Framework for MLTSS
Quality in Pennsylvania and Virginia

National HCBS Conference

Paul Saucier
Senior Director
August 31, 2017
Connecting the silos for a broader view of quality.
Partnering with and overseeing accountable entities.
Addressing population health and well-being.
Our Panelists

Fuwei Guo, CCC Plus Operation Supervisor
Virginia Department of Medical Assistance Services

Jen Burnett, Deputy Secretary for Long-Term Living
Wilmarie Gonzalez, Director, Bureau of Quality Assurance and Program Analytics
Pennsylvania Department of Human Services, Office of Long-Term Living
FRAMEWORK OF MLTSS QUALITY IN VIRGINIA

NASUAD HCBS Conference 2017
Fuwei Guo
Agenda

- Overview: from CCC to CCC Plus
- Lessons learned from quality approach used in CCC
- Framework for quality in CCC Plus
- External evaluator role
- Approach to internal stakeholders
- State agency capacity: how has it changed?
1 in 8 Virginians rely on Medicaid

1 in 3 Births covered in Virginia

2 in 3 Nursing facility residents are supported by Medicaid

Medicaid is primary payer for **Behavioral Health** services

50% of Medicaid beneficiaries are children

62% of Long Term Services & Supports spending is in the community
Older adults and individuals with disabilities
23% of the Medicaid population = 66% of expenditures
Commonwealth Coordinated Care Overview

CCC is...
- Demonstration program blending Medicare & Medicaid into one health plan
- Goal: Improve health outcomes through more coordinated care
- Benefits: One system, one card, care coordination, expanded benefits

Participating Plans
- Anthem
- Humana
- VA Premier

Population
- Full Duals 21 & older
- Live in one of 5 CCC region: 102 participating urban and rural localities
- Includes: EDCD & NF

Status
- Automatic assignment ended March 2017
- Beneficiaries may no longer opt-in or change plans
- Enrollment has averaged 30,000 for 2017
Commonwealth Coordinated Care Plus Overview

**CCC Plus is...**
- New statewide Medicaid managed care program through CMS 1915 (B) and (C) combo waiver authority
- Goal: To improve health outcomes & provide care coordination
- Benefits: Person centered care and supports, care coordination, expanded benefits such as dental and hearing

**Participating Plans**
- Aetna
- Optima
- Anthem
- United
- Magellan
- VA Premier

**Population**
- 65 and older
- Adults and children living with disabilities
- Individuals living in Nursing Facilities and in one of five Virginia HCBS waivers

**Status**
- Enrollment phased in regionally Aug. 2017-Jan. 2018
- Continuous automatic assignment of newly eligible beneficiaries
- Beneficiaries enrollment locked 90 days after enrollment; annual open enrollment (October-December starting in 2018)
- Projected Enrollment after full implementation: 215,000 Virginians
### Key Differences

<table>
<thead>
<tr>
<th>CCC Plus</th>
<th>CCC</th>
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<tbody>
<tr>
<td><strong>Statewide in 6 regions</strong></td>
<td><strong>Not Statewide: 5 of the 6 regions</strong></td>
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<tr>
<td><strong>Required Enrollment</strong></td>
<td><strong>Optional Enrollment</strong></td>
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<tr>
<td><strong>Duals/non-duals, children/adults, NF and 5 HCBS Waivers</strong></td>
<td><strong>Full Dual adults; including NF and EDCD HCBS Waiver</strong></td>
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<td><strong>6 Health Plans</strong></td>
<td><strong>3 Health Plans</strong></td>
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<tr>
<td><strong>Coordination of Medicare benefits through companion DSNP or MA Plan</strong></td>
<td><strong>Coordination of Medicare benefits through same Medicare Medicaid Plan</strong></td>
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<tr>
<td><strong>Continuity of care period is 90 days</strong></td>
<td><strong>Continuity of care period is 180 days</strong></td>
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CCC Care Continuum and Initial Finding

Engagement
In Care
Assessment
Plans of Care

Process Measures
Access
Care Coordination
Utilization
Management

Outcome Measures
Member Satisfaction
Quality of Life
Lower Cost
Lessons Learned from CCC

✓ Mandatory enrollment with limited open enrollment period for MLTSS stability
✓ Tighten care management contractual requirements for MLTSS
✓ Continue partnering with CMS and Ombudsman for intensive contract and quality monitoring
✓ Using intelligent assignment to place members in the best plan
✓ Restructured Quality Framework
Lessons Learned from CCC - Quality

✓ Ensure access, choice and beneficiary protection
✓ Align with national and state quality strategy and initiatives
✓ Measure beyond HEDIS and CAHPS
✓ Use value-based payment program to drive improvement
CCC Plus Quality Framework

- **Aims:**
  - Member Experience/Engagement for Person-centered Care
  - Better Care
  - Maintain and Improve Population Health
  - Reduce Per Capita Costs

- **Priorities:**
  - Member Safety, Satisfaction and Quality of Life (4)
  - Access, Disease Management and Service Utilization (1)
  - Care Management and Coordination (2)
  - Prevention, Healthy Living and Aging Well (3)
  - Value-Based Payment (5)
CCC Plus Quality Measurement

- CMS Medicaid Core Sets
- HEDIS and CAHPS
- AHRQ PQIs
- Quality of Care and Life
- Home Grown Measures
- State Population Health
- CMS Waiver Assurance

17
External Evaluator Role

- Contribute to ongoing managed care monitoring and oversight with objective facts and analytical insights
- Foster transparency and external stakeholder involvement
- Identify program implementation themes and effectiveness
Approach to Internal Stakeholders

✓ Training and education (e.g. brown bag lunches)
✓ Team up and lever on internal experts and SMEs
DMAS Agency Capacity Changes

- Internal Restructure for better Managed Care Oversight
- MMIS Redesign and Advanced Data/Analytics
- Better Staffed and Equipped Integrated Care Division
- More Collaborations and Less Silos
- Agency Wide Quality Strategy (in development)
Thank You!

For More Information . . .

Additional Virginia MLTSS Program information is available at:


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Framework for MLTSS Quality
In Pennsylvania

Jennifer Burnett, Deputy Secretary
Wilmarie Gonzalez, Bureau Director
Office of Long-Term Living

August 31, 2017
WHAT IS COMMUNITY HEALTHCHOICES (CHC)?

A Medicaid managed care program that will include physical health benefits and long-term services and supports (LTSS). The program is referenced to nationally as a managed long-term services and supports program (MLTSS).

WHO IS PART OF CHC?

• Individuals who are 21 years of age or older and dually eligible for Medicare and Medicaid.
  ✓ Individuals with intellectual or developmental disabilities who are eligible for services through the Office of Developmental Program will not be enrolled in CHC.

• Individuals who are 21 years of age or older and eligible for Medicaid (LTSS) because they need the level of care provided by a nursing facility.
  ✓ This care may be provided in the home, community, or nursing facility.
  ✓ Individuals currently enrolled in the LIFE Program will not be enrolled in CHC unless they expressly select to transition from LIFE to a CHC managed care organization (MCO).
CURRENT BARRIERS TO LTSS

• Participants show a tendency to under-plan and under-insure for long-term care until there is a crisis.

• Confusing information about how to receive services.

• The system is difficult to navigate, particularly when transitioning between care delivery systems.
  ✓ Lack of coordination between primary, acute, and LTSS organizations
  ✓ Limited coordination between Medicare Special Needs Plans and LTSS organizations

• There is limited availability of long-term care insurance products. Available products limit coverage and are costly.
420,618 CHC POPULATION

- 94% DUAL-ELIGIBLE
- 64% Healthy Duals
- 12% Duals in Waivers
- 18% Duals in Nursing Facilities
- 16% IN WAIVERS
- 20% IN NURSING FACILITIES

- 4% Non-duals in Waivers
- 2% Non-duals in Nursing Facilities
- 77,610
- 49,759
- 270,114
- 15,821
- 7,314
WHAT ARE THE GOALS OF CHC?

GOAL 1
Enhance opportunities for community-based living.

GOAL 2
Strengthen coordination of LTSS and other types of health care, including all Medicare and Medicaid services for dual eligibles.

GOAL 3
Enhance quality and accountability.

GOAL 4
Advance program innovation.

GOAL 5
Increase efficiency and effectiveness.
WAIVER TRANSITIONS JANUARY 2018

CHC WAIVER

Transferring to the CHC Waiver:
- Phase 1 Aging Waiver participants.
- Phase 1 Attendant Care Waiver participants ages 21 and older; participants under 21 will transition to the OBRA Waiver.
- The COMMERCIAL Waiver will become the CHC Waiver; Phase 2 & 3 COMMERCIAL participants will transition to the Independence Waiver.
- Phase 1 Independence Waiver participants ages 21 and older; participants under 21 will transition to the OBRA Waiver.
- Phase 1 OBRA Waiver participants ages 21 and older who are nursing facility clinically eligible; participants under 21 or not nursing facility clinically eligible will remain in OBRA.

TRANSITIONING TO LIFE:
Participants 55 and older who are nursing facility clinically eligible may choose to enroll or remain in a LIFE program instead of CHC.

1 Participants will receive behavioral health services through the Behavioral Health Managed Care Organizations.
2 Participants will receive an updated clinical eligibility determination.
HOW DOES CHC

**DHS**
- Pays a per-member, per-month rate (also called a capitated rate) to MCOs
- Holds the MCOs accountable for quality outcomes, efficiency, and effectiveness

**MCO**
- Coordinates and manages physical health and LTSS for participants
- Works with Medicare and behavioral health MCOs to ensure coordinated care
- Develops a robust network of providers

**Participants**
- Choose their MCO
- Should consider the provider network and additional services offered by the MCOs
STAKEHOLDER ENGAGEMENT

• Public Forums
  • Participants
  • Providers and Associations
• MLTSS Subcommittee (monthly meetings)
• Monthly Third Thursday Webinars
• Legislators
• CHC Website
Stakeholder Feedback on PA Draft Quality Strategy (Themes)

- Ensure that participants AND providers have mechanics in place to include:
  - An independent system (Beneficiary Support System, as defined under the managed care final rule).
  - Participant and provider hotline numbers continue at the state level.
  - Continuous communication
- Continue to promote stakeholder engagement among:
  - DHS
  - MCO
  - Providers
  - Participants
  - Advocates

- Continue to have program transparency:
  - Report on performance measures and outcomes to stakeholders:
  - Consumer and provider satisfaction surveys
  - Critical incidents / reports of abuse
  - Incorporate pay for performance initiatives
  - Monitoring of program
- Ensure participant choice
  - Community living
  - Nursing home
  - Service providers
- Diversity inclusion
  - Ethnicity
  - LGBT population
  - Various translations available
CHC Quality Components

- Critical Incidents
- Performance Measures
- Consumer Surveys
- Compliants & Appeals
- Network Standards
- Monitoring & Compliance
- Readiness Review
- External Quality Review (EQR)
- Performance Improvement Projects
- Value-based Payment (future)
- Independent Evaluation

Exist in current FFS
NEW in CHC
<table>
<thead>
<tr>
<th>National</th>
<th>State</th>
<th>Launch Indicators</th>
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<tbody>
<tr>
<td>• Healthcare Effectiveness Data &amp; Information Set (HEDIS)(Adults)</td>
<td>• LTSS Community Based Services</td>
<td>• Key data points provided frequently during launch</td>
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<tr>
<td>• CMS Adult Core</td>
<td>• Service Coordination and Care Coordination</td>
<td>• Focus on:</td>
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<tr>
<td>• CMS Nursing Facility</td>
<td>• Grievances, Appeals &amp; Critical Incidents</td>
<td>• Continuity of Services</td>
</tr>
<tr>
<td>• Consumer Assessment of Healthcare Providers &amp; Systems (CAHPS)</td>
<td>• Rebalancing</td>
<td>• LTSS Provider Participation</td>
</tr>
<tr>
<td>• CMS Medicare measures for Dual Eligible Special Needs Plans</td>
<td>• CHC HCBS Waiver Assurances</td>
<td>• Key Information Transfers (IT Systems)</td>
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</table>

**Launch Indicators**
- Key data points provided frequently during launch
- Focus on:
  - Continuity of Services (Participants & Providers)
  - LTSS Provider Participation
  - Key Information Transfers (IT Systems)
Independent Evaluation of CHC

Focus Groups with Participants

Participant and Caregiver Interviews

Key Informant Interviews with Stakeholders

Analysis of Administrative Data

Health Policy Institute Medicaid Research Center University of Pittsburgh

LTSS Provider Survey
PRIORITIES THROUGH IMPLEMENTATION

**READINESS REVIEW**
- Information systems
- Network adequacy
- Member materials and services

**STAKEHOLDER COMMUNICATION**
- Participants and caregivers
- Providers
- Public

**DHS PREPAREDNESS**
- General Information
- Training
- Coordination between offices
- Launch indicators
CONTINUITY OF CARE (COC)

• MCOs are required to contract with all willing and qualified existing Medicaid providers for 180 days after CHC implementation.

• Participants may keep their existing providers for the 180-day continuity of care period after CHC implementation.

• For nursing facility residents, participants will be able to stay in their nursing facility as long as they need this level of care, unless they choose to move.

• The launch indicators focus on continuity for Participants and Providers during the COC period.
RESOURCE INFORMATION

COMMUNITY HEALTHCHOICES WEBSITE
www.healthchoicespa.com

MLTSS SUBMAAC WEBSITE
www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/mltss/

CHC LISTSERV // STAY INFORMED
http://listserv.dpw.state.pa.us/Scripts/wa.exe?SUBED1=oltl-community
healthchoices&A=1

EMAIL COMMENTS TO: RA-MLTSS@pa.gov

PROVIDER LINE: 1-800-932-0939

PARTICIPANT LINE: 1-800-757-5042