

Strengthening Long Term Services and Supports (LTSS): Reform Strategies for States

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Meet the Today's Presenters



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Agenda



- Welcome and Background
- Reform Strategies for States
 - » Rebalancing Medicaid LTSS: Matching Care Settings to Individuals' Needs
 - » Advancing Integration of LTSS with Physical and Behavioral Health Services through Managed Care
- Ohio's LTSS Reform Journey
- Q&A

About the Center for Health Care Strategies and Manatt Health

Center for Health Care Strategies is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve beneficiaries of publicly financed care, especially those with complex, high-cost needs.



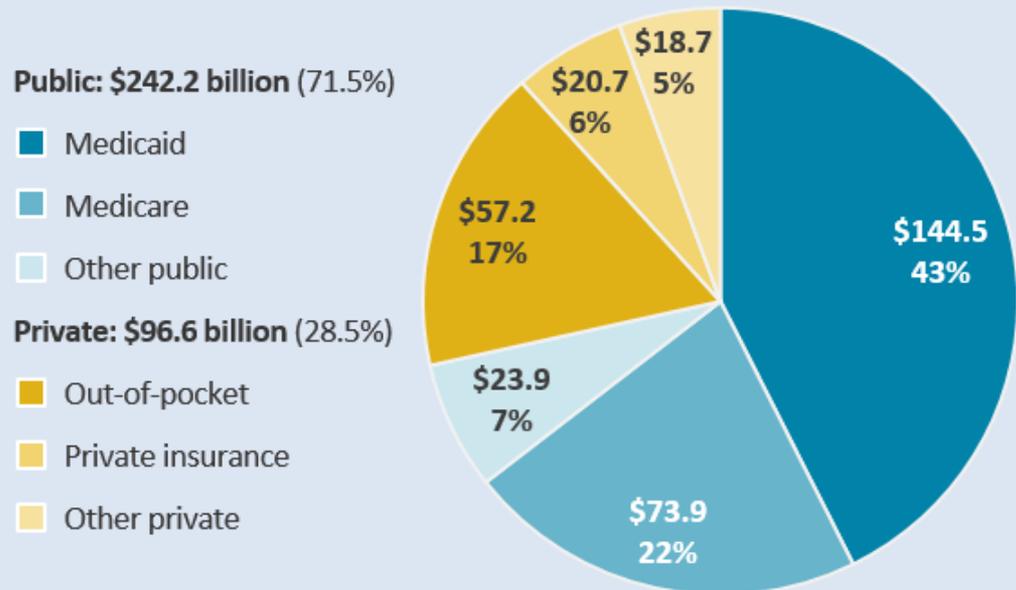
Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 90 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving health care policy and regulatory landscape.



Growing Demand and Role for Medicaid in LTSS

- Medicaid is the single leading payer of LTSS for older adults and persons with disabilities, comprising **1/3 of program spending** or **\$144B annually**.
- Projected population growth among individuals age 65 and older will only increase demand.
- State Medicaid programs are increasingly focused on **identifying and implementing varied LTSS reform strategies** to meet this demand.

National Spending for LTSS, by Payer, 2013



Toolkit Overview



- Examines recent trends and provides a targeted menu of state LTSS reform strategies
 - » Rebalancing Medicaid LTSS: Matching Care Settings to Individuals' Needs
 - » Advancing Integration of LTSS with Physical and Behavioral Health Services through Managed Care
- Manatt Health and CHCS:
 - » Conducted interviews with **10 innovator states** and **Community Catalyst**
 - » Consulted with an **advisory committee of national experts**
- Future toolkit enhancements will add **provider-led integration strategies, case study enhancements, and new learnings**

Rebalancing Medicaid LTSS: Matching Care Settings to Individuals' Needs

Rebalancing Medicaid LTSS: Overview



- **Historically, programs were not designed to support individual choice of settings:**
 - » Facility-based care is an “entitlement”
 - » HCBS often has waiting lists
 - » Limited coordination for HCBS consumers across all service areas

Rebalancing: Shifting bias by devoting a greater proportion of Medicaid spending to HCBS instead of institutional care

- **Efforts are driven by:**
 - » Beneficiary preferences for HCBS
 - » HCBS is typically less expensive than comparable institutional care
 - » States’ community integration obligations under the Americans with Disabilities Act and the Olmstead decision

Rebalancing Medicaid LTSS: Overview of Strategies



STRATEGY 1: Develop LTSS System Infrastructure to Promote Greater Access to HCBS

Impetus: Expanding coverage, access, and use of HCBS depends on investments in LTSS infrastructure, access points, and workforce.



STRATEGY 2: Invest in Programs and Services that Help Nursing Facility Residents Return to and Remain in Their Communities

Impetus: Nursing facility residents may be able to live safely in the community with appropriate supports, often at lower cost.



STRATEGY 3: Expand Access to HCBS for “Pre-Medicaid” Individuals

Impetus: Providing limited LTSS to those at risk of needing nursing facility care may delay or prevent more expensive service utilization and keep individuals in their homes.



STRATEGY 1: Develop LTSS System Infrastructure to Promote Greater Access to HCBS



Strategy Elements

- Access to information and referrals
- One standardized assessment for all settings to create “one stop” entry point
- Direct care and informal caregiver workforce supports
- Development of person-centered care plan



Examples of Implementation Mechanisms

- Federal, state, or private foundation grant funding
- Section 1115 waiver authority
- State-based managed care contracting and state regulatory changes
- Pilot programs



Results to Date

- Reports on BIP success show expanded access to HCBS
- Some states are focused on sustainability planning as BIP funding ends

Federal Program Example:

The **Balancing Incentive Program (BIP)** provided eligible states with an increased Medicaid federal matching rate for community-based services. Under BIP, 18 states received a total of \$2.4 billion to increase access to new or expanded services and infrastructure.



STRATEGY 1: Develop LTSS System Infrastructure to Promote Greater Access to HCBS



Key Lessons

- Understand LTSS infrastructure landscape to **leverage existing systems**
- **Engage leadership** across state agencies and other stakeholders early
- **Collect program data** and ensure staff capacity to analyze impact
- **Develop robust sustainability plan** for when current funding ends

Case Study: Massachusetts' One-Stop Information and Referral Network

- Received \$135 million in BIP funding in April 2014 and expanded access to HCBS via:
 - » **Expanded choice counseling** through state's Aging and Disability Resource Consortia (ADRCs)
 - » **Improved eligibility assistance** through co-location of Medicaid eligibility counselors and ADRCs
 - » Supported **direct care worker training**
- **Created MassOptions, a single access point for entire LTSS system**, which includes several community partners and provides free information via website, call center, and referral form
- HCBS spending as a share of LTSS expenditures rose from 45% in 2009 to 74% in 2017





STRATEGY 2: Invest in Programs and Services that Help Nursing Facility Residents Return to and Remain in Their Communities



Strategy Elements

- State investments in:
 - » transition services
 - » tenancy-sustaining services
 - » affordable housing options



Examples of Implementation Mechanisms

- Federal funding (MFP, Section 811 Housing and Urban Development)
- Tax credits
- Section 1915(c) and 1115 waivers
- State-based managed care contracting authority



Results to Date

- Through MFP, states have transitioned 63,337 individuals from institutional settings
- Saved an estimated \$204 to \$978 mil.
- Senate bill proposed in Dec 2017 would renew and expand MFP

Federal Program Example: Money Follows the Person (MFP) is a national demonstration to support transitions of Medicaid beneficiaries from facility-based to community-based care.



STRATEGY 2: Invest in Programs and Services that Help Nursing Facility Residents Return to and Remain in Their Communities



Key Lessons

- **Work collaboratively** with diverse stakeholders and non-traditional partners
- **Analyze data** to identify opportunities for specific populations
- **Provide pre-transfer services** in addition to tenancy-sustaining services
- Coordinate with state and local housing authorities and private developers to **secure affordable housing**

Case Study: Texas' MFP Behavioral Health Pilot

- Created **MFP Behavioral Health Pilot** in 2008 to: **integrate community-based behavioral health services** into existing HCBS benefit for individuals with serious mental illness / substance use disorders
- As of 2017:
 - **Transitioned 454 individuals**; more than two-thirds remain in the community today
 - **Saved the state's Medicaid program \$24.5 million**
- Overall, TX has transitioned more than **46,000 nursing facility residents** to the community with state- and federally-funded MFP programs





STRATEGY 3: Expand Access to HCBS for “Pre-Medicaid” Individuals

 Strategy Elements	<ul style="list-style-type: none">■ Provide limited HCBS benefit packages to support at-risk individuals
 Examples of Implementation Mechanisms	<ul style="list-style-type: none">■ Section 1115 waivers■ State general funds
 Results to Date	<ul style="list-style-type: none">■ Vermont expanded access to HCBS for pre-Medicaid individuals while remaining budget neutral and achieving high program satisfaction■ Washington will track both individual and caregiver outcomes for both the new Medicaid Alternative Care and Tailored Supports for Older Adults benefits<ul style="list-style-type: none">» State will also evaluate impacts to Medicaid expenditures» Implemented in September 2017



STRATEGY 3: Expand Access to HCBS for “Pre-Medicaid” Individuals



Key Lessons

- Engage providers, beneficiaries, legislators, and others early and often
- Use Medicare and Medicaid data to **analyze nursing facility utilization** and inform program planning
- **Educate medical providers** about person-centered care and the impact of HCBS

Case Study: Vermont’s Choices for Care 1115 Waiver Expands HCBS to At-Risk Group

- Maintained access to Medicaid LTSS for those who meet income and clinical criteria
 - » Create a new moderate needs group for individuals who meet income requirements and are at “moderate” risk level of needing LTSS
 - » Receive limited Medicaid LTSS services and care management
- VT **reinvests system savings** to better support community-based providers
- Medicaid LTSS users receiving HCBS increased from **30% in 2005 to 56% today**



Advancing Integration of LTSS with Physical and Behavioral Health Services through Managed Care

Advancing Integration of LTSS: Overview



- **More than a third of states operate a managed LTSS (MLTSS) program, seeking to:**
 - » Reduce care fragmentation and improve health outcomes
 - » Deliver person-centered and community-based care
 - » Reduce overall program costs for LTSS populations
- **State strategies focus on:**
 - » Better coordination with physical and behavioral health, and social supports
 - » Inclusion of new and diverse populations (e.g., those eligible for both Medicaid and Medicare; individuals with intellectual and developmental disabilities)
- **CMS recognized MLTSS in the Medicaid Managed Care Regulations in 2016, with new expectations for:** beneficiary protections, stakeholder engagement, enrollment and care management supports, access and quality measurement

Advancing Integration of LTSS: Overview of Strategies



STRATEGY 1: Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries

Impetus: Aligning Medicare and Medicaid service delivery, financing, and administration through one managed care plan may improve quality, minimize confusion for beneficiaries, and increase efficiency.



STRATEGY 2: Integrate Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care

Impetus: Managed care may help reduce fragmentation, increase access to community services, and improve quality and lower costs.



STRATEGY 3: Enroll Individuals with Intellectual and Developmental Disabilities in Managed Care

Impetus: The expansion of managed care to special populations has prompted a few states to develop managed care programs for individuals with I/DD.



STRATEGY 1: Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries

 Strategy Elements	<ul style="list-style-type: none">States align MLTSS programs with Medicare managed care products for dually eligible beneficiaries to streamline access to services, provider networks, and administrative processes
 Examples of Implementation Mechanisms	<ul style="list-style-type: none">Financial Alignment InitiativeFully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)Aligned MLTSS and D-SNPs through state Medicaid agency contractingSection 1115 waiver
 Results to Date	<ul style="list-style-type: none">Limited findings report lower emergency department and readmission rates, shorter hospital stays, increased preventive care utilization, some evidence of cost savings, and some improvements in client satisfactionSeveral implementation challenges to address prior to launch

Case Studies: Arizona and New Jersey – Two Paths toward Alignment

- Arizona** Long Term Care System (ALTCS) program requires all ALTCS Medicaid health plans to offer companion D-SNP and promotes aligned enrollment for dually eligible beneficiaries
- New Jersey** required that D-SNPs qualify to be Medicaid health plans in 2012 and uses 1115 waiver authority to enroll dually eligible beneficiaries to FIDE SNPs if they select the same organization's Medicaid health plan



STRATEGY 2: Integrate Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care



Strategy Elements

- Include LTSS populations and services in managed arrangements to create comprehensive benefit packages that cover physical and behavioral health services, and LTSS under a single capitated rate



Examples of Implementation Mechanisms

- Section 1932 state plan amendment
- Section 1915(a), 1915(b), 1915(c) and 1115 waivers



Results to Date

- One survey of 12 MLTSS programs found in some states: (1) improvements in quality of life; (2) decreases in hospital stays and duration; (3) increases in non-emergency transportation utilization; (4) decreases in waiver wait list times; (5) improved access; and (6) more reliable budget predictability
- Some state consumer advocates report concerns with access to services

Case Study: Virginia's Commonwealth Coordinated Care Plus Program

- **Launched statewide MLTSS program** in August 2017, Commonwealth Coordinated Care Plus (CCC Plus)
- Built CCC Plus model on its financial alignment demonstration, Commonwealth Coordinated Care
- **Requires CCC Plus plans to offer a companion D-SNP** to give dually eligible beneficiaries the option to enroll in the same plan for Medicare services





STRATEGY 3: Enroll Individuals with Intellectual and Developmental Disabilities in Managed Care

 Strategy Elements	<ul style="list-style-type: none">▪ Transition LTSS benefits into existing managed care programs▪ Create care coordination entities▪ Integrate LTSS with all services under new program
 Examples of Implementation Mechanisms	<ul style="list-style-type: none">▪ Section 1115 waiver▪ Section 1945 health home state plan amendment
 Results to Date	<ul style="list-style-type: none">▪ Preliminary, mixed results in a few states▪ AZ: high client satisfaction, improved health outcomes, eliminated waitlists▪ NY: high voluntary enrollment in managed care for individuals with I/DD

Case Study: New York's Integration Effort for Individuals with I/DD

- New York's State Department of Health is **seeking an 1115 waiver to:**
 - » Combine all 1915(c) habilitation services in a more flexible arrangement Transition the I/DD population to mandatory managed care
- Concurrently, New York Office for People with Developmental Disabilities is rolling out a new initiative through existing health home authority





Many Lessons from Integration-Focused Strategies Are Relevant Across States

- Conduct **ongoing, targeted** beneficiary, provider, state agency/legislative **stakeholder engagement**
- **Define program goals** and **collect baseline data** to track goals at the outset
- **Collect data to support program planning**, risk adjustment, monitoring, and evaluation
- **Dedicate sufficient resources** and time for careful planning, such as beginning program with voluntary phase-in
- Other lessons specific to different integration strategies:
 - » **Medicare-Medicaid Benefits:** ensure state Medicare expertise; identify areas for state and federal program flexibilities; invest in behavioral health integration for individuals with these needs
 - » **For individuals with I/DD:** Utilize data reporting and health information technology to engage and connect individuals and their families to providers

Ohio's LTSS Reform Journey

“Strengthening Long-Term Services and Supports: Reform Strategies for States”

Karla Warren
Integrated Care Manager
HCBS Conference
Aug. 29, 2018

Ohio's LTSS Reform Journey

Overall health system performance has been focus, state agencies and stakeholders coming together to:

- » Improve care coordination,
- » Extend coverage to more very low-income Ohioans,
- » Prioritize home- and community-based services,
- » Rebuild community behavioral health system capacity,
- » Enhance community developmental disabilities services and
- » Align population health planning and priorities.

HOME Choice – Ohio's Money Follows the Person

HOME Choice Successes

- Transitioned the greatest number of persons with a mental illness/substance abuse disorder (MI/SUD) diagnosis
- Worked with all population and disabilities and ages
- Experience with all payment structures – developmental disabilities, aging, adults with disabilities and children
- Two professional hands on to assist in transition
- Case management for both waiver and non-waiver transitions

End of MFP – HOME Choice 2.0

- **Transition Coordination**
 - » Contract with Ohio Medicaid
 - » General Revenue Fund (GRF) with 50% Admin funding from CMS
 - » Available to waiver and non-waiver participants
 - » 180-day prior to discharge and 30-days in the community post discharge
- **Community Transition Service (\$2000 per person)**
 - » **For non-waiver:**
 - State funds: GRF 100%. Authorization & payment process to be determined.
 - » **For Waiver:**
 - Approved by waiver services coordinator , added to waiver plan 180 days prior to discharge.
 - » **Transition Coordinator (TC) function to “purchase” and invoice for reimbursement.**
- **Managed care**
 - » TC will not be contracted with plan; but will have more interaction with plan in 2.0
 - » Considerations about authorizations, payment of waiver services and provider network

MyCare Ohio – Financial Alignment Demonstration

MyCare Ohio

- There are approximately 113,000 individuals enrolled in MyCare Ohio, making Ohio’s dual demonstration the second largest in the country.
- Nearly 70 percent of MyCare Ohio enrollees elect for their plan to coordinate both Medicare and Medicaid benefits, which is the highest “opt-in rate” among dual programs in the country.

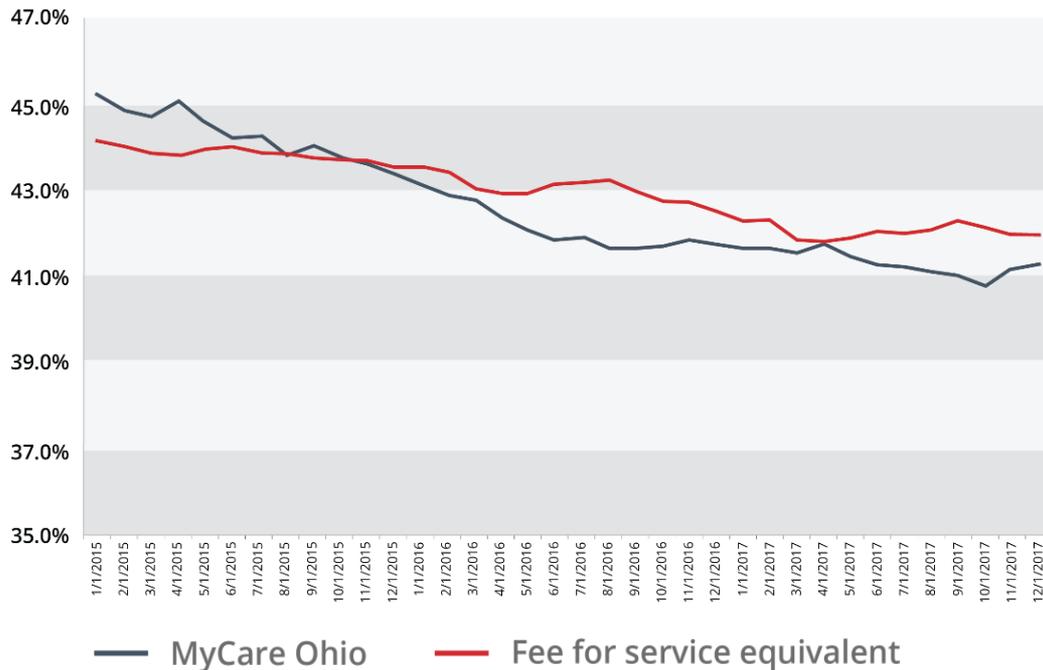


Demonstration Region	Managed Care Plans Available
Northwest	Aetna Buckeye
Southwest	Aetna Molina
West Central	Buckeye Molina
Central	Aetna Molina
East Central	CareSource United
Northeast Central	CareSource United
Northeast	Buckeye CareSource United

MyCare Ohio Enrollment Rebalancing

Enrollment Rebalancing

Percent of Nursing Facility Level of Care Members in an Institutional Setting



- Enrollment rebalancing in MyCare outpaced the FFS Equivalent population.
- With estimated 2% incremental rebalancing, there is an estimated annual savings of approximately \$30 million above what would have been achieved under the traditional fee-for-service program.

2017 Care Management Satisfaction Survey

- 70% reported being satisfied with their care manager.
- 68% reported a care plan was developed for them, and of them:
 - » 92% reported participating in the development of their care plan.
 - » 90% reported knowing the goals of their care plan.
- Care managers could be more aware of members' health care needs.
 - » 53% indicated their care manager did not always seem to know about their health care needs.
- Better communication of member information between care managers during care manager transitions.
 - » 46% stated that they had to report information about themselves to their new care manager.

MyCare Ohio CAHPS Survey Results

Measure	Responses	2015	2016	2017	2015 vs. 2017
Getting Needed Care	Always	56	62	63	+7
	Sometimes/Never	16	11	11	-5
Getting Appointments and Care Quickly	Always	52	52	59	+7
	Sometimes/Never	21	21	17	-4
Doctors who Communicate Well	Always	N/A	78	79	-
	Sometimes/Never	N/A	6	5	-
Customer Service	Always	71	73	79	+8
	Sometimes/Never	10	10	5	-5
Care Coordination Composite	Always	70	72	73	+3
	Sometimes/Never	11	10	8	-3
Getting Needed Prescription Drugs	Always	78	80	80	+2
	Sometimes/Never	6	4	5	-1
Rating of Health Plan	9 to 10	51	58	66	+15
	0 to 6	19	14	9	-10
Rating of Health Care Quality	9 to 10	56	61	63	+7
	0 to 6	14	11	12	-2

Note: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is conducted annually to assess the experiences of beneficiaries in capitated model demonstrations. The table above provides the 2015, 2016, and 2017 survey results for the top and bottom response categories on select CAHPS measures.

MyCare Ohio 2017 HEDIS (CY 2016) Results

National Comparisons

- 59% of MyCare Ohio statewide HEDIS results exceeded the 75th national NCQA Medicaid percentile
 - » Compared to other Medicaid health plans on a national level, 59% of MyCare Ohio plans' HEDIS results are in the top 25%
- 50% of the MyCare Ohio statewide HEDIS results exceeded the 90th national NCQA Medicaid percentile
 - » Compared to other Medicaid health plans on a national level, 50% MyCare Ohio plans' HEDIS results are in the top 10%

National Core Indicators – Aging Disabilities (NCI-AD)

- MyCare waiver members' results:
 - » 89% always get enough assistance with everyday activities when they need it (78% state average)
 - » 79% believe their services meet all their needs and goals (70% state average)
 - » 96% have transportation to get to medical appointments (92% state average)
 - » 88% know whom to contact if they want to make changes to services (72% statewide average)

The Future of MLTSS in Ohio

MLTSS is Ohio's next opportunity to improve care

- The vision is to create a person-centered care management approach – not a provider, program, or payer approach
- Services are integrated for all physical, behavioral, long-term care, and social needs
- Services are provided in the setting of choice
- Easy to navigate for consumers and providers
- Transition seamlessly among settings as needs change
- Link payment to person-centered performance outcomes
- Program costs are predictable and less expensive than in the uncoordinated fee-for-service alternative

MyCare Ohio Lessons Learned	Considerations for Future Implementations
Member transition	<ul style="list-style-type: none">• Phased in approach with transitions occurring every 60 days to permit care coordination/service authorization and other pre-enrollment activities between fee-for-service entity and managed care plan
Managed care plan readiness	<ul style="list-style-type: none">• Ensure appropriate contracts are in place prior to a member's enrollment effective date (i.e. case management contracts, provider contracts) and must be prepared to pay those providers• Plans must have services that the member is currently receiving appropriately loaded in the system to ensure service authorizations prior to member's enrollment.
Comprehensive assessments	<ul style="list-style-type: none">• Standardize comprehensive waiver assessment across all avenues

MyCare Ohio Lessons Learned	Considerations for Future Implementations
Waiver services	<ul style="list-style-type: none">• Streamline waiver services• Package of services and supports to promote independence in the community that align waiver service definitions and provider qualifications• Streamline waiver code set to allow for ease of billing for providers and payments by managed care plans
Provider reimbursement	<ul style="list-style-type: none">• Examination of prompt pay requirements to clarify state expectations for timely payment of provider claims and require penalties by provider type
Value-based contracting	<ul style="list-style-type: none">• Reward higher performing providers (i.e. nursing facility providers) and set standards around value based contracts• Require MCPs to enter into value based contracts with specific provider types, including nursing facilities and provider quality incentive payments

MLTSS Next Steps

- Working with a MLTSS legislative committee and other interested stakeholders to develop an effective MLTSS model for consideration by the next Administration.
- Take this opportunity to align waiver functions based on lessons learned from MyCare Ohio.
- Build a rational, sustainable delivery system that is not fragmented and works well for members and providers that will serve as a sound foundation for implementing MLTSS in the future.
- Extend the MyCare Ohio program for an additional three years to allow those individuals to continue to receive the benefits of care coordination.

Thank You!

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Question & Answer



The screenshot shows the CHCS website header with the logo and tagline. The navigation menu includes 'ABOUT US', 'TOPICS-', 'PROJECTS', 'RESOURCES', and 'BLOG'. The main content area features the title 'Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States'. Below the title, it lists the funder (The SCAN Foundation and the Milbank Memorial Fund) and the author (Stephanie Anthony, Arielle Traub, Sarah Lewis, and Cindy Mann, Manatt Health; Alexandra Kruse, Michelle Herman Soper, and Stephen A. Somers, PhD, Center for Health Care Strategies). A 'DOWNLOAD FULL TOOLKIT »' button is visible. Social media sharing icons for Twitter, Facebook, LinkedIn, Google+, Email, and Print are provided. The text describes the toolkit's purpose and content, and a 'RELATED TOPICS' section lists 'Managed Long-Term Services and Supports', 'Medicare-Medicaid Integration', and 'Medicare-Medicaid/Long-Term Care'. A thumbnail image of the toolkit cover is also shown.

CHCS Center for Health Care Strategies, Inc.
Advancing innovations in health care delivery for low-income Americans

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ABOUT US TOPICS- PROJECTS RESOURCES BLOG

Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States

Funder: The SCAN Foundation and the Milbank Memorial Fund
Author: Stephanie Anthony, Arielle Traub, Sarah Lewis, and Cindy Mann, Manatt Health; Alexandra Kruse, Michelle Herman Soper, and Stephen A. Somers, PhD, Center for Health Care Strategies
December 2017 | Toolkit

[DOWNLOAD FULL TOOLKIT »](#)

RELATED TOPICS

- Managed Long-Term Services and Supports
- Medicare-Medicaid Integration
- Medicare-Medicaid/Long-Term Care

Long-term services and supports (LTSS) enable more than 12 million people to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. With Medicaid LTSS expenditures of more than \$140 billion annually and the aging population projected to grow 18 percent by 2020, the increasing demand for LTSS is putting more pressure on Medicaid at both the federal and state levels.

This toolkit, developed with support from The SCAN Foundation and the Milbank Memorial Fund, provides a targeted menu of LTSS reform strategies adopted by state innovators that may be replicated by other states. It identifies concrete policy strategies, operational steps, and federal and state authorities that states have used to advance their LTSS reforms. It also highlights opportunities and challenges that states faced in designing and implementing reforms.

Download the full toolkit at CHCS.org

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