

The Coordination Crisis: Why Care Management Is the Make-or-Break Factor in MLTSS

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The United States is in the early stages of a demographic transformation that will reshape every corner of the healthcare system. By 2030, all Baby Boomers will be 65 or older. Nearly 27 million Americans will require some form of long-term services and supports. States, health plans, and providers are scrambling to build the infrastructure to meet that need and most of them are behind.

Managed Long-Term Services and Supports (MLTSS) was designed to be the answer. By integrating long-term care into managed care frameworks, MLTSS promised to improve quality, control costs, and keep people in their homes and communities rather than in nursing facilities. Over the past decade, the model has gained real momentum: more than 26 states now operate MLTSS programs, covering over a million beneficiaries and accounting for a growing share of Medicaid's \$200 billion annual long-term care spend.

But there is a problem the industry has been slow to confront. MLTSS is not failing because of inadequate funding, regulatory barriers, or insufficient political will. It is failing — where it is failing — because of a care coordination gap that runs through nearly every program, plan, and population it touches.

At PPI, we see this gap every day. Not as an abstract policy problem, but as the operational reality facing the Medicaid health plans and government-program organizations we work with through Care Compass. And we believe closing it requires something specific: not better marketing, not more investment, not more conferences. It requires a platform that actually connects the work.

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THE GAP IS HIDING IN PLAIN SIGHT

Ask any health plan executive running a Dual Eligible Special Needs Plan (D-SNP) what keeps them up at night, and the answer is almost always the same: we can't get to the members who need us most. D-SNP enrollment has grown to more than 5.7 million

members nationally up 150% since 2018 and yet fewer than 40% of those members with long-term support needs receive adequate care management. The gap is not a secret. It is a structural reality.

The reason is straightforward. Most health plans were built for acute care. Their care management platforms, their staffing models, their workflows — all of it was designed around the rhythm of hospital admissions, specialist referrals, and 30-day readmission windows. Long-term services and supports operate on an entirely different cadence. LTSS is not episodic. It is continuous, community-based, and deeply relational. The tools and processes that work in acute care management are simply not equipped to handle it.

CMS recognizes this. The Highly Integrated Dual Eligible SNP (HIDE SNP) requirements that took effect in 2025 push D-SNP plans toward deeper Medicare-Medicaid integration which means the coordination gap is no longer just an operational problem. It is a compliance problem. Plans that are not closing the gap are not just underserving their members. They are falling behind on federal requirements with real regulatory consequences.

12M Dual-eligible Americans	<40% Receiving adequate LTSS care management	\$200B+ Annual Medicaid LTSS spending	26+ States with active MLTSS programs
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WHAT GOOD LOOKS LIKE — AND WHY IT'S STILL RARE

The evidence on what works in MLTSS is not ambiguous. Integrated care programs that coordinate the full continuum assessment, enrollment, care planning, service coordination, and claims consistently outperform fragmented alternatives on every meaningful outcome measure. Fewer hospitalizations. Fewer nursing facility admissions. Lower total cost of care. Better member satisfaction.

What these programs have in common is not a particular payment model or a particular set of vendors. They have one accountable entity managing the full workflow, and a platform that connects all of it. When care planning is disconnected from claims adjudication, members fall through the gaps. When enrollment data doesn't flow to the care team, risk stratification fails. When compliance reporting requires manual reconciliation across systems, organizations spend clinical bandwidth on spreadsheets instead of members.

The programs that get MLTSS right have solved the infrastructure problem. Most have not. And with 26 states now operating MLTSS programs and more transitioning every year the gap between what is possible and what is being delivered represents millions of members who are enrolled in managed care but not actually being managed.

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THE PROVIDER REVOLUTION AND WHAT IT DEMANDS

Something important is happening at the edges of the MLTSS market that does not yet get enough attention. Providers — hospitals, health systems, Federally Qualified Health Centers, and specialty care organizations serving elderly and physically disabled populations — are moving toward plan sponsorship. They are tired of referring patients into managed care arrangements that coordinate poorly, and they are recognizing that the capitation revenue in MLTSS represents a sustainable model for the populations they have always served.

This is a healthy development for the market. Provider-led plans tend to have deeper community roots, stronger member trust, and more established relationships with the social service organizations that LTSS members depend on. When providers lead, outcomes tend to improve.

But provider-led plans face the same infrastructure problem in its most acute form. A federally qualified health center has clinical expertise and community relationships. It almost certainly does not have a purpose-built LTSS care coordination platform, a trained care coordination team, or the operational infrastructure to manage a capitated long-term care population at scale. The cost of building that from scratch is prohibitive. It is the single largest reason that promising MLTSS entrants stall before they launch.

The market needs a different model one where infrastructure is not a barrier to entry but a shared foundation that enables more organizations to participate, more members to be served, and more of the coordination gap to close.

WHAT CLOSING THE GAP ACTUALLY REQUIRES

Closing the MLTSS care coordination gap is not primarily a technology problem though technology is part of the answer. It is a capability problem. And capability is built from people, process, and platform working together in a model designed specifically for long-term care populations, not retrofitted from acute care management.

Effective MLTSS coordination starts with rigorous assessment. The level-of-care determination that qualifies a member for MLTSS is not a checkbox it is a clinical and functional evaluation that requires trained assessors, standardized instruments, and a clear process for translating findings into a care plan. Organizations that treat this step as administrative overhead consistently underperform on member outcomes.

It continues with a care plan that is genuinely individualized. The dual-eligible population is not homogeneous. A 67-year-old with early-stage Parkinson's disease and strong family support has entirely different coordination needs than an 82-year-old with advanced

dementia living alone. Care plans that treat these members similarly as they often do in generalist care management programs fail both of them.

And it requires one connected system. The MLTSS organizations we work with are often managing too much complexity across too many platforms. Every morning starts with a reconciliation problem nobody budgeted for: data that lives in one system needs to be in another, claims that should be auto-adjudicated require manual intervention, and compliance reporting that should take minutes takes days. The administrative burden does not just cost money. It costs clinical attention — and for a population that needs continuous, proactive support, that is a patient safety issue.

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THE MARKET INFLECTION POINT

Several forces are converging to make 2025 and 2026 a pivotal period for MLTSS. CMS HIDE SNP requirements are pushing D-SNP plans toward deeper integration. The HCBS Settings Rule continues to drive institutional populations into community-based settings that require more sophisticated ongoing support. States not yet in MLTSS are facing increasing federal pressure to transition. And the aging of the Baby Boom generation is creating demographic urgency that cannot be deferred.

The organizations that will lead in this market over the next decade are building coordination capability now not waiting for the next enrollment cycle or the next regulatory deadline. The competitive landscape is shifting, legacy platforms are sunseting, their clients are under pressure to migrate, and the window for real transformation is open in a way it has not been before.

For health plans, the question is not whether to invest in LTSS coordination capability but how quickly to act. For provider-led organizations and FQHCs, the question is whether the MLTSS opportunity is worth pursuing and what it takes to pursue it credibly. For state Medicaid agencies, the question is which plans and programs are closing the coordination gap and which are papering over it with generalist tools.

At PPI, we work at the intersection of all of these. As a care coordination technology provider, managed care consultancy, health plan services partner, and TPA, our platform Care Compass was built specifically for this market — and for this moment. We are not retrofitting acute care management tools for a population that needs something different. We built the right thing for the right population from the start.

The 12 million Americans who depend on MLTSS and the millions more who will need it in the years ahead deserve a system that actually coordinates their care. That means rigorous assessment. Individualized care planning. Proactive outreach. One connected system instead of fragmented tools.

The coordination gap is not inevitable. It is a solvable problem. And solving it not talking about it is what MLTSS was always supposed to be about.

About Care Compass, Powered by PPI

Care Compass is the operating platform for running a Medicaid health plan or government-program well from enrollment through claims adjudication, in one connected system. PPI brings care coordination technology, managed care consulting, health plan services, and TPA capabilities together under one platform, purpose-built for the elderly and physically disabled populations at the heart of the MLTSS market.

To learn more or request a demo, visit ppi.com



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Chris brings a deep knowledge of both technology and end-to-end claims reimbursement and contracting. Over a 40-year career in healthcare and software, he has merged complex technology skills with a deep understanding of the healthcare industry. At PPI, Chris leads technology efforts to create a more efficient, effective, and accurate Claim and Care Management software solution.