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Improving the quality and cost-effectiveness of publicly financed health care

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Managed Long-Term Services and Supports: Landscape from Readiness Review to Ongoing Oversight

NASUAD HCBS Conference 2014

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Sarah Barth, Director of Integrated Health and Long-Term Services, CHCS

Agenda

I. **Welcome and Introductions,** Michelle Herman Soper

II. **Ready, Set, Go! Readiness Review for Care Coordination and Provider Network Adequacy in Five States,** Lynda Flowers

III. **OneCare Medicaid+Medicare Early Indicators Project,** Dorothée Alsentzer

IV. **Managed Long-Term Services and Supports: Ongoing Program Monitoring and Oversight,** Sarah Barth

V. **Questions and Discussion**

Platforms for Service Delivery and Integration

Approach	State Examples
PACE	Most states
Medicaid FFS with enhanced care coordination	CO, NC
Medicaid managed long-term services and supports	AZ, CA,DE, NJ, FL, KS, MI, MN, NM, NY, TX
Joint state & federal Financial Alignment Initiative	CA, CO, CT, IL, MA, MN, NY, OH, RI, SC, VA, TX, WA
Dual Eligible Special Needs Plans (D-SNPs)	AZ, HI, NM, TN
Fully Integrated D-SNPs	MA, MN, WI

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Center for Health Care Strategies, Inc.

A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care

- **Priorities**: (1) enhancing access to coverage and services; (2) integrating care for people with complex needs; (3) advancing quality and delivery system reform; and (4) building Medicaid leadership and capacity.
- **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.
- **Funding:** philanthropy and the U.S. Department of Health and Human Services.

CHCS' Current Projects to Support Medicare-Medicaid Integration

Project	Description	Funder
Implementing New Systems of Integration for Dual Eligibles (INSIDE)	Brings together 16 states implementing programs of integrated care for group learning and innovation sharing	The Commonwealth Fund, The SCAN Foundation
Promoting Integrated Care for Dual Eligibles (PRIDE)	Convenes seven integrated health organizations to identify and test innovative strategies that enhance and integrate care for Medicare-Medicaid enrollees	The Commonwealth Fund
Integrated Care Resource Center (ICRC)	Provides technical assistance to states pursuing financial alignment demonstrations and other integrated care models at every level of design and implementation	Centers for Medicare & Medicaid Services (CMS)

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READY, SET, GO! READINESS REVIEW FOR CARE COORDINATION AND PROVIDER NETWORK ADEQUACY IN FIVE STATES

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What We Looked At: The Cornerstones

State processes/capacity to determine:

- Readiness to provide care coordination
- Provider network adequacy

How We Defined Care Coordination

- Educating consumers about a range of LTSS-related topics
- Assessing consumers' physical, psychosocial, cultural, and environmental needs
- Assessing and addressing the needs of engaged family caregivers
- Determining the LTSS service package

How We Defined Care Coordination, cont'd.

- Contacting LTSS Service providers to ensure service delivery
- Monitoring service delivery (including client-centeredness)
- Ongoing assessment of consumers (and family caregivers) to determine if needs or preferences have changed

How We Defined Network Adequacy

MCO has:

- Desired number of contracted providers for each LTSS provider type
- Ensures that contracted providers are adequately credentialed (federal, state, and local)
- Conducts required provider background checks

How We Defined Network Adequacy, cont'd.

MCO:

- Negotiates adequate payment rates
- Ensures the full execution of contracts between MCOs and LTSS providers
- Ensures that provider ID numbers and payment rates are accurately loaded into the MCO's IT system

States We Examined

- Wanted geographic variation
- Wanted diversity of experience with managed care (24 years in AZ; 3 years in TN)
- Arizona, Minnesota, Tennessee, Texas, and Wisconsin

Five Themes Emerged

Theme No. 1

Robust information technology (IT) systems provide critical support for:

- Care coordination (e.g., transmitting service orders to appropriate providers)

- LTSS providers (e.g., ensuring timely provider payments to LTSS providers with thin margins)

Theme No. 2

Operating managed LTSS programs requires states to work in partnership with contracted MCOs

- Partnering is critical to MCO success
- State oversight is critical to program success
- The two can be compatible

Theme No. 3

It helps when states stay involved in care coordinator training during the readiness review process and, to some degree, on an ongoing basis. Important for:

- Rapid dissemination of changes in state policy
- Consistency among care coordination processes across multiple MCOs
- Quality

Theme No. 4

Network adequacy benchmarks help MCOs understand what is involved in developing adequate LTSS provider networks. Different approaches to benchmarking:

- Numerical (TN)
- Generally accepted community standards (MN)
- Time and distance standards (all states)
- Tying enrollment to network adequacy (all states)

Theme No. 5

Ensuring "readiness" does **not occur at a single point in time**, but is an ongoing process

- State officials have to remain intimately involved in the early days (especially with MCOs new to LTSS)
- "Readiness" is a misnomer. States and MCOs engage in ongoing learning and problem solving

Conclusion

Consumer engagement is a critical feature of developing, implementing and long-term oversight of managed LTSS.

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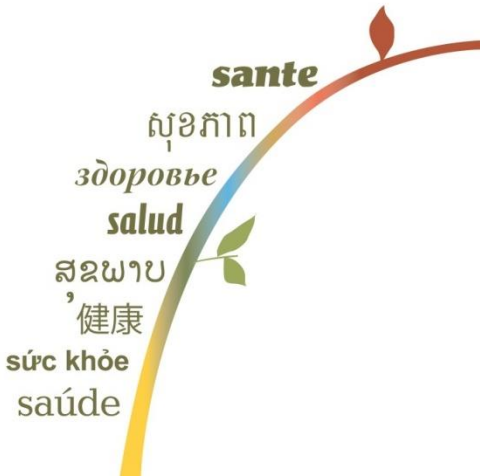
OneCare
Medicaid+Medicare
Early Indicators Project

NASUAD HCBS Conference

September 17, 2014

Dorothée Alsentzer, JD

MassHealth Policy Analyst



Early Indicators Project (EIP)

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- Project timeframe: October 1, 2013 to March 31, 2015

- The project analyzes *early* quantitative and qualitative indicator data to assess the perceptions and experiences of individuals who have enrolled (both self-selected and auto-assigned) in One Care, as well as those who have chosen to opt out

- Distinct from overall One Care programmatic evaluation/quality measures

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Observation

- Important to clarify distinction between early indicators and quality measures/programmatic evaluation process
  - Lesson 1: Include concept of early indicators vs. programmatic evaluation and quality measures early on in demonstration stakeholder engagement
  - Lesson 2: Include key stakeholders in development and deployment of the early indicators project

Community Involvement

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- One Care Implementation Council — an independent advisory body comprised of members from the disabilities community, health care providers, and advocates

- MassHealth invited the One Care Implementation Council to identify representatives to participate in an EIP work group:
  - Twice-monthly meetings
  - Members review and provide input on:
    - Indicator data elements
    - Questions for surveys and focus groups
    - Survey and focus group methodologies
    - Data review and trend identification
  - Members represent views of and report back to the full Implementation Council

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Convening the Work Group

- Keep the group reasonably small
  - MassHealth (3), Implementation Council (4), UMass (2)
- Select members who can attend meetings in person, and have some knowledge/background in data analysis or survey methods
- Set ground rules
  - Establish and agree to project scope (no “scope creep”)
  - Agree on deliverables timeline for scope components
  - Expect and be able to do work between meetings

Indicator Measures

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- Characteristics of early indicators:
  - Truly early — information must be available in the short term
  - Measurable — data exists, is readily accessible, and timely
  - Actionable — provides information that can point to actions or steps we can take to achieve a course correction

- Ensure focus on early indicators:
  - Identify sources that are already collecting and reporting data
  - Review sources' existing reports to determine available data
  - Deploy surveys and focus groups within first few months of program

Observation

- Contractual reporting requirements are extensive but not necessarily conducive to early, actionable data collection
  - Lesson: Include reporting requirements for quality measures *and* early indicator measures in ICO contracts if feasible

Quantitative Indicators

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- Internal enrollment activity data:
  - Longitudinal enrollment data
  - Enrollment penetration (by county and rating category)
  - Longitudinal opt-out data
  - Longitudinal rate of plan-to-plan switches and dis-enrollments

- Other data:
  - Plans — initial assessments; LTS coordinator assignment rates
  - MassHealth customer service — call volume; percent answered; wait time; English and Spanish
  - Independent ombudsman — tracking number and topic of calls (reported by caller, plan, action taken, etc.)
  - State SHIP program — One Care encounters; topics; referrals to other resources; member disposition

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Qualitative Indicators: Four Focus Groups

Focus Group	Date	Feedback on Materials	Reasons for Decision	Early Experiences
Early opt-outs	Dec. 2013	X	X	
Early opt-ins	Dec. 2013	X	X	X
Spanish-speaking enrollees	Mar. 2014	X		X
Auto-assignees	Apr. 2014	X		X

Survey #1

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- Survey 1: Initial One Care mailing recipients (December 2013)
  - N = 300
  - Opt-outs, opt-ins, and no-action members
  - Telephone only
  - Reaction to materials, expectations, and early experience
- Results indicated that
  - Opt-ins found the One Care info from MassHealth clear and helpful in their decision; expected simpler, better care in One Care
  - Opt-outs were reluctant to disrupt existing self-built provider networks; generally happy with status quo
  - Those who were still waiting did not find the info from MassHealth easy to understand; generally needed more information to make a decision

Survey #2

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- 6,000 randomly selected enrollees in three cohorts of 2,000 each
  - Goal of 50% response rate (3,000 completed surveys total)
  - Administered by mail, phone, and on-line
- Samples enrollees who have been enrolled for approx. 120 days
  - Self-selects and auto-assignees

Cohort: Month of enrollment	Enrollee cohort sampled
Cohort 1: January-March 2014	June-August 2014
Cohort 2: April-June 2014	August-October 2014
Cohort 3: July-September 2014	November 2014 – January 2015

Major Domains

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- Comprehensive survey of enrollees' early experiences in One Care
  - One Care enrollment process
  - Transition into One Care
  - Care team
  - Assessment and care planning processes
  - Overall satisfaction with the individualized care plan
  - Extent to which needs for care are being met under One Care
  - Overall perceptions of One Care
  - Demographic information

Preliminary results (N=375)

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- Preliminary analysis of 375 early responses from Cohort (target N=1,000)
- A summary of preliminary results will be available soon on the One Care website: http://www.mass.gov/eohhs/consumer/insurance/one-care/one-care-early-indicators-project-eip-reports.html

Question	Yes	No	Unsure
Have you had contact with Care Coordinator?	76%	17%	6%
Do you need/want LTS Coordinator?	40%	40%	18%
Have you been offered LTS Coordinator?	46%	20%	33%
Do you plan to stay in One Care?	85%	3%	11%

Rate your satisfaction with:	Completely or somewhat satisfied	Somewhat or extremely dissatisfied	Not sure / refused
Your Care Coordinator	89%	6%	4%
Your LTS Coordinator	95%	3%	2%
Your One Care plan	94%	4%	2%
Your services under One Care	93%	4%	4%

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Observations

- Data collection from outside entities—especially those not required to report to MassHealth—can be challenging
  - Lesson 1: make the most of data in hand
  - Lesson 2: if outside data is essential, determine exactly what is needed and level-set expectations for format and periodicity
  - Lesson 3: expect the unexpected and plan accordingly
- Data gets more interesting over time
  - Lesson 1: build in work time to consider what trends are meaningful
  - Lesson 2: consider updating the periodic reports to include new types of analysis

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Limitations

- EIP only tangentially covers provider experiences (Ombudsman, MassHealth customer service)
- Focus groups and surveys are limited in scope; not representative of the entire One Care-eligible or enrolled population
- Much of the quantitative data dependent on member action, *e.g.* making a phone call to ask a question, ask for assistance, or make a complaint
  - Ombudsman, SHINE, CST, One Care plans (grievances/appeals)
- Feedback on materials is only actionable for future notices and publications—doesn't remedy problems reported with respect to early mailings
- Scope does not include provider feedback

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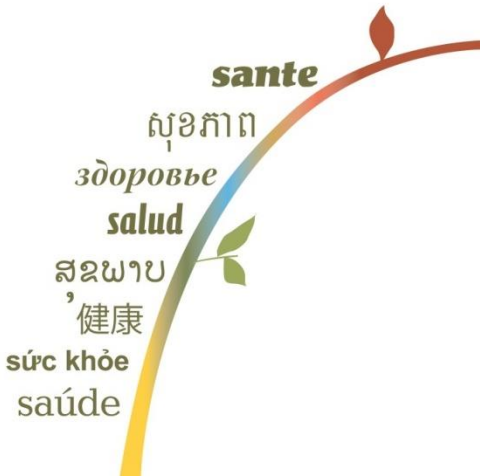

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Improving the quality and cost-effectiveness of publicly financed health care

Managed Long-Term Services and Supports: Ongoing Program Monitoring and Oversight

National Association of States United for Aging and Disabilities
National Home and Community Based Services Conference 2014

Sarah Barth, JD
Director of Integrated Health and Long-Term Services

Managed Care as a Purchasing Strategy for LTSS

- Managed care can be a tool to reduce fragmented acute and primary care, behavioral health, and LTSS
- With strong oversight and incentives MLTSS programs can provide high-quality, person-centered and cost-effective care to eligible beneficiaries in the setting of their choice

Lessons Learned: Building a Strong MLTSS Program

- Develop a communication plan and engage stakeholders during design, implementation and ongoing program oversight;
- Involve IT staff at outset of program design and planning;
- Clearly outline MCO responsibilities and expectations in contracts;
- Create strong state infrastructure for program monitoring; and
- Create LTSS-specific quality measures.

Develop a Communication Plan and Engage Stakeholders

- Connect with stakeholders early on to understand their priorities and values
- Once known, provide a good level of detail/specificity of the program design in basic terms that are understandable to stakeholders
- Have beneficiary representatives on advisory committees addressing program design, implementation and oversight
- Engage providers at all stages

Broad Stakeholder Composition: Include the MCOs

- Communication plans should bring together beneficiaries, managed care organizations (MCOs) and providers
- Having stakeholders meet the MCOs and problem solve early on helps build a relationship and better ensures that design processes and systems will work for all

Include Program Oversight in the Communication Plan

- Consider a permanent subcommittee to the Medicaid Advisory Committee to address MLTSS program design and implementation issues and to share successes with:
  - Beneficiaries and their families
  - Advocacy and community-based organizations
  - Providers
- MCOs
  - Require Consumer Advisory Councils for each MCO
  - Require consumer review of MCO performance measures and/or report card

Involve IT Staff in Program Design, Implementation and Monitoring

- Successful program designs require identification of system limitations and workarounds up front
- Successful program transition and implementation requires information sharing with MCOs on eligibility and enrollment data; provider lists; and care plans (electronically if possible)
- Successful program reporting and monitoring requires codes for encounter data; working around system limitations; and enabling report submission

Clearly Outline MCO Responsibilities and Expectations in Contracts

- Most states start with very prescriptive contracts and monitoring practices and over time, if MCO performance is consistently high, move focus to a few high-risk, high-cost areas
- Address upfront:
  - Transition policies
  - Network adequacy
  - Care/Service coordination
  - Member education
  - Member complaint resolution
  - Reporting
  - Quality Improvement

Create LTSS-Specific Quality Measures

- Create LTSS-specific measures from the outset
- Many states track process measures (days to assessment; care plan completion)
- Capitated financial alignment demonstrations are incorporating LTSS-specific measures (transition of members between community, waiver and long-term services; unmet need in LTSS)*
- Incorporate Quality of Life Measures

Source:* Sabiha Zainulbhai, Lee Goldberg, Weiwen Ng, and Anne H. Montgomery , **Assessing Care Integration for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative, The Commonwealth Fund, March 2014

Rates: Promoting Rebalancing and Choice of MLTSS

Mechanism	State
Plans responsible for NF and HCBS under blended capitation rate (full risk, full profit)	MN, NJ, WI
Plans responsible for NF and HCBS under blended capitation rate (risk and profit shared with state)	AZ, HI, TN
HCBS available as an entitlement (enrollment not capped) for NF level of care	TN, TX, WI
Higher rate for HCBS services	MN
Transition allowance benefit	TN
Plans required to work with consumers who want to transition	HI, MN, TN, TX
Performance measures require service timelines for sentinel events	AZ,TN, TX
Performance measure with penalty for NF utilization	TX

Source: Mildred Consulting -- Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services -- Recommendations for California. 2012. http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/Mildred_Flexible_Accounting.pdf

Create Strong Organizational Structure for Program Monitoring and Oversight

- **Leadership** - Strong organizational capacity requires leadership
- **Staffing** – Shift from fee-for-service to risk-based MLTSS requires staff with communication skills for stakeholder engagement and contract management expertise
- **Partnerships** - Partner with sister agencies to incorporate their expertise (e.g. Aging, Disability and Mental Health)
- **Health plan relationships** – Partner with plans to tap into expertise and ability to innovate
- **Medicare knowledge**: Build staff Medicare knowledge

Key Areas of State Expertise for Monitoring Health Programs

- Communications expertise
  - Beneficiary engagement
  - Provider engagement
  - Health plan relationships
- Contracting expertise
  - Development
  - Readiness reviews
  - Oversight and compliance
- Medicare Advantage requirements
- Data analysis and information systems
- Rate setting and quality measurement

Health Plan Capacity

- Organizational knowledge: sub-populations and state requirements
- Consumer and family engagement
- Highly skilled care management staff
- Virtual, real time access to care plans
- Transition planning across care settings
- Provider network
- Consumer protections

New Provider Relationships

- **Provider networks** – Shift from state provider agreements to health plan contracts with providers
- **"Non-traditional providers"**—Community and HCBS organizations new to managed care (and Medicare)
- **Network adequacy** – Include factors such as number and location of providers; consider non-traditional factors for paraprofessionals and non-licensed HCBS providers
- **Provider qualifications** – Establish minimum provider qualifications or use past performance considerations, references, or licensure/certification to ensure quality service delivery
- **Provider training** – Consider requiring specific training to address major goals, areas of concern, and/or target populations

Resources

- *Engaging Providers in Building Managed Care Delivery Systems : Tips for States.* S. Barth and J. Klebonis. Center for Health Care Strategies, April 2014.
- *Building State Capacity to Implement Integrated Care Programs for Medicare-Medicaid Enrollees.* M. Herman Soper. Center for Health Care Strategies, July 2013. http://www.chcs.org/usr_doc/Building_State_Capacity.pdf
- *Developing Provider Networks for Medicaid Managed Care Long-Term Services and Supports Programs: Considerations for States.* J. Klebonis and Sarah Barth. Center for Health Care Strategies, July 2013. http://www.chcs.org/usr_doc/Developing_Network_Adequacy_for_MLTSS_FINAL__2_.pdf
- *Three State Paths to Improve Medicaid Managed Long-Term Care: Florida, New Jersey, and Virginia.* S. Barth and B. Ensslin. Center for Health Care Strategies, July 2013.
- *A Communications Work Plan to Engage Stakeholders in Medicaid Managed Long-Term Services and Supports Program Development.* S. Barth and B. Ensslin. Center for Health Care Strategies, May 2013.

Questions and Discussion