who Enrolls in Medicaid Managed Care Programs that Cover Long-Term Services and Supports?

Implications of Enrollee Diversity for a National Cross-State Evaluation

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Introduction

As of July 2016, 23 states were providing long-term services and supports (LTSS) to some Medicaid beneficiaries through managed care delivery systems. Such efforts are intended to promote greater use of person-centered home and community-based services (HCBS), rather than institutional care, and to improve quality and control costs.

Broadly defined, managed LTSS (MLTSS) refers to arrangements between state Medicaid agencies and contracted managed care plans in which the state pays the plans a fixed per member per month (PMPM) capitated rate to deliver all covered benefits to each enrollee. These benefits can include primary care, acute care, and behavioral health services in addition to LTSS. Contracts between states and managed care plans establish the access, quality, and other performance standards for the health plans. To give the plans a financial incentive to reduce the use of higher cost institutional care and keep members living independently in the community, most states set the capitation rate at a level that blends the expected costs of institutional care and lower cost HCBS, which makes it more cost-effective to provide HCBS rather than institutional care.

State MLTSS programs are diverse in many ways—from the types of beneficiaries enrolled to the range of benefits

covered, the kinds of managed care plans that participate, and the ways in which capitation rates are set. The programs also use different quality and performance measures, may be implemented either statewide or only in certain areas of the state, and operate under different federal authorities.¹

This issue brief supports the national evaluation of Medicaid Section 1115 demonstrations (see box at the end) by describing the diversity of the beneficiary groups enrolled in 35 MLTSS programs operating in 23 states as of July 2016. Because beneficiary diversity can affect a range of health, service use, cost, and quality outcomes, the national cross-state evaluation will need to account for this variation when comparing the performance of MLTSS to fee-for-service (FFS) delivery systems. As already noted, state MLTSS programs also vary in other ways—such as benefit packages, types of participating health plans, rate-setting methods, and approaches to integrating Medicare and Medicaid benefits. Such differences in program design and operation may also affect key outcomes, but are not discussed in this brief.

Why diversity among MLTSS enrollees matters.

Evaluators may seek to compare the effects of various state MLTSS programs on a number of important outcomes, such as changes in the use of HCBS, access to and quality of services, cost, and enrollees' experiences with care and quality of life. To ensure their comparisons are fair, evaluators must account for

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

For the past two decades, states have increasingly turned to private managed care plans to deliver long-term services and supports (LTSS) to Medicaid beneficiaries with disabilities who need assistance with activities of daily living. Section 1115 is one of several federal authorities that states can use to operate managed long-term services and supports (MLTSS) programs. In contrast to fee-for-service, which pays providers for each service they deliver, states that operate MLTSS programs pay managed care plans a fixed per-member-per-month (PMPM) amount to provide all covered services for enrollees. The capitated PMPM payment arrangement – combined with contract requirements to protect enrollees – can create an incentive for the plans to improve care coordination, reduce unnecessary services, and increase the availability of less costly home and community-based services as an alternative to institutional care.

various differences between the features of the programs. But the diversity of the people enrolled in state MLTSS programs is so great—and the evolution of some states’ program design so swift—that this poses enormous challenges to a rigorous national evaluation of these programs.

For example, consider a state MLTSS program that enrolls only adults under age 65 with physical disabilities who are living in the community, covers particular benefits, and sets capitation rates in a certain way. Such a program would not necessarily have the same results as one that enrolls adults age 65 and older and has a different mix of benefits and rate-setting policies. And even if two programs cover people in the same age group with similar types of disabilities, the average age and level of disability in one program may be different from that of another.

To make comparisons as fair as possible, evaluators seek to compare beneficiaries with similar characteristics in programs that have mostly similar features. In such a comparison, differences

in outcomes can be attributed to any program features that are different. In the national cross-state evaluation, researchers will set up these comparisons by matching the characteristics of MLTSS enrollees (the treatment group) to those of FFS beneficiaries (the control group)—or by adjusting for known differences between the two groups using statistical techniques.

Organization of this brief. This brief describes the differences in state MLTSS eligibility policies related to the characteristics of beneficiaries, which are important to consider when evaluating program outcomes like service use and spending patterns. These eligibility policies are related to (1) age and type of disability; (2) dual-enrollment status; (3) level of care needed; (4) mandatory, passive, or voluntary enrollment; and (5) living situation at the time of MLTSS enrollment (Table 1). Each section briefly discusses how differences in the populations enrolled could affect LTSS use, quality, and cost. The brief concludes with a discussion of how the national cross-state evaluation will account for these differences.

Table 1. Populations enrolled in state MLTSS programs, July 2016

State	Program name	Start date	Enrollees by age and type of disability				Enrollees by Medicare status	Type of Medicaid enrollment			Enrollees’ level of LTSS need		
			Children with disabilities	Adults w/physical disabilities	Adults with I/DD	Older adults 65+	Medicare-Medicaid Enrollees	Mandatory	Passive	Voluntary	Institutional LOC	LTSS less than institutional LOC	No minimum need for LTSS
AZ	Arizona Long Term Care System (ALTCS)	1/1/1989	x	x	x	x	x	x			x		
CA ^a	Cal Medi-Connect	4/1/2014		x ^b		x ^b	x		x		x	x	x
CA	Managed Medi-Cal Long-Term Supports and Services	4/1/2014		x	x ^c	x	x	x			x	x	x
DE	Diamond State Health Plan (DSHP) Plus	4/1/2012	x	x	x	x	x	x			x	x	x
FL	Statewide Medicaid Managed Care Long Term Care Programd	8/1/2013		x		x	x	x			x		
HI	QUEST Expanded Access (QExA), QUEST Integration (QI)	QExA: 2/1/2009 QI: 1/1/2015	x	x	x	x	x	x			x	x	x
IL	Medicaid Integrated Care Program (ICP)	5/1/2011		x	x	x		x			x	x	x
IL ^a	Medicare-Medicaid Alignment Initiative	3/1/2014		x		x	x		x		x	x	x
IA	Iowa Health Link	4/1/2016	x	x	x	x	x	x			x	x	x
KS	KanCare (MLTSS Component)	1/1/2013	x	x	x	x	x	x			x	x	
MA	Senior Care Options (SCO)	3/1/2004				x	x			x	x	x	x
MA ^a	One Care	1/1/2014		x	x		x		x		x	x	x
MI	Medicaid Managed Specialty Support & Services Program	1/1/1998	x ^e		x	x	x	x			x		
MI	MI Choice	10/1/2013		x		x	x	x			x		
MI ^a	MI Health Link	3/1/2015		x	x	x	x		x		x	x	x

(continued)

State	Program name	Start date	Enrollees by age and type of disability				Enrollees by Medicare status	Type of Medicaid enrollment			Enrollees' level of LTSS need		
			Children with disabilities	Adults w/physical disabilities	Adults with I/DD	Older adults 65+		Medicare-Medicaid Enrollees	Mandatory	Passive	Voluntary	Institutional LOC	LTSS less than institutional LOC
MN	Minnesota Senior Health Options (MSHO)	1/1/1997				x	x		x	x	x	x	
MN	Minnesota Senior Care + (MSC+)	1/1/2005				x	x	x		x	x	x	
NC	Mental health, developmental disability (DD), and substance abuse services	1/1/2005	x ^e		x ^f	x ^g	x	x		x			
NJ	NJ MLTSS	7/1/2014		x		x	x	x		x ^h			
NM	Centennial Care ⁱ (MLTSS component)	1/1/2014	x	x	x	x	x	x		x			
NY	Mandatory Managed Long Term Care	1/1/1998		x		x	x	x ^j		x	x		
NY	Medicaid Advantage Plus (MAP)	1/1/2006		x		x	x		x	x			
NY ^a	Fully Integrated Duals Advantage	1/1/2015		x		x	x		x	x			
OH ^a	MyCare	5/1/2014		x	x	x	x	x		x	x	x	
PA	Adult Community Autism Program	1/1/2009			x	x	x		x	x			
RI	Rhody Health Options (MLTSS Component)	11/1/2013		x	x	x	x		x	x			
RI ^a	Integrated Care Initiative, Phase 2	12/1/2015		x	x	x	x		x	x		x	
SC ^a	Healthy Connections Prime	2/1/2015				x	x		x	x		x	
TN	TennCare CHOICES in Long-Term Care	3/1/2010	x ^k	x		x	x	x		x	x		
TN	TennCare Employment and Community First CHOICES	7/1/2016	x		x		x		x	x			
TX	Texas STAR+PLUS	1/1/1998	x ^l	x	x	x	x	x		x	x	x	
TX ^a	Texas Dual Eligibles Integrated Care Demonstration Project	4/1/2015		x	x	x	x		x	x		x	
VA ^a	Commonwealth Coordinated Care	3/1/2014		x	x	x	x		x	x		x	
WI	Family Care	1/1/1999		x	x	x	x	x		x	x		
WI	Family Care Partnership	1/1/1996		x	x	x	x		x	x			

Source: Truven Health Analytics' assessment of 1115 Demonstration Special Terms and Conditions, memoranda of understanding between CMS and FAI demonstration states, and state sources. Some information may be out of date if program changes were not reflected in source materials.

^a Financial Alignment Initiative.

^b Excludes people in the following waivers: Nursing Facility/Acute Hospital, HIV/AIDS, Assisted Living, and In Home Operations.

^c Excludes people living in ICF-I/DD if live in Two Plan/Geographic Managed Care County.

^d An earlier MLTSS program, the Florida Long-Term Care Community Diversion Program, was phased out as the current program was phased in.

^e Children with SED and/or DD.

^f Adults with SMI and/or SUD and/or DD.

^g Older adults with SMI and/or SUD and/or DD.

^h Beneficiaries with long-term nursing home stays as of the start-up date (7/1/14) were exempt from MLTSS, but all new nursing home residents from 7/1/14 forward are included in MLTSS.

ⁱ An earlier MLTSS program, CoLTS, was subsumed into Centennial Care on 1/1/2014.

^j MLTC was voluntary up until 8/31/2012 when the state began a phased, mandatory roll-out program under a section 1115 demonstration.

^k Children in nursing homes only.

^l This group is not mandatory.

CMS = Centers for Medicaid & Medicare Services; DD = developmental disabilities; FAI = Financial Alignment Initiative; ICF-I/DD = institutional care facilities for individuals with developmental disabilities; LOC = level of care; LTSS = long-term services and supports; SED = serious emotional disturbances; SMI = serious mental illness; SUD = substance use disorder.

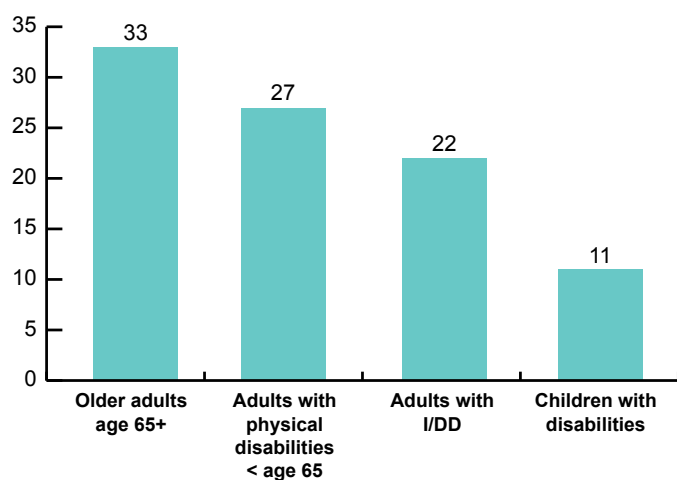
How Do State Enrollment Criteria Differ?

Age and disability of MLTSS enrollees

MLTSS programs typically serve one to four major subpopulations: (1) adults age 65 and older, (2) adults under age 65 with physical disabilities, (3) adults with intellectual or developmental disabilities (I/DD), and (4) children with disabilities. The most common population covered by MLTSS programs is adults age 65 and over (Figure 1). These older adults are covered in all 23 states operating MLTSS programs and in all but 2 of the 35 MLTSS programs. In addition, 27 programs enroll adults with physical disabilities and nearly two-thirds (22 of 35) enroll adults with I/DD—more than twice the number reported in 2012 (Saucier et al. 2012).² This increase reflects states' growing confidence in MLTSS as a model capable of providing appropriate services and adequate protections for this vulnerable group of people.

Of these four subpopulations, children with disabilities are least often included in MLTSS programs (only 11 of 35 programs do so). States may choose to exclude children for several reasons. The first is that this population is small but includes people with very high costs—increasing the financial risk to managed care plans. Another is that children need a wide range of specialists, not all of whom participate in Medicaid managed care networks (Hula et al. 2014). One program (TennCare CHOICES) enrolls children only if they live in nursing facilities.

Figure 1. Number of MLTSS programs enrolling selected population groups (N=35 programs in 23 states)



Though some states have developed specialty MLTSS programs serving single populations, most (31 of 35) enroll more than one population group. Seven enroll all four target groups, 13 enroll three groups, and 11 enroll two groups. They most often cover both older adults and adults with physical disabilities.

When measuring changes in LTSS use and spending patterns, the cross-state evaluators must account for any differences in LTSS use and costs by age and type of disability among people enrolled in MLTSS versus FFS programs.

Because these subpopulations have different LTSS use and spending patterns, the national cross-state evaluation team will need to examine each group separately. For example, in federal fiscal year 2015, national HCBS expenditures were 44 percent of total Medicaid LTSS spending for older adults and adults under age 65 with physical disabilities. But among people with I/DD, HCBS expenditures were 76 percent of total LTSS spending (Eiken et al. 2017).

These percentages varied by state. For instance, in 2012—the year before its MLTSS program began—Kansas was using institutional care more frequently for certain populations than for others. That year, HCBS accounted for only 32 percent of Kansas's LTSS spending for older adults and adults under age 65 with physical disabilities—but HCBS comprised 84 percent of LTSS spending for people with I/DD. The existing balance of spending gave the state's managed care plans more opportunity to shift spending toward HCBS for the older adults and adults with physical disabilities than it did for the people with I/DD. As another example, Delaware began its MLTSS program in 2012 with an even greater reliance on institutional care; in 2011, HCBS accounted for just 17 percent of LTSS spending for older adults and people with physical disabilities, and HCBS accounted for 69 percent among people with I/DD (Eiken et al. 2015). Consequently, when examining change over time in the balance of LTSS expenditures, the national cross-state evaluation team must consider differences in each state's starting point under FFS for each subgroup that later enrolled in MLTSS.

Dual eligibility

As of 2010, the majority of people—68 percent—using Medicaid-funded LTSS were dually enrolled in Medicare and Medicaid (Medicaid and CHIP Payment and Access Commission [MACPAC] 2014), which explains why 34 of 35 MLTSS programs serve dual enrollees.³ Most programs cover dual enrollees who qualify to receive full Medicaid benefits—meaning that Medicaid pays for their Medicare premiums, deductibles, and other cost sharing as well as LTSS and other services not covered by Medicare.⁴

Dually eligible and Medicaid-only beneficiaries differ in the amount of their LTSS funding that goes toward institutional care versus HCBS. For example, in FFS programs in 2012, 21 percent of dual enrollees used Medicaid-covered LTSS for institutional care—compared with only 5 percent of Medicaid-only beneficiaries with disabilities (Medicare Payment Advisory Commission [MedPAC] and MACPAC 2017). Accordingly, a

much bigger portion of total Medicaid LTSS spending went toward institutional care for FFS dual enrollees than for nondual disabled beneficiaries (50 versus 15 percent). To the extent that MLTSS programs are expected to rebalance their ratio of institutional-to-HCBS use and spending, we would expect to see a greater shift toward HCBS for dual than for nondual enrollees who are already using institutional care less intensively.

Even within the dual population, there are major age-related differences in level of disability, living arrangements, and health conditions to consider when comparing outcomes for people in MLTSS programs versus FFS programs. For example, in 2012, more than one-third (36 percent) of dual enrollees age 65 and older had three or more limitations in activities of daily living, compared with one-quarter of those under age 65 (24 percent). Dual-eligible beneficiaries age 65 and older were also more likely than younger people to live in an institution (26 percent versus 12 percent) (MedPAC and MACPAC 2017). And nearly a quarter (23 percent) of dual enrollees over age 65 had Alzheimer’s disease or a related dementia, compared with just 3 percent of those under age 65. On the other hand, mental health conditions such as anxiety disorders, bipolar disorder, depression, and schizophrenia were much more common among under-65 dual enrollees than among older enrollees (MedPAC and MACPAC 2017).

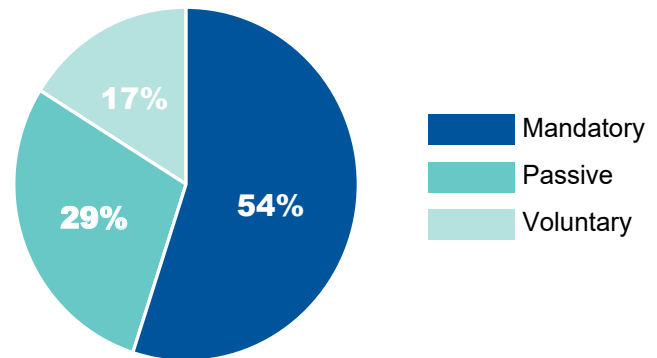
Mandatory, passive, and voluntary enrollment

State MLTSS programs use three types of enrollment policies. They can (1) require eligible people to enroll in managed care (mandatory enrollment), (2) automatically assign them to a managed care plan but allow them to opt out (passive enrollment), or (3) allow people to choose to participate in managed care (voluntary enrollment). These different policies may affect the number of high-need beneficiaries who enroll in an MLTSS program.

The majority of state MLTSS programs—54 percent (19 programs)—mandate enrollment for eligible people (Figure 2). Of the 10 programs (29 percent) that use passive enrollment, 9 are Financial Alignment Initiative (FAI) programs, also known as dual demonstrations, in which both the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies contract with health plans to deliver and integrate all Medicare and Medicaid benefits (Medicare rules prohibit mandatory enrollment). The remaining 6 programs (17 percent) allow people to enroll in MLTSS voluntarily.

Several factors explain states’ preference for mandatory enrollment. First, it ensures that managed care plans have enough enrollees to spread out the financial risk, making their participation in MLTSS more financially viable. Second, mandatory enrollment allows states to better predict the number

Figure 2. Percentage of MLTSS programs by type of enrollment (N=35 programs in 23 states)



of enrollees and the expected use of certain services, letting them set more accurate capitation rates for health plans. Third, this type of enrollment reduces the potential for plans to “cherry-pick”—or induce the enrollment of people with better health and minimal LTSS needs, leaving higher-need populations in FFS. Cherry-picking can occur under voluntary enrollment policies regardless of whether they allow beneficiaries to opt out of or into managed care (Liberky et al. 2014).

Some evidence shows that people who enroll voluntarily are different from those who are required to enroll. For example, Burns (2009) found that adults with disabilities in mandatory enrollment programs were more likely to report fair or poor health compared with similar adults in voluntary enrollment programs; also, those in voluntary or mandatory managed care programs were somewhat healthier than those in FFS programs. If people who choose to enroll in MLTSS programs are healthier or sicker, or different in other ways from those mandated to enroll, they may have different use and cost patterns compared with those in voluntary programs or in FFS.

In voluntary programs, people who choose to enroll in MLTSS may be healthier or sicker, or different in other ways from those mandated to enroll.

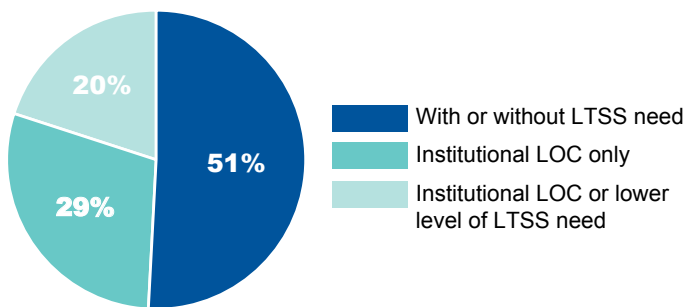
Level of need for LTSS

State MLTSS programs use one of three LTSS eligibility criteria: the enrollee (1) needs an institutional level of care (LOC), (2) needs an institutional LOC or meets a less-stringent LTSS standard, or (3) may or may not need any LTSS (that is, the beneficiary is enrolled based on his or her population group—for example, people age 65 or older—regardless of whether the person needs LTSS). MLTSS programs that use the first criterion enroll people who need help doing a certain number of activities of daily living (the number varies by state) or who have serious health conditions that warrant institutional care. MLTSS programs using the second criterion enroll beneficiaries who

need some LTSS but do not qualify for institutional LOC, as well as those qualifying for institutional LOC. States using these first two criteria employ various instruments to assess a person's ability to do activities of daily living, such as eating, bathing, and toileting, and sometimes *instrumental* activities of daily living, such as housekeeping, using transportation, and handling their finances. Programs using the third criterion enroll people who are either dually eligible or are Medicaid-only beneficiaries, regardless of a demonstrated need for LTSS. This is a very heterogeneous group; some require care in nursing homes, some can live at home or in the community with moderate supports, and some do not need any LTSS.

As shown in Figure 3, 18 of the 35 MLTSS programs (51 percent) enroll people with or without a need for LTSS, whereas 7 programs (20 percent) enroll people who show some need for LTSS. Ten programs (29 percent) limit enrollment to people who have an institutional LOC need—a significant decrease from 2012, when just over half of programs then in operation used this criterion (Saucier et al. 2012). The main driver of this decline was the advent of the FAI demonstrations serving dual enrollees (CMS 2015). Most of these demonstrations include dual enrollees who are admitted based on their eligibility for both Medicare and Medicaid, regardless of whether they need LTSS. Of the 18 MLTSS programs that enroll people without demonstrated LTSS needs, half (9) are FAI demonstrations.

Figure 3. Percentage of MLTSS programs by eligibility criteria related to need for long-term services and supports (N=35 programs in 23 states)



When assessing changes in the use of HCBS and institutional care after states switch from FFS to MLTSS, researchers must account for people's needs for different levels of care. States that set a higher LOC standard for MLTSS enrollees are likely to have people who use institutional services more often or show a higher use of HCBS when they enroll in MLTSS programs, compared with MLTSS enrollees in states with lower or no need for LTSS.

When states switch from FFS to MLTSS, patterns of HCBS use and institutional care may change, or “rebalance.” In measuring this, evaluators must account for the mix of MLTSS enrollees who need different levels of care.

Living arrangements

State MLTSS programs generally require people who become Medicaid eligible while living in the community to enroll in a managed care plan. But institutional residents are not always required to do the same. For example, if people become eligible for Medicaid while in a nursing facility, Tennessee and Hawaii require them to enroll in a managed care plan immediately. If these enrollees then want to return to the community, the plan is responsible for helping them do that. But in Massachusetts and Wisconsin, people in nursing facilities who are already Medicaid eligible—or become eligible during their admission—do not have to enroll in managed care until they return to the community (Lipson and Valenzano 2013). Note that 33 of the 35 MLTSS programs now include people who reside in or are being admitted to nursing facilities.

These types of policies can change over time. For example, MLTSS programs may at first limit enrollment to people living at home or in the community and then phase in enrollment of people in institutions over time. This approach gives managed care plans time to establish transition services or to coordinate with Money Follows the Person programs, which help people move from institutions back to the community. For example, New York enrolled current HCBS users into its mandatory Managed Long-Term Care program in September 2012 but delayed enrolling newly admitted nursing home residents until February 2015. When New Jersey began its MLTSS program in 2014, it enrolled people into managed care plans who had been admitted to nursing facilities since the program's start but excluded those who had been living in nursing homes before then. And the Texas MLTSS program, STAR+PLUS, just began enrolling nursing home residents into managed care plans in 2015, even though the program launched back in 1998.

MLTSS enrollment policies that differ by place of residence also are important for defining subgroups for evaluations. For example, the national cross-state evaluation team may assess inpatient admissions and other service-use patterns separately for people living in nursing homes versus those living at home or in the community at the time of enrollment. This difference is also important when examining rates of transition from institutional to community care or vice versa; states that enroll all residents of institutions into MLTSS programs as soon as the programs start would likely have different transition rates than those phasing these individuals in over time or excluding them altogether.

Implications for the MLTSS Evaluation

To make fair and accurate comparisons between MLTSS and FFS programs and across state MLTSS programs, the national cross-state evaluation team will account for variation in the populations enrolled in each state's MLTSS programs. Major differences include age, type of disability, dual-eligibility status, mandatory versus voluntary enrollment, and level of need for LTSS. The evaluators will also consider whether MLTSS programs integrate Medicare and Medicaid benefits or use passive enrollment for dual enrollees, given that this is likely to affect use of hospital and nursing home care.

By controlling for differences in the characteristics of enrollees, the evaluation team will be better able to determine the effects of MLTSS on access, use, costs, and the quality of LTSS and medical care compared with FFS.

METHODS AND DATA SOURCES

Truven Health Analytics collected information on state MLTSS programs in operation as of July 2016 from publicly available program documents produced by states, researchers, or CMS. Sources included special terms and conditions of the Section 1115 demonstrations, memoranda of understanding between CMS and states, contracts with health plans, and program information that states posted on their websites. The state information sources included reports on enrollment statistics; reports to legislatures; evaluation reports; external quality review reports; and other program information for stakeholders, including frequently asked questions.

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Restricting the national analysis to programs that are similar will make it easier for evaluators to determine the effects of key program differences on LTSS access, use of LTSS, and overall costs.

ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid Section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program and to inform CMS's decisions regarding future Section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four types of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports. This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. These briefs will inform an interim outcomes evaluation report in 2017 and a final evaluation report in 2019.

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Endnotes

¹ Twelve of the 23 states operating MLTSS programs have received federal approval to operate them as Section 1115 demonstrations. This authority allows states to alter eligibility requirements, cover additional benefits, and mandate enrollment of certain population groups—policies not allowed under regular Medicaid rules or 1915(b) managed care and 1915(c) HCBS waivers. Some states use Section 1115 demonstration authority to simplify program administration, which reduces reporting requirements associated with multiple 1915(b) and 1915(c) waivers for people with different types of disability. Section 1115 authority alone does not signify which populations will be enrolled, so we included all states operating MLTSS programs in this review, regardless of the federal authority under which they operate.

² Although more states are enrolling people with intellectual or developmental disabilities into managed care plans, many carve out HCBS for this group and provide these services through FFS waiver programs.

³ The one exception is Illinois’s Integrated Care Program, which does not serve dual enrollees. However, the state’s financial alignment initiative (FAI) demonstration does cover dual enrollees.

⁴ For partial-benefit dual enrollees, Medicaid pays Medicare premiums and, depending on household income, either all or part of Medicare deductibles and cost-sharing. Partial dual enrollees do not qualify for state Medicaid benefits.