Agenda

• Introduction
• Overview of MLTSS Programs
• States’ Interest in MLTSS
• Key Elements for Successful MLTSS Programs
• Open Discussion
NASUAD: Who We Are

• **State Association:** 56 members, representing state and territorial agencies on aging and disabilities

• **Our Mission:** To design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability, and their caregivers.
NASUAD: Who We Are

• Our members include:
  – State Unit on Aging directors
  – Medicaid Long-term Services and Supports directors
  – Developmental Disabilities Services directors

• 11 staff manage Federal policy (congressional and executive branch), administer 6 Federal and Foundation grants, and publish Medicaid Integration Tracker and Friday Update

• Conveners of the National Home and Community Based Services Conference - largest conference of its kind with over 1,400 attendees, 5 plenaries, 5 all-day preconference intensives and 115 sessions over 3 ½ days
NASUAD Provides Leadership, Technical Assistance, and Policy Support to State LTSS Systems in the Following Areas:

- Promoting Community Integration
  - MLTSS
  - Medicaid HCBS regulations
  - DOL regulations

- Encouraging Health & Wellness
  - Oral Health

- Supporting Consumer Access
  - I&R Support Center
  - MIPPA Resource Center
  - Volunteer Resource Center
  - SNAP Enrollment

- Promoting Sustainability
  - Disability Organizations
  - Business Acumen
  - Agency Redesign

- Preventing Abuse and Exploitation
  - Ombudsman Resource Center
  - Elder Justice
  - Adult Protective Services

- Measuring Quality
  - NCI-AD
  - NQF HCBS Quality Committee
  - Alzheimer’s Workgroup
  - LTQA

NASUAD Provides Leadership, Technical Assistance, and Policy Support to State LTSS Systems in the Following Areas:
NASUAD’s MLTSS work

• Grant from ACL to help states and CBOs address the implications of MLTSS programs
  – Talk to/educate executive branch leadership, legislators, providers, other stakeholders on national perspective
  – Published “CBOs and MLTSS: An Issue Brief to Assess CBO Readiness” in December, 2014 (with funding from SCAN Foundation)

• Soon-to-be released analysis and implications of new Medicaid managed care regulations on MLTSS programs

• Represented states on National Quality Forum’s Home and Community-Based Services Quality Workgroup
  – Released final report recommending domains of measurement and promising measures for further refinement
My Credentials

• 20 years in Medicaid managed care:
  – Worked in Medicaid MCOs in Maryland doing operations and regulatory compliance for 10 years
  – Increasingly senior positions in CMS on Medicaid delivery systems since 2005

• Senior Policy Advisor on Medicaid managed care at Center for Medicaid & CHIP Services (4 years)
  – National expert on MLTSS
  – One of primary authors of CMS MLTSS guidance and MLTSS sections of new Medicaid managed care regulations

• Providing intensive TA to new MLTSS states at NASUAD

• Semi-annual full day conferences on MLTSS
Overview of MLTSS Programs
What is Managed Long-Term Services and Supports (MLTSS)?

- MLTSS is the delivery of long term services and supports (state plan, waiver or both) through capitated Medicaid managed care plans

- Plans can be a managed care organization, pre-paid inpatient health plan, or a pre-paid ambulatory health plan (depending on scope of benefits provided)

- In many cases, plans are covering medical services as well, which provides a comprehensive delivery system for beneficiaries
Current MLTSS program (regional **)
State MLTSS Programs at a Glance

- There are 8 comprehensive MLTSS programs that include all Medicaid services (acute, behavioral, LTSS), operate statewide and enroll most populations:

|----------------|-----------------|

* indicates programs which include persons with intellectual/developmental disabilities
There are 12 states have at least one separate program for acute care and LTSS:

<table>
<thead>
<tr>
<th>State</th>
<th>Year</th>
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<tr>
<td>Arizona</td>
<td>1988</td>
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<tr>
<td>New York</td>
<td>1997</td>
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<td>Wisconsin</td>
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<td>Minnesota</td>
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<td>South Carolina</td>
<td>2015</td>
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<tr>
<td>Rhode Island</td>
<td>2016</td>
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Notes: * indicate dual-only programs through CMS
- Pennsylvania will join this list when they launch their Community Healthchoices program in 2017
- Virginia plans to close its’ duals demonstration in 2017 and create a new MLTSS program in 2018
State MLTSS Programs at a Glance

• These states have MLTSS programs for limited populations or in limited geographic areas:
  – Michigan and North Carolina both have a statewide, county-based capitated program for mental health and I/DD services only
  – California integrated LTSS into its Medi-Cal health plans in 5 counties
  – Massachusetts, Minnesota and Wisconsin have more than one program for its LTSS populations
MLTSS programs generally focus on fully integrating benefits

Percent of States Including Selected Services in MLTSS

- Medicaid primary and acute care
- Medicaid home and community based services
- Nursing facility services
- Self-directed services
- Medicare primary and acute care services

Source: NASUAD 2015 State of the States Survey
States using varied strategies to coordinate care for dual eligibles

- Financial alignment demonstration
- Coordination between Medicare Advantage and Medicaid MCOs
- Fully integrated D-SNPs
- Other initiatives

Source: NASUAD 2015 State of the States Survey
Trends for 2017 and beyond

• MLTSS continues to be the biggest trend/opportunity for states to address accountability, cost efficiency and better outcomes for consumers

• Expansion of existing programs either statewide or beyond dual eligibles

• Inclusion of LTSS services for individuals with intellectual/developmental disabilities in MLTSS programs
  – Currently only IA, KS, TN, and TX use MCOs to deliver these services
Focus on quality - consumer concern about potential MCO service denials has amplified calls for outcome measurement

- 30 measures in duals demonstrations
- NASUAD-sponsored National Core Indicators for Aging and Disabilities (NCI-AD) consumer quality of life survey in ~13 states in 2016
- CMS-sponsored TEFT experience of care survey in 9 states
- National Quality Forum completed of 2-year HCBS Quality Measurement project

» Multi-stakeholder committee has developed a conceptual framework, conducted an environmental scan, identified gaps as well as promising measures and recommended new measure development efforts for those gaps

Trends for 2017 and beyond
Trends for 2017 and beyond

• States without managed care capacity OR hostility toward managed care looking at partial-risk alternatives like ACOs

• States also looking at expanding pay-for-performance/value-based purchasing from NFs and other large providers to HCBS providers
  – Nascent effort due to lack of standardized measures and need for significant stakeholder engagement

• More and more involvement by MCOs in states’ Olmstead plans, as well as housing and employment first initiatives
States’ Interest in MLTSS
Why are states pursuing MLTSS?

- In FFY 2014, LTSS expenditures represented about 34% of all Medicaid expenditures (~$146B)\(^1\)
  - These services constitute the largest group of Medicaid services remaining in traditional fee-for-service system
  - Fragmented approach to the ‘whole person’
  - Of note: managed care expenditures have DOUBLED since FY 2012 (to almost 15% of all LTSS expenditures)

- In FFY 2013, total LTSS expenditures were spent on fewer than 10% of all Medicaid beneficiaries\(^2\)

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1 Truven Health Analytics, June 2016
2 MACPAC, June 2014 Report, Chapter 2
Why are states pursuing MLTSS?

• Accountability rests with a single entity
  – Integrating acute and long-term care makes the consumer (rather than their ‘services’) the focus
  – Financial risk for health plan provides opportunity to incentivize/penalize performance for health outcomes and quality of life

• Administrative simplification
  – Eliminates need to contract with and monitor hundreds/thousands of individual LTSS providers
  – Can build on managed care infrastructure to provide support to members
Why are states pursuing MLTSS?

• Budget predictability
  – Capitation payments greatly minimize unanticipated spending
  – Can more accurately project costs (especially with LTSS as enrollment doesn’t have as much variation based on economic circumstances)

• Shift locus of care to community settings
  – Most consumers express preference for community-based services
  – Health plans may be able to effectuate transfers from institutions to community more easily
Why are states pursuing MLTSS?
Why are states pursuing MLTSS?

• Graph is misleading however.
  – 75% of consumers with I/DD are served in community settings
    • Closures of ICF-I/DDs across the country
    • Strong pattern of family caregiving
  – Only 41% of older adults and consumers with physical disabilities are served in community settings
    • An increase since 2002 when 22% of these consumers were in community
    • Opportunities exist to serve consumers in less restrictive settings
Select Achievements

There have been no national studies assessing the efficacy of MLTSS programs; however, there are anecdotal indications of improvement

1. Increase in consumers served in home and community based settings
   - Tennessee spent 19% of its total LTSS expenditures on HCBS in 2010; by 2014, HCBS were over 50% of total HCBS expenditures

2. Improved health outcomes for LTSS consumers ³
   - New York MLTSS plans improved consumers’ functional ability; increased administration of flu vaccines; and showed high member satisfaction

Key Elements for a Successful MLTSS Program
Keys to Success

• Critical elements in high-functioning MLTSS programs
  – Strong care coordination requirements and structure
  – Network adequacy standards
  – Provider contracting and training at start-up
  – Consumer protections - ombudsman; strong choice counseling
  – Timely assessments and service delivery; back up plans; service verification (safety/fraud and abuse)
  – STRONG state agency management controls and health plan accountability mechanisms (contract language and financial consequences)

• Many mirror 2013 CMS guiding principles for MLTSS 4 as well as 2014 AARP Issue Brief 5

• Incorporated into successful programs: AZ, TN, NJ and TX

Keys to Success

• State must take responsibility for the success of the program
• It is a multi-faceted approach, including....
  – MCO contract
  – MCO expectation-setting/training
  – Consumer and provider education
  – Beneficiary support system
  – State oversight and monitoring
• All of this can be imperiled WITHOUT thoughtful planning and design in collaboration with stakeholders and implementation timeframes that accommodate systemic change
Keys to Success

1. Strong care coordination requirements:
   – Continuity of care period where current care plans continue unmodified *(will be required by MMC regs by 7/1/18)*
     ❖ All states have taken this approach
   – State review of service plan reductions (at least first year)
     • Important to define what a ‘reduction’ is
     • Substitution of services may be OK if identified needs are met appropriately
     ❖ KS, TN, TX
   – Detailed contract language for care coordination and care plan development
     ❖ TN, NJ, DE, AZ
Keys to Success

2. Network Adequacy Standards:
   – Definitely an area for more creativity, esp. for services delivered in the home (will be required by MMC regs by 7/1/18)
     ❖ TN, DE, AZ assess network adequacy in operation by assessing gaps between services needed, authorized and delivered

3. Provider contracting and training (at start-up)
   – MCO training; LTSS provider outreach/communication and training, both from state and MCOs
   – Standardized provider contracts, credentialing and authorization forms, mandatory claims testing between MCOs and providers
     ❖ TN has done most of these
Keys to Success

4. Consumer Protections:
   – Clear and consistent communication about upcoming changes (and their advocates)
     ❖ TN, NJ, TX, duals alignment demonstrations
   – Multi-modal choice counseling for plan selection (will be required by MMC regs by 7/1/17)
     ❖ FL
   – Post-enrollment consumer assistance (will be required by MMC regs by 7/1/18)
     ❖ KS, IA, FL, NM, NY, duals alignment demonstrations
LTSS “Ombudsman” Program

• Core functions:
  – Access point for complaints and concerns about MCO enrollment, access to services, and.
  – Advocate on member’s behalf to informally resolve problems with their providers or MCO
  – Help members understand MCO appeal process and right to State fair hearing
  – Assist members in filing an MCO appeal, including guiding them through needed documentation
  – Assist members in requesting a State fair hearing
  – Referring beneficiaries to legal counsel if necessary.
LTSS “Ombudsman” Program

• System design options
  – State-managed (ideally outside Medicaid agency)
  – Contracted

• Identification of trends, patterns critical part of MCO monitoring
  – What MCOs are getting most complaints?
  – What topic(s) are most frequently asked about?
  – Are there regional/county-based differences?
Keys to Success

5. Timely assessments and service delivery; service verification (safety/fraud and abuse)

- Assessments, care plans and service delivery timeframes at least as stringent as FFS
  
  - Most have shortened timeframes from FFS, including duals alignment demonstrations

- Visit verification systems (proposed to be mandatory for states in House mental health bill)
  
  - TN, TX, IL, OH, KS
6. Strong State oversight and accountability mechanisms

- State staff experienced in program management, contract monitoring, provider network adequacy, quality assessment, and rate setting
  - AZ, TN, FL, NJ, DE, NY

- Contract with stringent MCO reporting and liquidated damages for immediate financial consequences
  - TN, DE, NJ, TX

- Public reporting of MCO performance
  - NY, MN
Questions/Discussion