MLTSS
LEADERSHIP SUMMIT

NATIONAL MLTSS HEALTH PLAN ASSOCIATION: 2024 MLTSS LEADERSHIP SUMMIT REPORT

September 24-26, 2024

101 Constitution, Washington DC

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The National MLTSS Health Plan Association ("MLTSS Association") held its 2024 annual Leadership Summit in Washington DC from September 24, 2024 – September 26, 2024, under the theme, "Connect. Engage. Build." The Leadership Summit drew leaders from across the health care industry, as well as state and federal governments, to engage in discourse on solutions to the biggest challenges facing managed long-term services and supports (MLTSS) today. (Please see the Appendix for a complete overview of the agenda and the list of participating organizations.)

KEY THEMES

Throughout the Leadership Summit, several underlying themes emerged as primary MLTSS priorities through panel discussions, breakout sessions, and conversations with industry leaders:

- Strategies for improving care coordination, benefit alignment, and beneficiary experiences for dually-eligible individuals
- Advancing value-based contracting in MLTSS
- Promoting independence for the LTSS population
- Supporting the direct care workforce to preserve the future of MLTSS
- Encouraging effective care coordination
- Strategies for improving the delivery of MLTSS

Across each of these themes, attendees discussed challenges facing MLTSS plans, states, and beneficiaries, along with strategies to meet these challenges. Throughout this report, each theme is discussed in detail with emphasis on pain points, barriers, and other limitations to progress highlighted during the Leadership Summit. This discourse is followed by key lessons learned and best practices to point stakeholders toward pathways for future advancement.

THEME 1. STRATEGIES FOR IMPROVING CARE COORDINATION, BENEFIT ALIGNMENT, AND BENEFICIARY EXPERIENCES FOR DUALLY-ELIGIBLE INDIVIDUALS

The integration of Medicare and Medicaid benefits for the dually-eligible (duals) population continues to be a priority for the Centers for Medicare and Medicaid Services (CMS), health plans, and industry partners. At the MLTSS Leadership Summit, industry stakeholders and regulators convened to discuss the impacts of recent policy changes regarding the enrollment of duals into integrated plans; challenges and strategies for successful integration; approaches for addressing issues associated with unaligned enrollment; and best practices to improve beneficiary experiences and outcomes in the future.

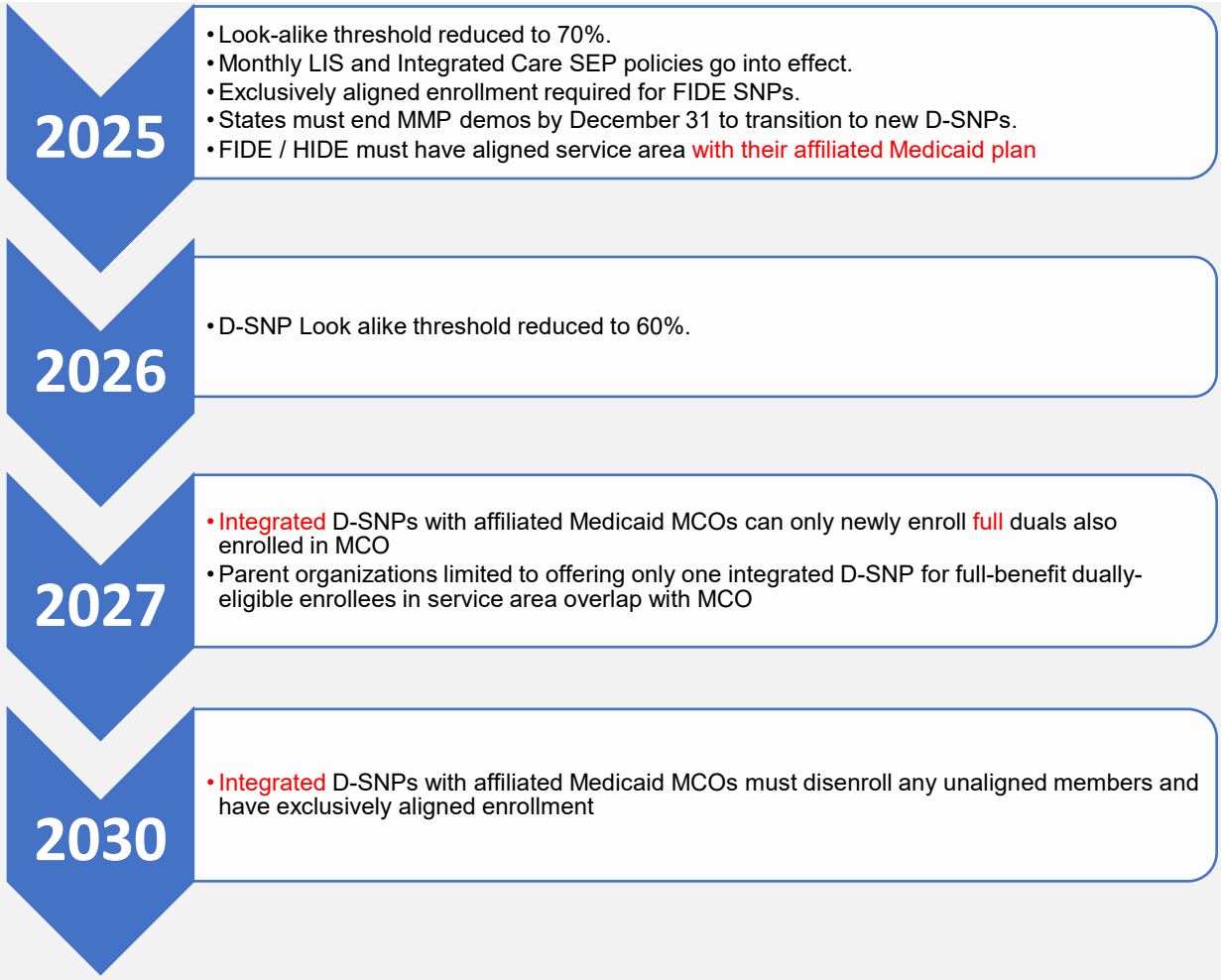
Challenges

During these sessions, attendees and panelists reflected on many of the challenges dually-eligible beneficiaries, states, and health plans must overcome when navigating the complex web of policies, programs, benefits, and other requirements that impact the dually-eligible population.

Upcoming Enrollment Policy Changes

Major integration challenges include upcoming policy changes to D-SNP enrollment, with an emphasis on the enrollment limitations expected in 2027 and 2030 (see Figure 1). As CMS moves towards having more duals in aligned plans and providing more opportunities for duals to enroll in integrated plans, health plans and states must meaningfully discuss and plan for the operational impacts of these new policies. While these changes are intended to increase alignment for duals, state policies and program design will impact their effect. As a result, state awareness and education will be crucial for smoother implementation. Relatedly, health plans must assess current market entry and expansion strategies to remain competitive amidst the changing landscape.

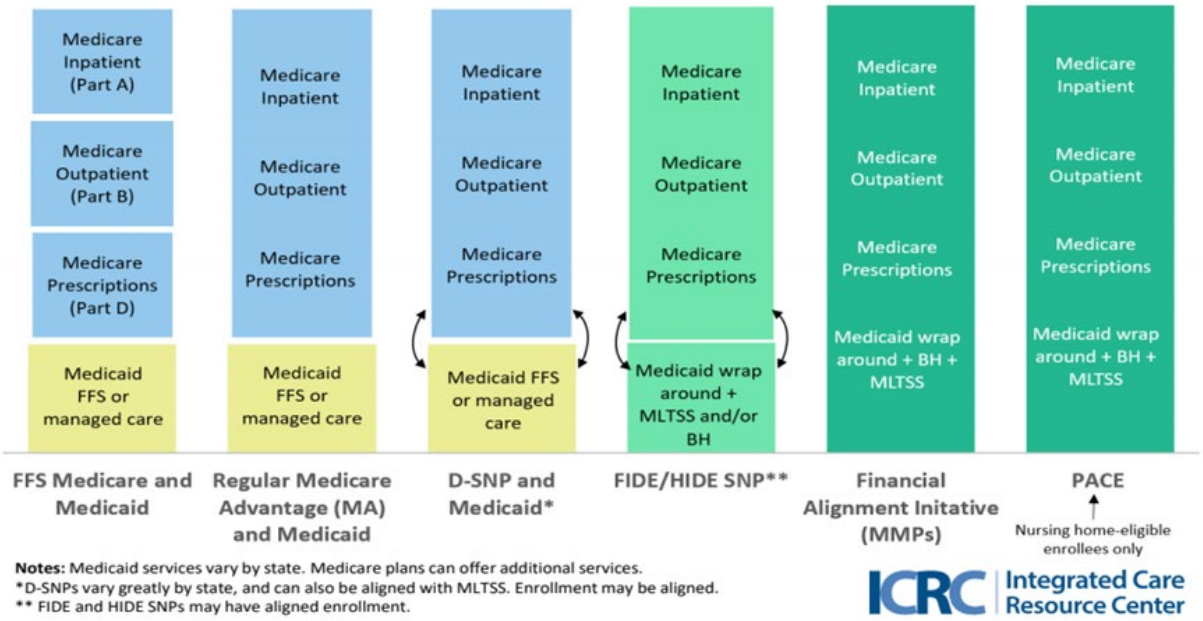
FIGURE 1: KEY UPCOMING CHANGES TO D-SNP ENROLLMENT POLICIES



Dually-Eligible Navigation of Coverage Options

Another integration-related challenge highlighted during the Leadership Summit was the complexity of options available to duals. Due to the various permutations of Medicare and Medicaid coverage options for duals, this population faces a unique challenge when attempting to select the best plan to meet their health care needs.

FIGURE 2. EXISTING COVERAGE OPTIONS FOR DUALLY-ELIGIBLE INDIVIDUALS[1]



Speakers also highlighted the additional complexities created by concurrent but un-coordinated legislative and regulatory efforts to reform integrated care for duals. Specifically, speakers discussed the similarities and differences between the DUALS Act of 2024 and CMS's rulemaking activity over the past several years, with special reference to the CY 2025 Medicare Advantage and Part D final rule. Both Congress and CMS have prioritized efforts to facilitate access to integrated care options for duals, including proposals for special enrollment periods (SEPs) to facilitate enrollment into integrated plans and policy changes to facilitate aligned enrollment. While these policies support similar goals, if implemented together, the differences in timelines and approaches to alignment (among other inconsistencies) may cause significant disruptions to care delivery pathways, plan offerings, beneficiary communication and other regulatory processes (*see MLTSS Association and SNP Alliance joint letter to Congress on the DUALS Act*). Therefore, as integrated care for duals continues to be a priority for policy makers, it is important that efforts are coordinated to streamline processes and simplify messages for duals as much as possible.

State Program Design and Limitations

Any conversation about advancing integration of Medicare and Medicaid benefits and services for duals must address the role that states play as a partner to both CMS and health plans. The ability of states to adequately share timely eligibility and coverage data for duals with relevant stakeholders along with state Medicaid program design features like carved out services and populations, opt-in and opt-out

[1] Integrated Care Resource Center: Capitated Managed Care: Spectrum of Integration

policies, enrollment periods, and Medicaid managed care organization (MCO) contracting requirements have significant impacts on the ways in which federal policies are implemented from state to state. Furthermore, many states lack the resources to meaningfully track and engage Medicare policies as they change each year. This presents a major challenge and limiting factor to integration efforts as federal dual eligible policies do not pre-empt state Medicaid policies. As a result, continued education of, and partnership with, states is as critical to facilitating health plan efforts as it is for ensuring the success of federal goals.

Key Learnings and Future Outlooks

While much of the Leadership Summit discourse around integrated care was focused on common challenges for states, duals and plans, the Leadership Summit provided attendees with forward-looking perspectives to inform future efforts:

1. Representatives from the Medicare-Medicaid Coordination Office (MMCO) emphasized the value of providing comprehensive technical assistance (TA) to states as they implement the concurrent policies impacting duals over the next few years (e.g. the MMP transition process, the 2025 MA-PD Final Rule policies, and other program implementation efforts). To support state efforts, MMCO announced that the agency is currently working on developing new state-targeted TA to help mitigate issues in the future.
2. After codifying major changes to D-SNP enrollment and alignment policies in 2024, MMCO indicated that the agency will be increasing its focus on policies directly impacting dually-eligible beneficiaries. They indicated a special interest in addressing and remedying access issues and simplifying plan options for duals to facilitate more seamless navigation.
3. Finally, MMCO encouraged attendees to continue to reach out to the agency with questions, feedback, and other pertinent information to inform their efforts. MMCO appreciated the MLTSS Association's role in flagging a recent error on Medicare Plan Finder that allowed CMS to quickly act to prevent confusion during the annual enrollment period. They urged stakeholders to continue to partner with them to improve outcomes going forward.

THEME 2. ADVANCING VALUE-BASED CONTRACTING IN MLTSS

Value-based contracting (VBC) represents a transformative approach to health care delivery, emphasizing person-centered care to improve outcomes and enhance quality of life for individuals. Unlike fee-for-service (FFS) models that prioritize the volume of services provided, VBC focuses on achieving measurable outcomes that truly matter to individuals, such as independence, well-being, and overall health. Despite its potential, VBC remains underutilized in MLTSS, underscoring the need for broader adoption and strategic implementation. To address this, the MLTSS Association launched the Value-Based Contracting Workgroup in 2024. This workgroup, comprised of member MCOs, has developed a white paper, Advancing Value-Based Contracting in MLTSS: A Paper to Stimulate Collaborative Discussions with Key Partners, that provides recommendations to accelerate intentional partnerships and the strategic adoption of VBC in MLTSS. The importance of VBC was also a central theme at the MLTSS Leadership Summit, where stakeholders explored innovative approaches, discussed barriers, and identified actionable solutions to drive progress in advancing VBC for MLTSS populations.

Challenges

Cultural and Structural Resistance to Change

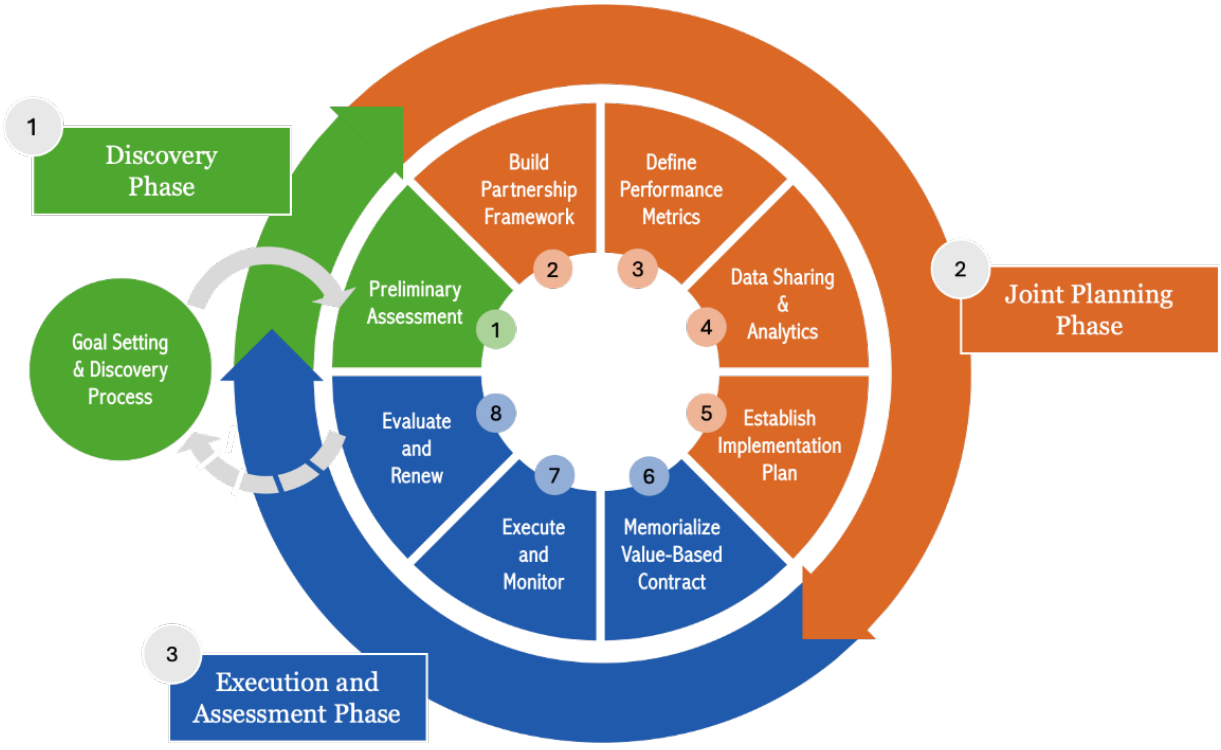
The transition to value-based contracting in MLTSS has been hindered by longstanding reliance on FFS models, which prioritize service volume over outcomes. Leadership Summit speakers noted that decades of entrenched FFS practices have shaped payment structures, organizational cultures, and provider business models, making change difficult. Many stakeholders are hesitant to embrace financial risks or invest in outcomes-based approaches without clear pathways or proven frameworks. This resistance is compounded by a lack of experience with VBC and a general reluctance to abandon familiar processes. Overcoming this resistance requires significant cultural shifts, including educating stakeholders about the value of independence and quality outcomes, encouraging innovative solutions and flexibility, and demonstrating the tangible benefits of VBC adoption.

> *"We need to shift our way of thinking of value to paying for outcomes rather than volume. High quality, low quantity [care] shouldn't be viewed as cheap; instead, we should focus on paying for results. For individuals with higher needs, the emphasis must be on delivering better quality services, not simply more services."*
>
> ***MLTSS Subject Matter Expert***

Stakeholder Misalignment and Limited Collaboration

At the MLTSS Leadership Summit, panelists emphasized the critical role of collaboration in successful VBC models but identified stakeholder misalignment as a persistent challenge. Misaligned incentives and silos between health plans, providers, states, and direct care workers (DCWs) create barriers to coordinated care delivery. Complex organizational structures and varying levels of sophistication among stakeholders further complicate efforts to align VBC goals. Speakers stressed the importance of early and continuous engagement to break down silos, build trust, and create shared accountability. Establishing open communication and involving stakeholders at all levels of implementation were highlighted as essential strategies to foster alignment and collaboration. In their white paper, the Value-Based Contracting Workgroup discusses the need for strong collaboration between MCOs and providers for the successful implementation of VBC and establishes a stepwise approach in the planning, execution, and evaluation of a plan-provider VBC relationship. The Value-Based Contracting Workgroup white paper also discusses the importance of strong partnerships between MCOs and providers for the successful implementation of VBC. The paper outlines a stepwise approach to planning, executing, and evaluating plan-provider VBC relationships, providing a framework that is intended to illustrate what should be considered in each step of the process.

FIGURE 3: DEVELOPMENT OF PLAN AND PROVIDER RELATIONSHIP FRAMEWORK



Provider Readiness and Capacity Issues

Provider readiness emerged as a potential challenge to the adoption of VBC. Panelists noted that some providers may lack the technical infrastructure, operational capacity, and experience needed to succeed in VBC models. Gaps in data-sharing capabilities, outcome measurement tools, and workforce training may create further challenges. Additionally, providers can face administrative burdens and resource constraints that make it difficult to invest in or adopt new care delivery models. Leadership Summit participants and speakers discussed how tailored support, such as phased approaches, targeted investments in training, and technological assistance, can help to address these capacity issues and enable providers to transition effectively to outcome-based care.

Regulatory and Measurement Challenges

Leadership Summit speakers identified regulatory inflexibility and outdated measurement systems as significant obstacles to advancing VBC in MLTSS. Current regulations often limit the ability of health plans and providers to innovate, stifling the development of flexible care delivery models such as in-lieu-of services (ILOS). Additionally, existing metrics tend to focus on service delivery rather than outcomes that truly matter to individuals, such as independence and quality of life. This lack of meaningful, standardized quality measures further complicates efforts to demonstrate the value of VBC. Panelists called for greater regulatory flexibility, the development of outcome-focused metrics, and increased investment in data systems to address these challenges and support the expansion of VBC.

Key Learnings and Future Outlooks

1. Speakers emphasized that successful VBC initiatives require collaboration across all stakeholders, including plans, states, providers, and DCWs. Engaging these groups early in the process and fostering ongoing dialogue improves buy-in and ensures alignment with shared goals. Building trust through regular communication and joint accountability mechanisms was highlighted as essential for fostering long-term collaboration.
2. Speakers stressed the critical role of DCWs in VBC models and the need for investments in their training, administrative support, and overall empowerment. Panelists noted that reducing burdens on frontline workers improves care delivery and outcomes, while ensuring that DCWs operate at the top of their skillsets optimizes resource utilization.
3. Panelists highlighted the importance of addressing technology gaps and investing in data-sharing infrastructure to enable providers and plans to measure outcomes effectively. They emphasized the need for data-driven

decision-making and transparency to track performance and drive continuous improvement in VBC models.

4. Speakers called for the development of standardized yet flexible quality metrics that align with desired outcomes, such as independence and well-being. They discussed the benefits of phasing in these measures and ensuring they reflect the unique needs of the MLTSS population.
5. Workforce development emerged as a critical area for ensuring the sustainability of VBC models. Targeted investments in recruitment, retention, and training were identified as key strategies to address workforce gaps and support the transition to outcome-based care.

THEME 3. PROMOTING INDEPENDENCE FOR THE LTSS POPULATION

LTSS programs provide care for older adults and people with disabilities who require extra assistance. LTSS can be delivered in institutional settings or through Home and Community-Based Services (HCBS), which allow individuals with increased health care needs to maintain their personal autonomy, as opposed to entering an institutional setting. While LTSS programs promote independence and reduce paternalism in the health care system, there are still some difficulties, including the historical carving out of certain LTSS populations from managed care, cost containment issues, and workforce challenges. Further, while enabling technologies are an important way to improve independence among the LTSS population, barriers to adoption and utilization remain. Speakers at the MLTSS Leadership Summit highlighted some key strategies to address these challenges and discussed best practices for promoting further independence in LTSS.

Challenges

Supporting Individuals with Intellectual and Developmental Disabilities (IDD) Within Managed Care Systems

The IDD population has historically been carved out of managed care, largely due to the cost of managing their complex care needs. Speakers at the Leadership Summit discussed some of the challenges the IDD population faces as a result of these carve-outs. They highlighted the need for MCOs to proactively engage individuals with IDD and their families, emphasizing the importance of self-advocacy, patient autonomy, and active family involvement in care models. Reactive approaches must shift to proactive ones, with MCOs working to understand family needs and provide necessary supports, such as respite care, rather than relying on traditional support systems alone. There is also a need for continuous communication, well-trained

medical staff, and targeted education to reduce stigma, address health disparities, and foster dignity and well-being for individuals with IDD. Collaborative efforts to equip caregivers and clinicians with the skills to meet the unique needs of the IDD population were identified as critical for improving outcomes and advancing meaningful system change.

> *"We want to empower individuals with IDD to advocate for themselves rather than treating them as children or simply telling them what to do. It's important to have adults in their lives who respect them and listen to their opinions. Health care providers should not dismiss their concerns, and family members should inquire about side effects and potential interactions with other medications. Ensuring that loved ones are involved in these conversations is essential for effective care"*
>
> ***Patient Advocate***

Cost Management Challenges for States and Plans

Managing costs for individuals with IDD, a population with significant health care needs, presents unique challenges for states and health plans. Historically, IDD populations have been carved out of clinical efficiency metrics, partly due to concerns about penalizing plans, which can hinder efforts to manage costs as opportunities for improved care and resource allocation may be overlooked. Speakers noted that health plans are focusing on the non-emergent use of emergency rooms and 30-day readmission rates as key areas for reform. They also emphasized the importance of creating more openness and communication with patients and families to build confidence in managed care systems' ability to support the IDD population through services such as family support, pharmacy services, and respite care. Proactively opening lines of communication, rather than waiting for a state request for proposal (RFP), was stressed as a critical step to enhance collaboration and manage costs effectively.

Use of Enabling Technology to Support Independence

> *"The technology-first movement is the de-institutionalization movement"*
>
> ***MLTSS Plan Representative***

Enabling technologies, also known as assistive or adaptive technologies, are incredibly important for advancing independence among the LTSS population, but there are numerous barriers to implementation and utilization. First, states have trouble being competitive with private plans when it comes to implementing and funding benefits, including enabling technology. There is also a lack of consistency in coverage and reimbursement across states. While some states have clearly identified reimbursement methodologies for enabling technology,

others include enabling technology under durable medical equipment (DME) or in lieu of services (ILOS). One Leadership Summit participant noted that using the ILOS pathway may contribute to some states falling behind on enabling technology adoption because it is difficult to track the return on investment (ROI) in ILOS, increasing the difficulty of justifying coverage to financial stakeholders. To increase uptake, states and plans can incentivize the use of enabling technology interventions. For example, Ohio did not reduce payments to providers for a certain period to incentivize better patient outcomes without the loss in revenue.

Enabling technology does not have to be complex or expensive to greatly improve a patient's wellbeing: "Simple, low-cost technologies like adult incontinence products or long-handled sponges can make massive impacts in an individual's quality of life and independence."

MLTSS Plan Representative

Another barrier to the adoption of enabling technology is that the service delivery system is falling behind. Leadership Summit participants noted that states and plans must prioritize quality of life, reduce administrative burdens, and increase support services for care managers to navigate technology to increase utilization. Further, while a state or plan may cover enabling technology, many providers lack awareness about the available technologies and therefore feel uncomfortable prescribing it to their patients. To combat this lack of information, states and plans should implement provider education and training initiatives to help build strong foundational systems to promote the use of existing, affordable enabling technologies.

Key Learnings and Future Outlooks

1. Speakers emphasized that it is important to approach cost management in a way that considers the unique challenges faced by individuals with IDD. MCOs must look beyond traditional metrics and address issues such as non-emergent emergency room visits and readmission rates, while ensuring adequate provider networks tailored to this population's needs. MCOs must also actively engage beneficiaries in their own care to ensure their health care needs are being met.
2. Many clinical and policy stakeholders struggle to identify the demand and potential ROI of enabling technology to help justify its coverage and reimbursement to financial stakeholders. Even when states or plans cover enabling technology, the workforce is often not trained on prescribing and matching devices to beneficiaries. There is an increasing need to promote education of care coordinators and other providers and ensure that successful experiences are replicated to create a system that supports assistive technology and promotes independence.

THEME 4. SUPPORTING SELF-DIRECTED SERVICES IN MLTSS

Self-direction is a well-established service delivery model that provides LTSS participants greater autonomy in managing their own health care by allowing participants to choose who provides their health care services, how those services are provided, and how their Medicaid dollars are spent. This person-centered delivery model promotes independence for older adults and individuals with IDD or chronic conditions and ensures that beneficiaries get the services they need. At the Leadership Summit, speakers and participants discussed best practices to promote self-directed service options, addressed the role of Financial Management Service (FMS) vendors, and considered the advantages and disadvantages of hiring a family member as a caregiver.

Challenges

Supporting Self-Direction in the Health Care System

While providing self-direction opportunities is key to ensuring alignment between health care solutions and beneficiary needs, implementation challenges exist. Fortunately, there are many ways in which the health care system can support self-directed services for the LTSS population, including ensuring that beneficiaries fully understand their care options, supporting care coordinators, and reducing gatekeeping. Leadership Summit panelists suggested that creating diagrams to outline onboarding steps and processes can improve health care system navigation and transparency for beneficiaries. Informed consent and educating beneficiaries about their options were also highlighted as critical.

Speakers also discussed targeting specific care coordinators for self-direction, citing California's Self-Determination Program as an effective model that utilizes specialist case managers. While some states require disability liaisons in contracts, speakers cautioned that this approach may not always be an effective form of engagement. Additionally, they suggested that states consider contracting with advocacy groups or associations for training and advisory roles, reducing reliance on families to educate care coordinators and MCOs. Finally, speakers highlighted the need for ongoing stakeholder engagement, rather than one-time efforts.

The Role of Financial Management Services in Self-Direction

Financial Management Service (FMS) vendors help individuals who are self-directing their care manage their personal care budget by handling financial services, like payroll processing, on the individuals' behalf. A significant challenge with FMS in self-direction is lack of trust between health plans, providers, and FMS vendors. Speakers emphasized that, from an FMS perspective, building relationships with managed

care coordinators is essential to fostering trust. Care coordinators need to know and trust that individuals will be well cared for, and FMS providers can help cultivate these relationships by dedicating time to meet with care coordinators—not to market themselves, but to build trust and confidence. Leadership Summit panelists also highlighted the importance of open communication with FMS providers.

Challenges and Opportunities in Allowing Paid Family Caregivers in Self-Direction

There are both advantages and disadvantages to hiring family caregivers for self-directed care. On one hand, speakers discussed instances in which some states have begun to make paid family caregivers a permanent service option in self-direction programs, providing beneficiaries with more caregiving options and alleviating some of the financial burdens that unpaid family caregivers often experience. However, not all individuals may want to hire a family member, especially if wages and benefits are inadequate. Therefore, it is important to ensure that individuals in self-direction programs have options beyond just hiring family members.

Key Learnings and Future Outlooks

1. Panelists agreed on the necessity for robust FMS and informational assistance to empower members as employers in self-direction programs. Partnerships between Centers for Independent Living and MCOs are essential in fostering this support.
2. Panelists called for immediate engagement among stakeholders, including health plans, MCOs, states, beneficiaries, and families, to build confidence in managed care's ability to support the LTSS population, rather than waiting for formal proposals.
3. Speakers emphasized the need for care coordinators to have confidence in their ability to support self-direction.
4. Leadership Summit attendees expressed concerns about potential isolation when family members are hired as caregivers, emphasizing the need for monitoring to ensure that choices genuinely reflect individual preferences rather than familial pressures. Protecting beneficiary choice is essential and should always be central to self-direction.

THEME 5. SUPPORTING THE DIRECT CARE WORKFORCE TO PRESERVE THE FUTURE OF MLTSS

Despite increasing demands for LTSS, a shortage of DCWs remains a significant challenge for individuals with LTSS needs, states, MCOs, providers, and the direct care workers themselves. At the MLTSS Leadership Summit, attendees came together to discuss barriers that prevent worker recruitment and retention and to consider possible solutions, including supporting caregivers, providing education and training, creating opportunities for advancement, and sustaining adequate wages.

Challenges

Growing Interest in Improving Caregiver Supports, But Organizations Need Help

At the Leadership Summit, a majority of attending organizations (62%) indicated that their organization is interested in prioritizing caregiver support; however, there is a lack of consensus about the best way to provide it. Speakers provided advice for organizations, including defining what "success" looks like, having an effective tracking process to monitor the organization's progress, and encouraging active participation by caregivers. At the strategy level, speakers recommended that stakeholders should align their caregiver support programs with their organization's goals to promote program success.

Building Trust with Caregivers is Essential

Caregiver distrust of health plans was identified as a significant challenge at the Leadership Summit. Speakers emphasized the importance of actively seeking out feedback from caregivers and incorporating that feedback in order to build trust. Speakers also noted that understanding the unique needs of caregivers from diverse backgrounds,

> *"Trust building is a big part of it. There's a lot of history around being in the workplace and being mistreated, discriminated against because of their home situations. The other piece is understanding the information and resources that build empathy with the individual and what they are going through. The ability to understand what their loved one is going through will sustain them through times of stress. Be upfront about understanding people of color, marginalized communities, LGBT, IDD – you have to start by recognizing that they are marginalized. It really starts with trust and empathy and understand that these programs are self-selecting."*
>
> ***Caregiver Advocate***

especially people of color, LGBTQ+ individuals, and individuals from other marginalized communities, can foster trust. To that end, speakers encouraged organizations to consider flexible caregiver supports and stressed that one-size-fits-all approaches are rarely effective.

Additionally, speakers noted that many caregivers do not recognize that they are caregivers. People become accustomed to providing care for their family members, but speakers noted that actively acknowledging these individuals as caregivers and offering them support makes them feel seen.

To highlight the importance of providing anonymous forums for caregivers to connect, one caregiver advocate recalled an interaction he had when his organization began implementing support groups: "We had a caregiver who was middle aged, lived with her mother with dementia, and supported her mom and daughter. She wasn't interested in self-paced training, so we recommended joining [an in-person] support group. She left a 3/5-star rating. She said, 'There are nice people, but I don't think a group is for me.' We lost her for a few months. Then, we invited her to an anonymous group; non-camera format, just a group chat. She left a 5/5 rating: 'Loving this model.'"

Caregiver Advocate

Addressing Social Isolation and Loneliness

Caregivers often experience social isolation and loneliness because of their role. Speakers highlighted the importance of meeting caregivers where they are and recognizing that the job of caring for a family member is a 24/7 endeavor. Providing caregivers with a forum where they can connect with one another reduces feelings of loneliness. Speakers indicated that while traditional support groups can foster a sense of belonging, some individuals may be reluctant to attend in-person and prefer to maintain their anonymity. Therefore, to effectively reach all caregivers, speakers encouraged organizations to utilize technology, including social media, to provide anonymous online spaces or private groups for caregivers to connect as part of a robust caregiver support program.

Advantages and Disadvantages of Government Intervention

Compelling health plans to provide caregiver supports would ensure that necessary supports are implemented, but compulsory requirements create new challenges in and of themselves. Government mandates for providing caregiver support, like a local support group or access to mental health services, could be an effective way to align initiatives across health plans and ensure that all caregivers have access to the same services. State-imposed requirements would also ensure that caregiver supports are actually implemented and can align expectations across plans. However, Leadership Summit participants highlighted

the potential drawbacks of too much government intervention, including the increased burden on providers if more requirements are added. Speakers also acknowledged that states have limited resources and expressed concerns about putting too many resources into one program. For example, if states focus their dollars on providing caregiver supports in Medicaid, a significant portion of the population who is Medicaid-ineligible would be left out. Speakers also opined that requiring too much structure in caregiver support programs would stifle innovation and the ability to tailor supports adequately to individual caregivers' needs.

Direct Care Workforce Limitations Resulting from the COVID-19 Pandemic

Many challenges have been created as the COVID-19 Public Health Emergency winds down, including the decreased availability of DCWs. Panelists highlighted the importance of investment in DCWs, especially in training and recruitment strategies. They noted that training is extremely important to DCWs, as workers desire professional skill building and career advancement opportunities. Retention was also underscored as a key priority once workers enter the field. One speaker recommended implementing a mentorship model wherein workers have direct access to an advisor that can answer their questions and provide support in real time. Panelists further stressed that providing caregivers with adequate, sustainable wages is critical to expand and maintain the direct care workforce. However, while stabilizing the workforce requires offering sustainable wages, speakers also noted that wage structures must be flexible to reflect geographic differences and local workforce demands. Finally, co-opetition among MCOs, wherein entities who traditionally compete for resources in a competitive market cooperate with one another, is essential to effecting system-wide improvements. Co-opetiton provides an opportunity for MCOs to learn best practices from one another and work together to bolster the direct care workforce.

Key Learnings and Future Outlooks

1. Understanding individual caregiver needs is essential to building trust between plans and caregivers. Actively seeking feedback from caregivers, listening to their needs, and adjusting supports accordingly is an effective way to promote trust and ensure that caregivers' needs are being met.
2. Requiring caregiver supports as part of Medicaid contracts or as another required policy can ensure that caregiver supports are being implemented across all plans. However, it is essential to balance the need for standardization with the potential for increased regulatory burdens on caregivers and plans, as well as resource limitations when implementing state- or program-level requirements.
3. Organizational accountability for recruiting, training, and retaining DCWs is crucial, especially as the workforce shortage intensifies. Strategies developed

during the pandemic, such as ARPA investments and recruitment initiatives, should be expanded to address workforce challenges. Building on local and state partnerships established during the COVID-19 pandemic will continue to improve workforce resilience and support.

4. Collaborating with state leaders, health plans, and other stakeholders is vital for tackling workforce challenges. Co-opetition allows for collective problem-solving, setting priorities, and coordinating with states to address workforce needs.

THEME 6. ENCOURAGING EFFECTIVE CARE COORDINATION

Care coordination is a fundamental component of MLTSS and involves the integration of various health and social services to meet the comprehensive needs of individuals requiring long-term care. Typically led by care coordinators—often nurses or social workers—this process involves assessing patient needs, developing personalized care plans, and facilitating communication among health care providers, patients, and their families. This approach to care ensures that services are not only accessible but also aligned with the individual's health goals and preferences, thereby enhancing the quality of care and improving health outcomes. Effective care coordination can also lead to a reduction in health care costs by minimizing service duplication and preventing unnecessary hospitalizations. By addressing systemic fragmentation, leveraging innovative care models, and fostering stakeholder collaboration, care coordination can improve health outcomes, reduce caregiver strain, and create efficiencies in service delivery. Leadership Summit sessions highlighted key challenges, such as data and resource limitations, as well as strategies for improving care coordination, including a session focused on the Guiding an Improved Dementia Experience (GUIDE) Model, which offers a comprehensive approach to coordinated dementia care.

Challenges

Fragmentation and Misalignment Across Care Systems

Fragmentation of care systems can create significant barriers to achieving effective care coordination. Disconnected workflows among acute care providers, LTSS plans, and community organizations can lead to breakdowns in communication, delays in care delivery, and inefficiencies during transitions of care. Without alignment in goals and processes across these stakeholders, person-centered care becomes difficult to achieve. Panelists emphasized the importance of streamlining workflows and integrating systems to reduce redundancies and ensure consistent care. The lack of coordination can be especially problematic in managing high-need

> *"Understanding what MLTSS truly means is crucial. Health care has largely been driven by volume, but people need to see how it directly impacts them. Doctors often focus on diagnosing what's immediately in front of them, while the rest can feel overwhelming. However, when you introduce a whole-person plan that is actionable and meaningful, it shifts the entire dynamic. It's like a lightbulb going off—suddenly, the doctor can grasp what's happening in a patient's home and provide more holistic care. That's the value proposition of MLTSS: delivering a different level of support and engagement that truly changes the game."*
>
> ***MTLSS Plan Representative***

populations, as gaps in communication can leave patients without critical services and supports.

Limited Access to Real-Time Data and Technology Integration

Outdated technology and fragmented data systems hinder the ability to share critical information in real-time, impeding the effectiveness of care coordination. Providers and care managers can sometimes face delays in accessing information necessary for timely interventions and seamless transitions between care settings. Panelists noted that while these limitations persist, the shift toward virtual health and real-time technology presents an opportunity to reorganize workflows and make care delivery more efficient. Investments in interoperable systems and real-time data-sharing capabilities were highlighted as critical to closing care gaps and enabling proactive coordination.

Challenges with Engaging Care Teams and Community Partners

Engaging care teams and community organizations in a unified approach to whole-person care remains a challenge. Primary care teams may lack the understanding or resources needed to fully participate in care coordination efforts, reducing their ability to deliver integrated care. Similarly, community organizations that provide essential non-medical supports can sometimes be excluded from care planning, creating disruptions in service delivery. Speakers emphasized that when care teams understand the full context of a patient's home life and care environment, outcomes can improve significantly. Models like GUIDE demonstrate the potential for success when care managers, community partners, and families work together to close care gaps.

Navigating Regulatory Changes and Resource Limitations

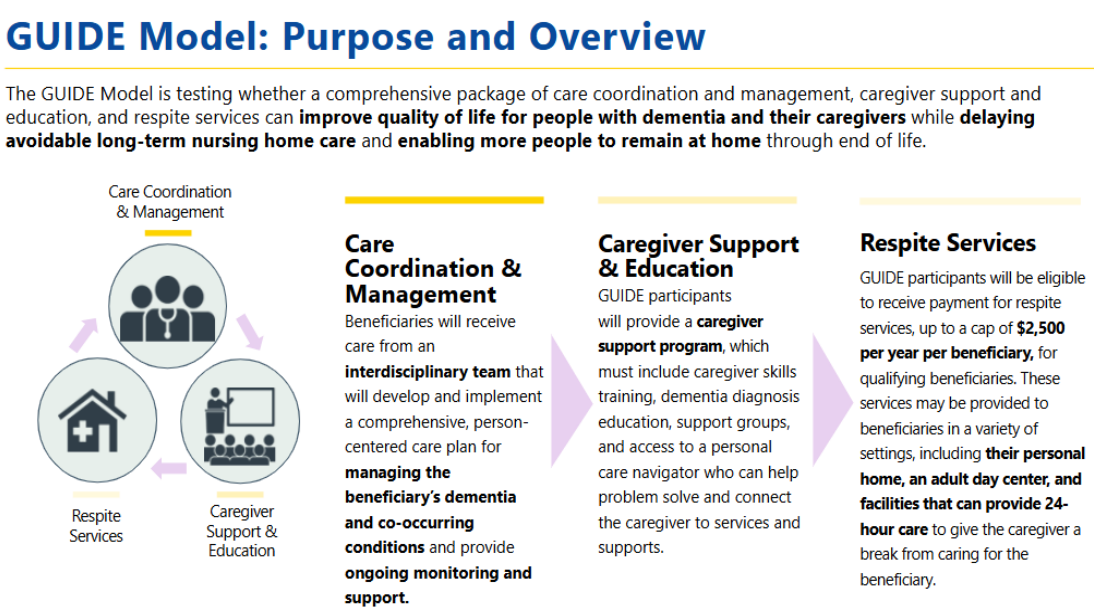
Rapid regulatory changes and resource constraints can create additional barriers to effective care coordination. State agencies and care providers can sometimes feel overwhelmed by evolving federal requirements, particularly in Medicaid and LTSS populations, leading to inconsistent implementation of new regulations. Additionally, service coordinators can sometimes lack the training, tools, and support

necessary to manage complex cases effectively. Panelists stressed the importance of proactive relationships with state agencies to anticipate and address regulatory changes. Such partnerships can help mitigate disruptions and support smoother transitions in care delivery.

Key Learnings and Future Outlooks

1. The GUIDE Model was presented as a key example of innovative care coordination. The model combines care coordination and management, caregiver support and education, and respite services to improve the quality of life for individuals with dementia and their caregivers. Speakers highlighted its potential to delay avoidable nursing home placements while enabling more individuals to remain at home through the end of life. The model's interdisciplinary care teams, personalized care plans, and emphasis on caregiver support were cited as critical elements for success.

FIGURE 4: OVERVIEW OF THE GUIDE MODEL[2]



2. Speakers noted that real-time technology and virtual health initiatives offer a significant opportunity to streamline care delivery and reduce fragmentation. These tools can improve workflows and enable more efficient transitions of care by ensuring that all stakeholders have access to accurate, up-to-date information. Panelists highlighted that real-time systems not only facilitate better coordination but also help care managers identify and address care gaps earlier, reducing delays and improving patient outcomes.

[2] NIA Impact Collaboratory Transforming Dementia Care: The GUIDE Model: A CMS payment model test to support people living with dementia and their family caregivers

3. Panelists emphasized that engaging care teams and community organizations in whole-person care is essential for improving outcomes. They noted that understanding a patient's home life and environment allows care teams to address both medical and non-medical needs more effectively. Collaborative models like GUIDE were highlighted as examples of how integrating community organizations and care managers can provide more holistic and effective support, particularly for high need populations.
4. Speakers stressed the importance of building strong, proactive relationships with state agencies to navigate regulatory changes and mitigate potential negative impacts on LTSS members. Regular engagement and open communication with state agencies were cited as critical to ensuring that providers and plans are prepared for new policies and regulations. Panelists shared success stories of using collaborative efforts with states to anticipate and adapt to changes, resulting in smoother implementation and better outcomes for beneficiaries.
5. Panelists highlighted the challenges faced by service coordinators and emphasized the need to equip them with adequate tools, training, and organizational support to ensure they can effectively navigate care systems and advocate for patients. Improved support for coordinators was seen as critical to enhancing person-centered care and improving overall outcomes.

THEME 7. STRATEGIES FOR IMPROVING THE DELIVERY OF MLTSS

Managed care offers significant benefits to the delivery of LTSS and is a crucial tool in advancing rebalancing efforts (i.e., the shifting of LTSS services from being delivered in institutional settings to home and community-based settings). Through managed care, LTSS beneficiaries receive coordinated services and benefits through care plans tailored to their complex care needs. States also benefit from the cost containment that MCOs offer when effective care coordination results in cost savings for a historically costly population. Managed care plans are particularly instrumental in facilitating rebalancing efforts through their LTSS provider and caregiver networks that help individuals remain independent in home and community settings. Medicaid managed care delivery systems have been at the center of significant attention across the health care industry, due in large part to the finalization of the Medicaid Managed Care Rule and the Medicaid Access Rule in the Spring of 2024. Both rules aim to improve access to services under the Medicaid program, increase transparency and accountability for both states and plans, and facilitate increased standardization across state programs. During the Leadership Summit, speakers and attendees engaged in robust conversations about the impact of these rules as well as various avenues for advancing the goals of MLTSS and the role of managed care plans in this effort.

Challenges

Scaling Innovation in MLTSS

State innovation, particularly as it pertains to the use of technology in health care, continues to be a priority in Medicaid programs, especially in a post-COVID society. During the Leadership Summit, speakers and attendees discussed balancing efforts to modernize Medicaid programs with ensuring that innovative approaches are responsive to the needs of the Medicaid population. Speakers addressed disappointments with the limited impact of the HCBS Settings regulations and noted that the path forward may require states to build their own creative solutions that others can emulate. Panelists also discussed challenges with the adoption of technology in Medicaid programs. Specifically, they noted that while the COVID-19 pandemic accelerated states' use of telehealth services, scalability has varied across regions and populations and cost continues to be a significant limiting factor to large-scale adoption. Also highlighted was the role of care managers and care coordinators in determining the utilization of in-person and alternative supports.

> *The pandemic was interesting. North Carolina advanced our use of telehealth in ways that, absent the pandemic, would have taken ten years.*
>
> ***State Representative***

> *I would issue a challenge to plans - what do your care managers actually know about how to help people access alternative supports? Look at your utilization history and I bet you will find 2-3% are on alternative supports, and 80-90% are on in-person supports. Then ask care coordinators if they know how to access those supports.*
>
> ***Former State Representative***

Varied and Uncoordinated Assessments

The development and use of high-quality MLTSS assessments is crucial to driving better outcomes for beneficiaries, but duplicated and inconsistent assessments result in uncoordinated and administratively burdensome efforts for health plans. Leadership Summit attendees engaged in robust discussions about a variety of approaches to improve procedures and outcomes from MLTSS assessments. (see Key Learnings and Future Outlooks below for best practices).

Key Learnings and Future Outlooks

1. While technology is an important tool for modernizing Medicaid delivery systems and understanding the needs of subpopulations (like those receiving LTSS), it is only as impactful as its ability to meet the identified needs of the population. Plans and states should prioritize identifying beneficiary needs and barriers to access when scaling telehealth solutions.
2. To improve the quality of MLTSS assessments, one panelist recommended leveraging a comprehensive framework, that includes the integration of various health and social needs; improving hiring processes for assessors; scheduling assessments with all individuals needed for input (including primary care providers and caregivers); and using technology to identify possible anomalies (especially when managing a high volume of members). Additional best practices discussed include leveraging state and external audits to rectify variations across assessment tools and keeping assessment and service planning roles separate to maintain objectivity.
3. Attendees and speakers also discussed potential pathways for better policies to improve MLTSS care delivery including coming up with clearer definitions for "value" and "quality" in the context of the LTSS and aging populations to drive better solutions; proactively minimizing the risk of fraud waste and abuse in order to reduce the amount of bureaucratic red tape applied to benefits like DMEs; and encouraging states to examine how Medicare utilization drives LTSS utilization for the dually-eligible population.

THE PATH FORWARD

The 2024 MLTSS Leadership Summit created a forum for state and federal representatives to engage with health plans, research institutions and other health care stakeholders to discuss tangible solutions and potential pathways to addressing some of the most challenging and persistent issues facing MLTSS plans and the individuals they serve. Collaboration between stakeholders was consistently highlighted as a key strategy for identifying and solving identified challenges. This was especially emphasized by state and federal representatives who recognize the unique voice of the MLTSS Association in raising issues that

> *"Everyone has a role to play—states, CMS, plans, and providers—in driving better outcomes. If we don't set the expectation for improved results, we simply won't achieve them. We need to engage in a 'hearts and minds' campaign to show why independence matters and create space for innovation in service delivery."*
>
> ***MLTSS Plan Representative***

most trade associations seem to ignore. As the health care landscape continues to evolve through rule implementation efforts and changing Administrations, the MLTSS Association is poised to engage on the issues that are important to member plans and the individuals they serve. With the partnerships forged and strengthened at the Leadership Summit, the MLTSS Association is even better equipped to offer thought leadership and education, build partnerships, and advocate for policies as the premier voice for the advancement of Medicaid MLTSS and integrated care in the United States.

APPENDIX

APPENDIX A: LEADERSHIP SUMMIT SESSIONS AND PARTICIPATING ORGANIZATIONS

DAY 1		
Session	**Description**	**Speakers**
State Officials Panel: Strengthening the Critical Partnerships between Medicaid & Managed Care	*State officials have one of the hardest jobs – caring for their most vulnerable and disadvantaged populations with limited budgets, outdated technology and ever-changing federal regulations. This panel discussed how states are tackling issues that improve health equity and access to services. These state leaders reflected on their experiences partnering with managed care plans, navigating these challenges together, to deliver innovative and high-quality care to their state residents.*	Sabrena Lea, North Carolina Department of Health and Human Services Patti Killingsworth, Former Chief of LTSS at TennCare
Federal Partners Highlight: The Power of Partnerships in Coordinating and Advancing Care for Older Americans & Persons with Disabilities	*As State Medicaid Agencies and managed care organizations continue to tackle the challenges with providing high-quality care coordination and home and community- based services to a growing diverse and complex LTSS population, leveraging aging and disability networks is more vital than ever before. ACL Deputy Administrator Kelly Cronin discussed trends in how area agencies on aging (AAAs), aging & disability resource centers (ADRCs), and centers for independent living (CILs) are strategically partnering with MLTSS plans and state regulators to address gaps in care, as well as the impact of recent updates in the Federal regulatory landscape intended to improve access, quality and value of HCBS for older adults and individuals with disabilities.*	Kelly Cronin, U.S. Administration for Community Living (ACL)
General Session: Transitions for Integrated Care	*Policymakers have long aimed to improve integrated care and enrollment for dually-eligible individuals while preserving consumer protections and choice. In 2024, Congress and CMS introduced policies focused on shaping integrated care for this population. This session explored the opportunities and challenges within current frameworks for aligning care and improving the enrollment experience for duals navigating Medicare and Medicaid. Panelists discussed federal and state rules on consumer choice, the DUALS Act of 2024, insights from the Massachusetts SCO demonstration, and lessons from the Financial Alignment Initiative. MACPAC also shared its June 2024 recommendations for*	Edo Banach, Manatt, Phelps & Phillips, LLP Michelle Martin, UnitedHealthcare Community & State Drew Gerber, Medicaid and CHIP Payment and Access Commission (MACPAC)

	optimizing State Medicaid Agency Contracts (SMACs) and strategies for improving care coordination, monitoring, and oversight.	
General Session: Opportunities & Challenges for Building Successful Value-Based Models in MLTSS	*Value-based contracting continues to be a predominant theme throughout the health care space, with CMS aiming to have all Medicare beneficiaries and most Medicaid beneficiaries in accountable care relationships by 2030. Despite this goal and the overall evolution of value-based approaches, advancement of meaningful value-based models in LTSS / MLTSS has lagged that of other health care sectors. In 2024, as a response to conversations that occurred during the 2023 Leadership Summit on these broad VBC themes, the National MLTSS Health Plan Association convened a working group of plan members focused on the advancement of VBC in MLTSS.* *This panel explored some of the themes emerging from the working group with a panel of experts at the forefront of VBC efforts in LTSS / MLTSS. We discussed the challenges faced by those who seek to proliferate VBC in this space along with the uniquely personal and participant-driven definitions of value that are the hallmark of true potential and success.*	Patti Killingsworth, CareBridge Dr. Lisa Mills, Subject Matter Expert Anna Keith, PA Health & Wellness Ashley Bunnell, UPMC Community HealthChoices
Lunch Session: The GUIDE Model: Guiding an Improved Dementia Experience	*The Guiding an Improved Dementia Experience (GUIDE) Model is a new voluntary nationwide model test that aims to support people with dementia and their unpaid caregivers. The GUIDE Model focuses on comprehensive, coordinated dementia care and aims to improve quality of life for people with dementia, reduce strain on their unpaid caregivers, and enable people with dementia to remain in their homes and communities. It will achieve these goals through Medicare payments for a comprehensive package of care coordination and care management, caregiver education and support, and respite services. GUIDE delivers on the Biden Administration's April 2023 Executive Order 14095 on Increasing Access to High-Quality Care and Supporting Caregivers, and advances key goals of the National Plan to Address Alzheimer's Disease. Through the GUIDE Model, CMS is testing an alternative payment methodology for participants that deliver comprehensive, coordinated dementia care.*	Julius Bruch, Isaac Health Elizabeth Burke, Center for Medicare and Medicaid Innovation (CMMI), CMS

	A significant portion of dually-eligible beneficiaries with an ADRD diagnosis also receive LTSS services. Thus, the GUIDE model lends itself to multi-payer stakeholder engagement. During this presentation, participants had the opportunity to learn about the specific elements and requirements of the GUIDE model, hear CMS' strategy for expanding the GUIDE model across the country in the future, explore the significant overlap between the GUIDE model.	
General Session: Preserving the Backbone of LTSS: Advancing Caregiver Supports as a Driver for MLTSS Innovation	*Caregivers play an essential role in sustaining MLTSS systems as they supplement paid services, divert members from costly settings, participate in person-centered planning, and support health-related decision-making. The importance of caregivers has been increasingly acknowledged at a national level, such as through the 2022 National Strategy to Support Caregivers and President Biden's 2023 Executive Order. However, states are taking many different approaches to supporting caregivers within their MLTSS program designs, such as including caregiver support as a covered benefit, encouraging plans to innovate and/or offer relevant value-added benefits, incorporating it into plan contract requirements, or asking caregiver-focused RFP questions.* *Panelists referenced the many opportunities for plan action documented in the comprehensive "Family Caregiver Strategy Action Guide for MLTSS Plans" developed by the National MLTSS Health Plan Association and the Long-Term Quality Alliance. Participants had the opportunity to engage in an interactive discussion about the most effective strategies for and barriers to plan implementation of caregiver support initiatives, the connections between caregiver support and workforce initiatives, and the models and channels that maximize caregiver engagement and individual outcomes.*	Jonathan Davis, Trualta Marvell Adams Jr., Caregiver Action Network Joy Tomlin, Molina Healthcare
General Session: Improving MLTSS Quality of Care to Achieve Optimal Independence for individuals with IDD	*People with intellectual and developmental disabilities have, for many years, been carved out of Medicaid managed care, primarily because managed care plans are perceived as having insufficient experience to effectively serve the population. But this is changing as more states look to the advantages of managed care to deliver*	Thomas Mangrum, Jr., Self Advocate Lorene Reagan, IntellectAbility David Rogers, Independent Living Systems-Florida Community Care

	comprehensive, person-centered care, and bend the cost trend for services for people with IDD. *This panel shared successful strategies for demonstrating organizational readiness for the IDD population from the RFP process through go-live and implementation. The panel is comprised of a person with lived experience, two managed care executives, and a former state IDD director with managed care experience. The panelists identified pain points and described interventions designed to promote health equity, minimize member and provider abrasion, and manage costs across all aspects of managed care operations. Using real-life scenarios, panelists drew on their lived experience and professional expertise to highlight the opportunities and pitfalls associated with managed care organizational readiness to serve people with IDD and provide a framework for structuring an effective organizational readiness review process. Attendees were encouraged to share their experiences (both positive and challenging) while demonstrating readiness to serve the IDD population.*	Kris Kubnick, Elevance Health
Breakout Session: Making Care Coordination Work	*Effective care coordination of LTSS populations is impaired by a rapidly changing regulatory environment, the prevalence of complex and chronic care needs, the multi-touch care continuum required, and the fragmented setup of the payer, provider, and CMS data. These major challenges require unique approaches that optimize person-centered coordinated care for positive outcomes at the member, organization, and care team levels, as well as nimbly adapt to evolving environmental changes while driving health improvements within LTSS populations. This session explored unique approaches to bridging seamless data interoperability practices with flexible configuration management to support a plan's integrated care processes and deliver more effective, efficient, productive coordinated care for diverse LTSS populations. Leaders discussed strategies for implementing interoperability within care management systems, which allows for the flexibility needed for complex populations and enables operational teams to spend more time with participants and less time working to meet shifting regulatory requirements.*	Rebecca Voss, Virtual Health Brendan Harris, UPMC

Breakout Session: Achieving High Quality MLTSS Assessment Outcomes	*Determining holistic needs, ensuring appropriate care, and building care plans for individuals who require assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) presents a unique set of challenges that are amplified within Medicaid populations who are often the most vulnerable and underserved members of our communities. Creating a person-centered care plan begins with assessing the needs of Medicaid members in the community. It is a core business process of MLTSS health plans, and these assessments can be fraught with complexities that MLTSS plans need to overcome. Moderators facilitated an interactive discussion regarding the following issues: managing a field-based, remote workforce; addressing the variation in quality of assessments between individual assessors and/or assessment organizations; conducting an assessment and achieving consistent interpretation; addressing comprehensive health assessments that are prone to misalignment across domains (such as cognition, behavioral health, physical functioning, diseases, supports, and other health related domains); the downstream impacts of health assessments on health plan operations and member outcomes; and other areas where regulatory agencies can assist in improving these core business processes. Promising practices and innovative strategies to overcome challenges in these areas will be highlighted.*	Matt King, QCSS Health Elaine Aguirre, The Columbus Organization
Breakout Session: Leveraging Enabling Technologies to Advance Independence First	*This facilitated session explored the latest developments, policy questions, and strategies for increasing access of older adults and individuals with disabilities to enabling technologies. Participants had the opportunity to share challenges faced with balancing demand for enabling technologies and ensuring coverage of such technologies leads to intended improved health and quality of life outcomes.*	Rachel Chinetti, Elevance Health Michelle Martin, UnitedHealthcare Community & State
Breakout Session: Taking Value-Based Care to the Next Level	*Strong collaboration between managed care organizations (MCOs) and providers is crucial to the success of value-based contracting in MLTSS. The LTSS landscape consists of a variety of service providers, many of whom are smaller, community-based organizations that may lack the resources, infrastructure, or knowledge necessary to engage*	Anna Keith, PA Health & Wellness Matt Lippitt, BAYADA Home Health Care

	effectively in value-based arrangements. This fragmentation presents challenges for plans and providers alike, including difficulties in tracking and reporting metrics, managing financial risk, and aligning care goals. To overcome these barriers, it is essential that MCOs and providers work together to build capacity, share resources, and establish clear expectations for performance. *Based on input from its member plans, the National MLTSS Health Plan Association has developed a stepwise framework in the planning, execution, and evaluation of a plan-provider VBC relationship. In this session, leaders discussed the key steps for the development of a successful value-based contracting relationship, highlighting recommendations from the Value-Based Contracting Workgroup paper.*	
Breakout Session: Strategies for Improving Self-Direction	*The ongoing caregiver shortage and workforce crisis, along with rising costs of care, necessitate different approaches to assuring members eligible for LTSS get what they need when they need it to live optimally independent lives in their homes and communities. Self-direction offers a compelling strategy to provide greater flexibility, opportunities for creative solution-building, and more personalized supports for individuals with LTSS needs. But operationalizing the core principles of self-direction in a Medicaid managed care model is easier said than done. This breakout session discussed the challenges states are facing in developing successful consumer-directed programs, and strategies and approaches MLTSS plans can take toward realizing the full potential of this innovative model in the years to come.*	Casey Sanders, Applied Self Direction Molly Morris, Applied Self Direction
Breakout Session: Success and Challenges of Coordinating Unaligned Dually-Eligible Population	*"Alignment" in the context of MLTSS occurs when the parent organization of a dually-eligible beneficiary's MLTSS plan is the same organization as that beneficiary's Medicare Advantage plan – typically some form of a dually-eligible special needs plan (D-SNP). While alignment of beneficiary's service delivery remains an overarching goal for most Medicaid and Medicare stakeholders, the practical reality is that the majority of dually-eligible MLTSS (and LTSS) beneficiaries remain unaligned. Until broader policy reforms, service delivery adjustments, and evolutions in beneficiary preference for alignment change this*	Judy Cua-Razonable, LA Care Health Plan David Kagan, LA Care Health Plan

	reality, MLTSS plans must continue to focus on the care coordination needs of unaligned beneficiaries at least as much as the needs of unaligned beneficiaries. *This panel explored the inherent challenges of this coordination process as well as practical approaches in addressing it. The breakout fostered a dialogue that can lead to the identification of recommendations in policy reform as well as best practices in care coordination.*	
Federal Partners Highlight: Candid Conversations Regarding Innovations in Medicare/Medicaid LTSS	*Over the past several years, the Centers for Medicare and Medicaid Services (CMS) Medicare and Medicaid Coordination Office (MMCO) have implemented transformative policies to improve the delivery of integrated care for dually-eligible individuals. The recent contract year (CY) 2025 Medicare Advantage and Part D final rule codifying significant changes to D-SNP enrollment policies to support and enhance alignment efforts for dually-eligible individuals across states. As states and health plans prepare for major changes like the upcoming sunset of the Financial Alignment Initiative and transition to new dually-eligible special needs plan (D-SNP) models in participating states, the implementation of new special enrollment periods, and enrollment limitations for integrated D-SNPs, there has been much discourse and scenario planning for the varied potential implications for states, health plans and beneficiaries. In this session, we heard from MMCO about the office's vision for the future of integrated care, their work with states and other stakeholders in preparation for upcoming policy deadlines*	Tim Engelhardt, Director, Medicare-Medicaid Coordination Office, CMS Gretchen Nye, Medicare-Medicaid Coordination Office, CMS

DAY 2		
Session	**Description**	**Speakers**
State Officials Panel: Looking Ahead - Next Steps for MLTSS from State Leaders	*Continuing conversations from Day 1, we were joined by three state leaders to explore their priorities for the upcoming year. In addition to discussing how their states plan to respond to the many recent regulatory changes, these state officials will share their insights and strategies for addressing the pressing challenges, such as the upcoming sunsetting of the Financial Alignment Initiative and the LTSS industry's lagging adoption of value-based*	Anastasia Dodson, California Department of Health Care Services John Bonin, State of Rhode Island Jennifer Langer Jacobs, State of New Jersey

	purchasing. Learn what keeps these leaders motivated to tackle these and other difficult issues during this panel discussion.	
General Session: Reinforcing the Front Line of the MLTSS System: Innovative Strategies for Recruiting, Developing and Advancing the HCBS Direct Service Workforce	*Supporting Direct Care Workers is critical to improving the quality and capacity of home and community-based service delivery systems. A long-standing direct care worker shortage, caused by low pay and poor working conditions and worsened by the COVID-19 pandemic, threatens access to essential care. Federal, state and local government leaders, providers, and plans are innovating to respond to the care crisis. The MLTSS Association explored this issue extensively with our members and partners, culminating with the Strengthening the Direct Care Workforce Framework published last year. This session will continue to build on these efforts by sharing innovative approaches to recruiting, training, developing and advancing DCWs as a core HCBS delivery and quality improvement strategy across Medicaid-funded managed LTSS systems. Panelists will also provide an overview of recent federal investments aimed at helping build a robust, competent direct care*	Caroline Ryan, ACL Sharon Alexander, AmeriHealth Caritas Jeff Cross, Benchmark Human Services
Federal Keynote: The Critical Role of Managed Care in Taking LTSS to the Next Level	*The majority of Medicaid and Medicare services are now delivered via managed care plans. Additionally, MLTSS programs have expanded from only eight states offering MLTSS programs in 2004, there are now 25 states offering a variety of MLTSS programs to serve older adults and individuals with a variety of disabilities. Managed care plans provide a variety of care management and administrative services on behalf of states. MLTSS plans have also been at the forefront of developing alternative payment models and innovative services to meet beneficiaries' complex health and social needs. Given tremendous growth and importance of MLTSS, state and federal policymakers are increasingly looking to managed care plans to drive innovation in the delivery, management, and quality of home and community-based services. During this panel discussion, two senior CMS officials will discuss recent regulatory changes to continue modernizing and expanding access to LTSS through managed care*	John Giles, CMCS, CMS Melissa Harris, CMCS, CMS

APPENDIX B: LEADERSHIP SUMMIT PARTICIPANTS

U.S. Administration for Community Living (ACL)
Kelly Cronin
Caroline Ryan

Aetna / CVS Health
Andrea Bennett
Molly Schild

AmeriHealth Caritas
Sharon Alexander
Chelsea Newhall
Erica Park

AnereS Strategies, LLC
Serena Lowe

Angels of Care
Kristen Robison
Brian Jones

Applied Self-Direction
Molly Morris
Casey Sanders

Attindas Hygiene Partners
John Shiner

BAYADA Home Health Care
Sue Chapman Moss
Matt Lippitt
Cris Toscano

Benchmark Human Services
Jeff Cross

Braided Health
Jeff Grahling
Michael Kinne

California Department of Health Care Services
Anastasia Dodson

CareBridge Health
Pam Coleman
Patti Killingsworth
Puneet Singh

Caregiver Action Network
Marvell Adams, Jr.

CityBlock
Reni Ellis
Winston Haung
Akhil Shah

Centene Corporation
Patti Barnett
Joe Elliott
Anna Keith
Emily Schutz

Centers for Medicare & Medicaid Services (CMS)
Elizabeth Burke
Michelle Conway
Tim Engelhardt
John Giles
Melissa Harris
Sara Klotz
Gretchen Nye
Christina Wu

Commonwealth Care Alliance
Jessica Hamilton
Whitney Moyer
Michelle Soper

Connect America
Dan Grappi
Joe Prasad

Consumer Direct Care Network
Ben Bledsoe
Bradley Rightnowar

Continual Care Solutions
Sean Ossont

Division of TennCare
Katie Evans

Elevance Health
Rachel Chinetti
Leigh Davison
William Dede
Merrill Friedman
Kris Kubnick

Healthsperien
Mosalewa Ani
Tom Bednar
Abigal Gadbois
Alli Hamburger
Anya Hirschfeld
Elizabeth Larky-Savin
Debbie McCarron
Wendy O'Brien
Amanda Spott

HHAeXchange
Russ Fendley
Melanie LeBlanc

Humana
Mark Hilliker
Tony Mollica

Impact 120 Strategy Consulting
Laura Chaise

Independent Living Systems - Florida Community Care
Josefina Carbonell
David Rogers
Chris Sullivan

IntellectAbility
Lorene Reagan

Iowa Department of Human Services
Liz Matney

Isaac Health
Julius Bruch
Joel Salinas

L.A. Care
Judy Cua-Razonable
David Kagan
Pearl Santos

MACPAC
Drew Gerber
Kate Massey

Manatt, Phelps & Phillips, LLP
Edo Banach
Emily Pantalone

MapHabit
Matt Golden

Medical Guardian
Alex Prough

Medline
John Raposo

Medscope
Chaston Thompson

Molina Healthcare
John Barth
Amy Miller-Bowman
Joy Tomlin

Mom's Meals
Catherine Macpherson
Edwin Scott

National MLTSS Health Plan Association
Mary Kaschak

Neighborhood Health Plan of Rhode Island
Mark Cooper

North Carolina Division of Health Benefits
Sabrena Lea

Pennsylvania Department of Human Services
Juliet Marsala

PointClickCare
Michael Keyes

Public Partnership LLC
Mark C. Altieri

QCSS Health
Lori Becerra
Matt King
Oliver Yu

Self Advocate
Thomas Mangrum, Jr

Self Employed
Lisa Mills

Sellers Dorsey
Rachel Feldman
Gary Jessee

Socially Determined
Andy Haslam
Trenor Williams

State of New Jersey
Jennifer Jacobs Langer

State of Rhode Island
John Bonin

TCARE
Jodi Fenner

Tenderheart
Roger Brown
Tina Harris

The Columbus Organization
Elaine Aguirre

Trualta
Tom McMahon

UnitedHealthcare
Amanda Cabral
Tiffany Cubbage
Barry Fabius
Michael Florczyk
Jaycee Jones
Rebecca Kinnebrew
Michelle Martin
Angela Massey

UPMC Health Plan
Ashley Bunnell
Brendan Harris

Vesta Healthcare
Scott Deas

Virtual Health
Rob McChane
Rebecca Voss

VNS Health
Ann Mary Ferrie
Meghan Henkel
Priya Mendon
Jeff Ribakoff

APPENDIX C: LEADERSHIP SUMMIT SPONSORS