NASUAD
National Association of States United for Aging and Disabilities

MANAGED LONG-TERM SERVICES AND SUPPORTS

PRE-CONFERENCE INTENSIVE

2018 HCBS CONFERENCE

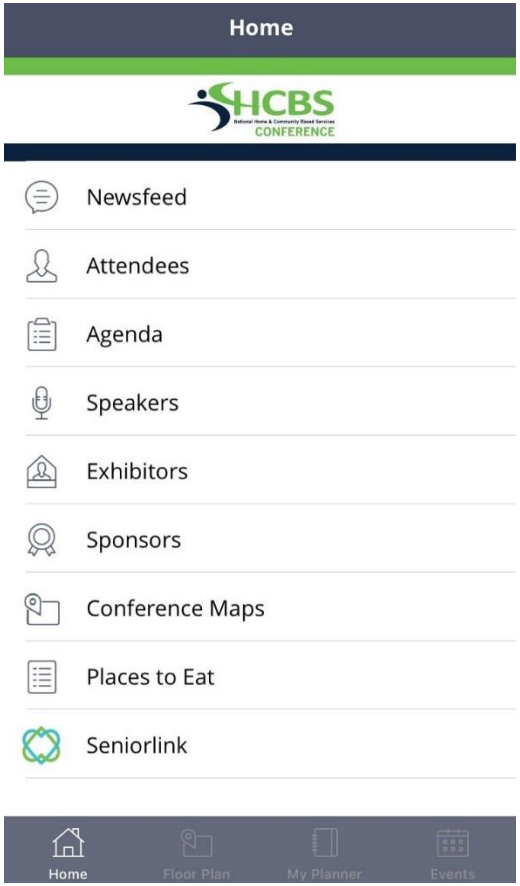
Camille Dobson
Deputy Executive Director

Welcome to the HCBS Conference

- HCBS is the premiere national conference on LTSS, including Medicaid, the Older Americans Act, and a broad array of programs, services, and supports for older adults and people with disabilities
- Learn more about NASUAD at www.nasuad.org
- Don't forget to sign up for:
  - NASUAD's Friday Update: a weekly electronic newsletter that consolidates federal and other news on aging and disability policy
    - http://www.nasuad.org/newsroom/friday-update
  - The State Medicaid Integration Tracker: a bi-monthly publication that highlights LTSS activities, including MLTSS, dual eligible programs and other integrated care activities in the states
    - http://www.nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker

Download the HCBS Conference App

- Keep track on conference happenings and share your thoughts on the newsfeed
- Create a personalized agenda to plan your week
- Connect with other attendees
- View hotel maps and maps of the surrounding area
- The app is free in Apple and Google Play online stores: Search “HCBS Conference”



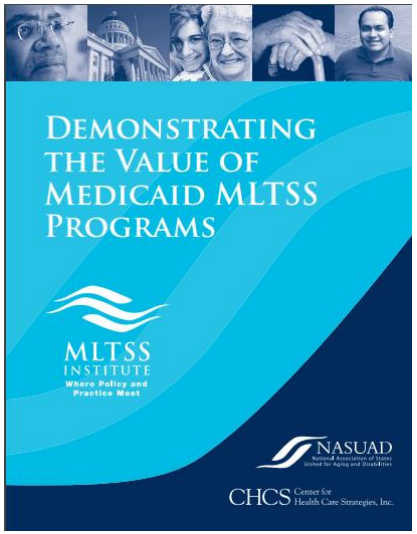
Connect to the Complimentary HCBS Wi-Fi

Complimentary Conference Wifi

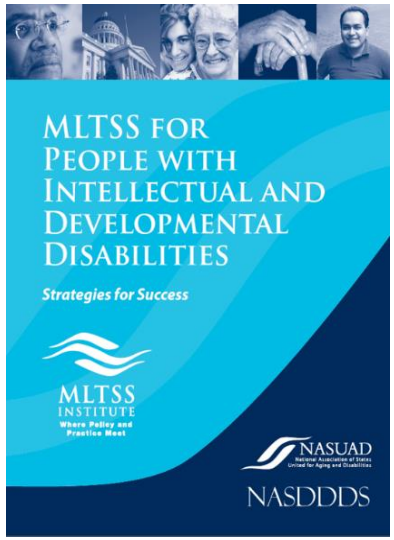
Network Name: **Marriott_CONF**
Password: **MERCER**

NASUAD's MLTSS work

- MLTSS Institute
  - Provide intensive technical assistance to states
  - Bring thought leaders together to discuss policy issues
  - Publish research papers (http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/resources)



May 2017



May 2018

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 most states, plans are covering medical services as well, which provides a comprehensive delivery system for consumers

Why Do States Implement MLTSS?

- Accountability rests with a single entity
  - Financial risk for health plan provides opportunity to incentivize/penalize performance
  - Plans can integrate siloed streams of care (primary/behavioral/long term care) more effectively
- Administrative simplification for state
  - Eliminates need to contract with and monitor hundreds/thousands of individual providers
  - Managed care plans take on claims payment, member management, utilization review, etc.

Why Do States Implement MLTSS?

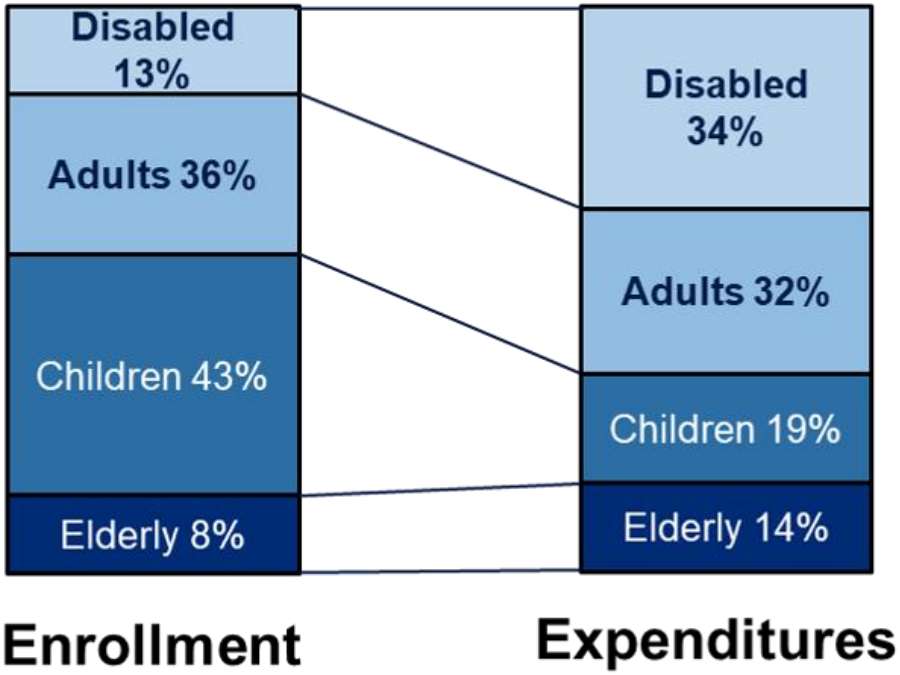
- Budget predictability
  - Capitation payments greatly minimize unanticipated spending
  - Can more accurately project costs (especially with LTSS as enrollment doesn't have as much variation based on economic circumstances)
- Shift services to community settings
  - Most consumers express preference for community-based services
  - Health plans have demonstrated effectiveness in diverting and reducing institutional stays

Why Do States Implement MLTSS?

- Innovation and Quality
  - MCOs can deliver services more flexibly than states
  - National companies, in particular, can bring best practices from other states/product lines
  - Local plans are grounded in their communities
  - Demonstrated improvement in quality outcomes (HEDIS) over FFS
- Consumer becomes the center, not their services
  - LTSS interventions can lower acute care costs
  - Increased likelihood of 'bending the cost curve'

Why Do States Implement MLTSS?

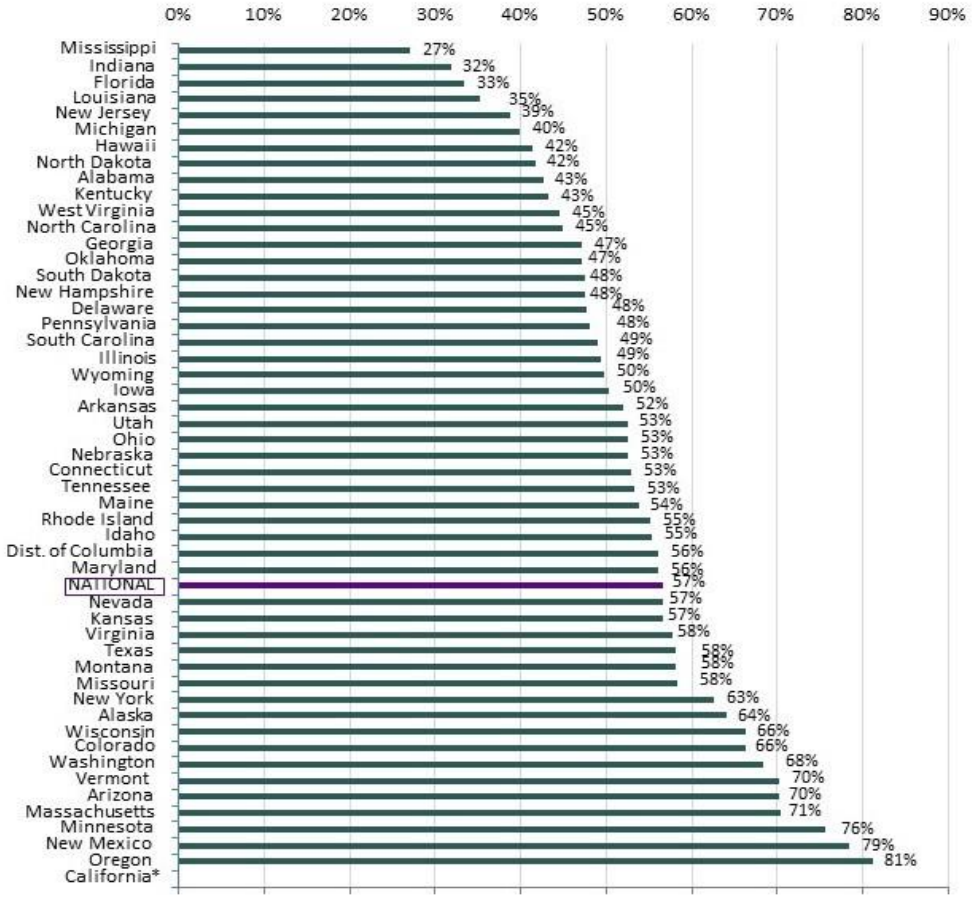
Nearly half of Medicaid spending is for the elderly and people with disabilities, FY2015



Source: Center for Budget and Policy Priorities

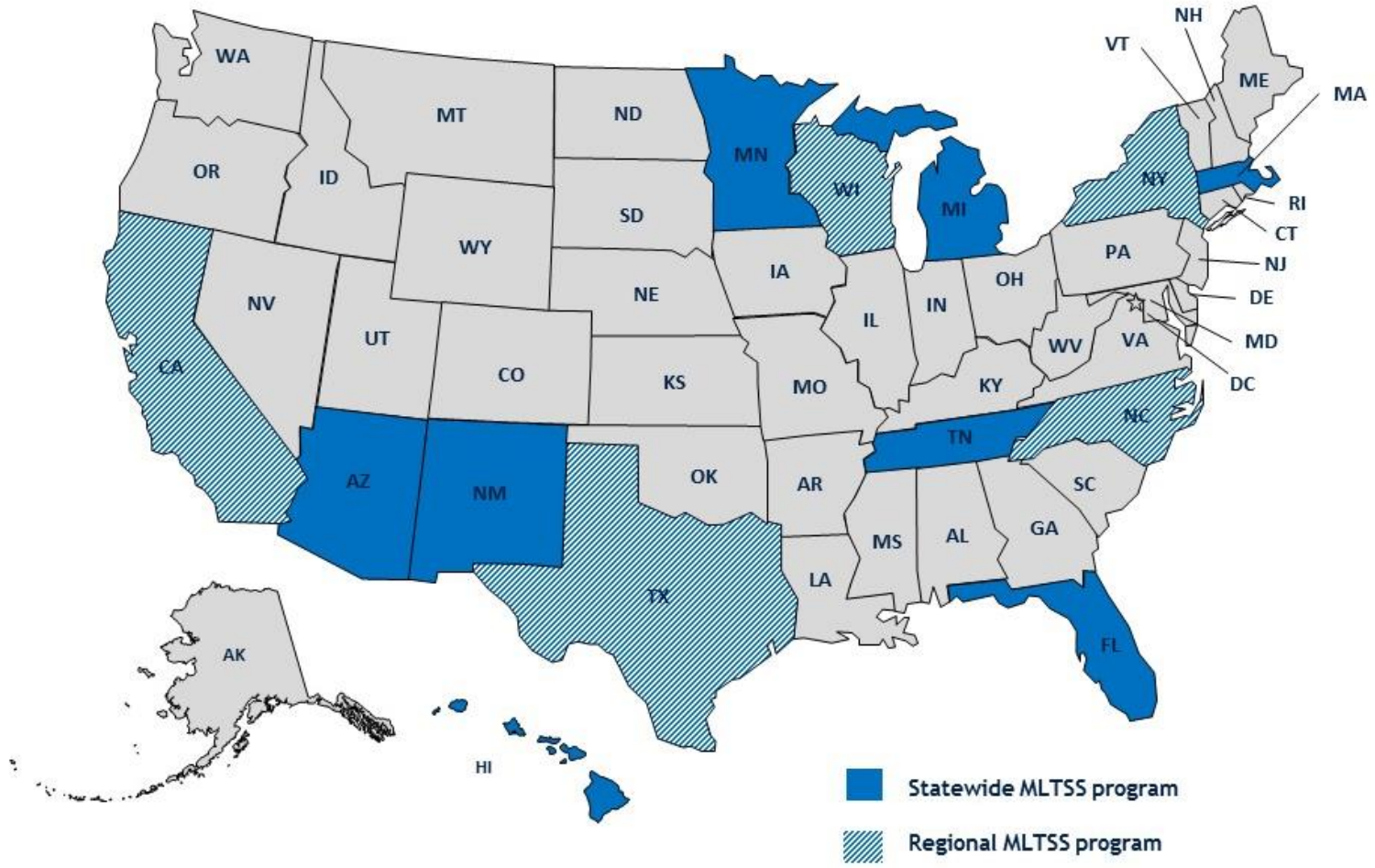
Why Do States Implement MLTSS?

HCBS Expenditures as % of all Medicaid LTSS Expenditures, FFY 2016



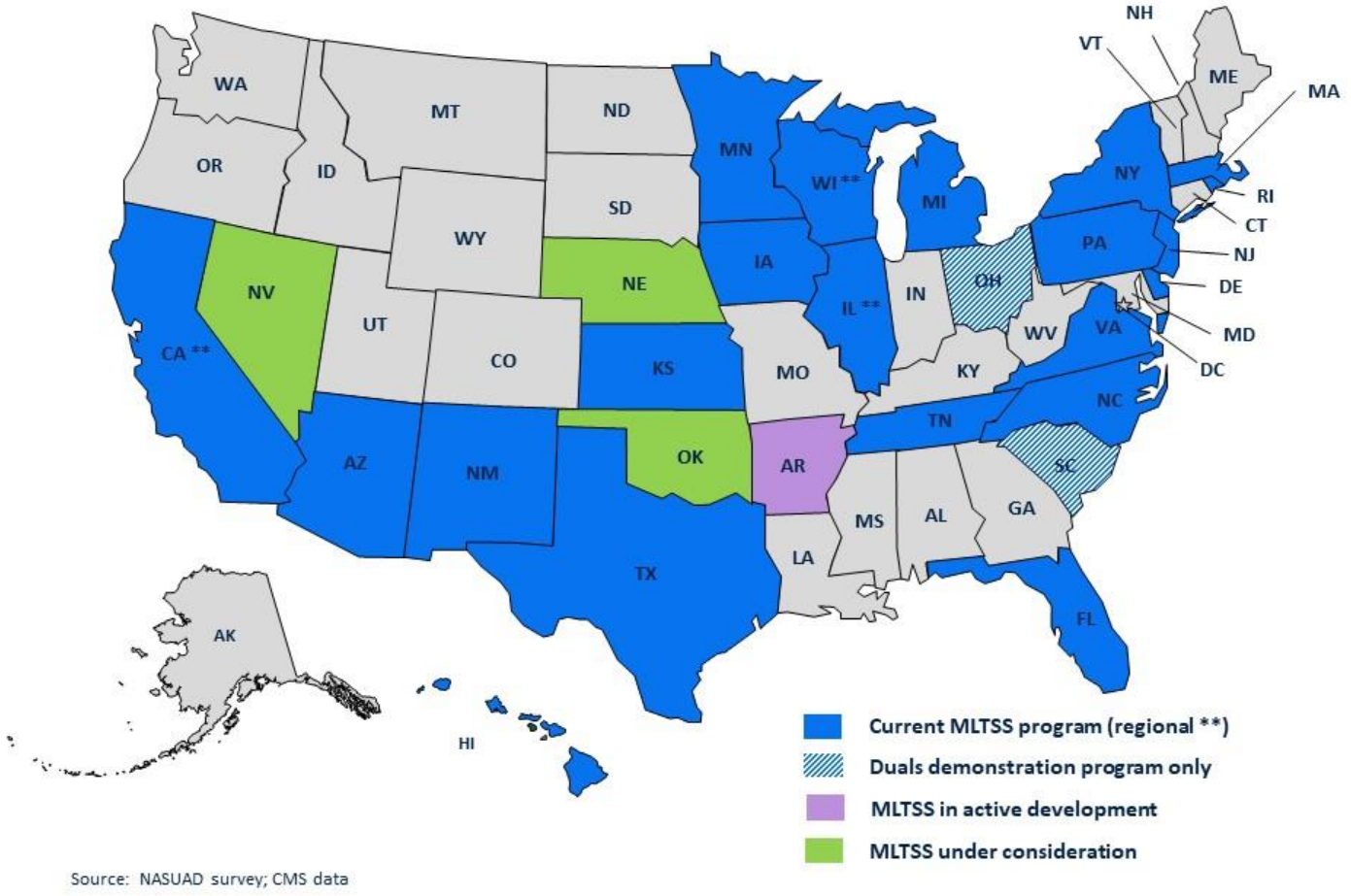
Source: IBM Watson Health, June 2018

MLTSS Programs - 2010



Source: NASUAD survey, Truven Health Analytics, 2012

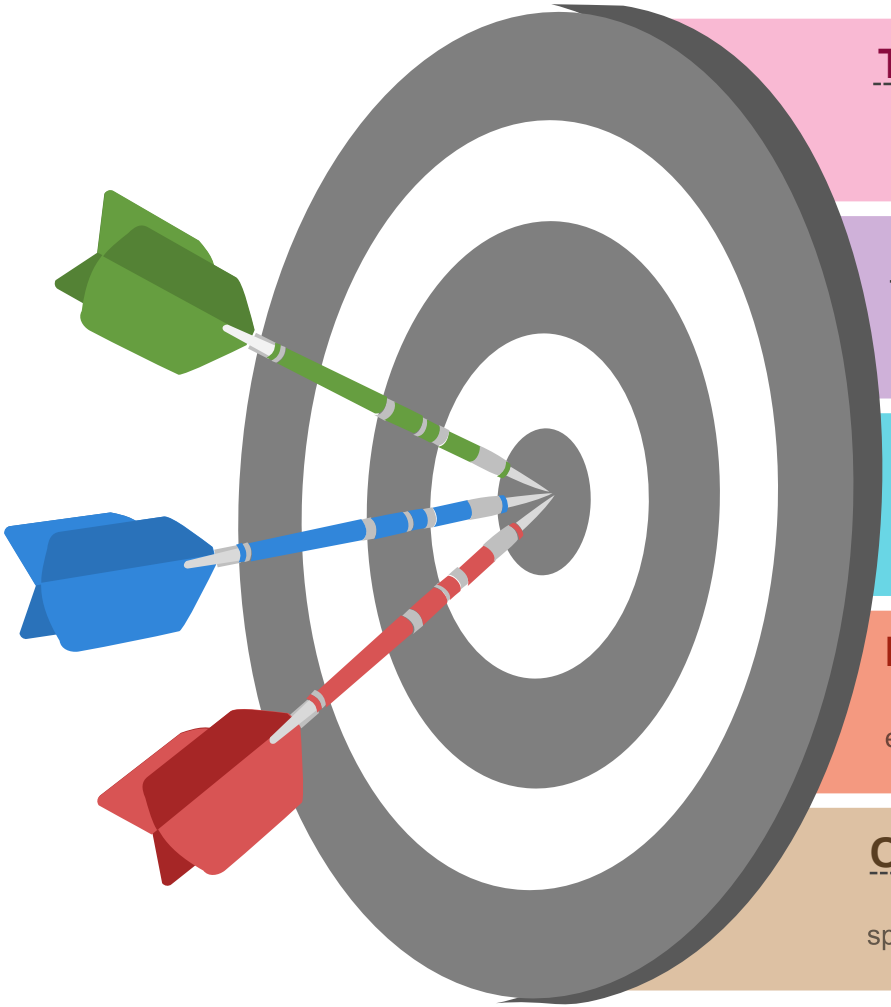
MLTSS Programs - 2018



Source: NASUAD survey; CMS data

Note: ID and VT are included in CMS' list of MLTSS States

Key Elements for an Effective MLTSS Program



Thoughtful Program Design

Populations; services; geographic reach; provider protections; quality goals

Stakeholder Engagement

Early and ongoing during design, implementation and operation

State Oversight Capacity

New roles and responsibilities; adequate staffing; information feedback loops

Rigorous RFP and Contract

Specific and detailed; performance expectations; translate FFS policies effectively

Consumer/Provider Support

Public education campaign; MCO/provider speed dating; choice counseling; ombudsman assistance

Trends for 2019 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, and TN use commercial MCOs to deliver these services

Trends for 2019 and beyond

- Focus on quality - concern about putting plans in charge of service plans has amplified calls for outcome measurement
- States without managed care capacity or unwillingness to implement or expand acute care managed care looking at managed FFS alternatives (ACOs in MA, PASSE in AR)
- States also looking at expanding pay-for-performance/value-based purchasing from NFs and other large providers to HCBS providers
- Increasing focus in MCOs on combatting social isolation and caregiver supports

Context for today's intensive

- Mature and new MLTSS programs alike face challenges in maximizing the benefits of MLTSS in a number of policy areas

- We picked 4 topics to focus on today (among many)
  - Dual eligible integration is an area of great interest for states
    - 75 - 90% of waiver consumers are dual eligibles
  - Lessons from program implementation provide valuable information to MLTSS states
  - HCBS workforce shortages, while not unique to MLTSS programs, pose real challenges to community living
  - Progress is being made in measuring quality in MLTSS but more still remains to be done

Context for today's intensive

- Goal for intensive: Share learnings on ongoing challenges in MLTSS for states, health plans, providers and consumers
- Outcome of intensive: Leave with greater understanding of each area and how innovations underway in states and plans could improve and/or inform MLTSS programs in your state.

Ohio | Department of Medicaid

John R. Kasich, Governor
Barbara R. Sears, Director

MyCare Ohio: Financial Alignment Demonstration

"Approaches to Serving the Dually Eligible"

HCBS Conference: Managed Long-Term Services and Supports Intensive

Karla Warren
Integrated Care Manager
Ohio Department of Medicaid

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.
- Medicaid participation is not optional.

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 Population

- Individual must be:
  - » Eligible for *all parts* of Medicare (Part A, B and D);
  - » Over the age of 18; and
  - » Reside in one of the demonstration counties.

- Eligible individuals include:
  - » Individuals in a nursing facility
  - » Individuals in some home and community-based setting programs (PASSPORT, Ohio Home Care, and Assisted Living)
  - » Individuals in the community not receiving LTSS who are dual eligible

Enhance Accountability and Quality Transparency

- Care Management Survey
- Care Management Comprehensive Reviews
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)
- Health Outcomes Survey (HOS)
- National Core Indicators – Aging Disabilities (NCI-AD)

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

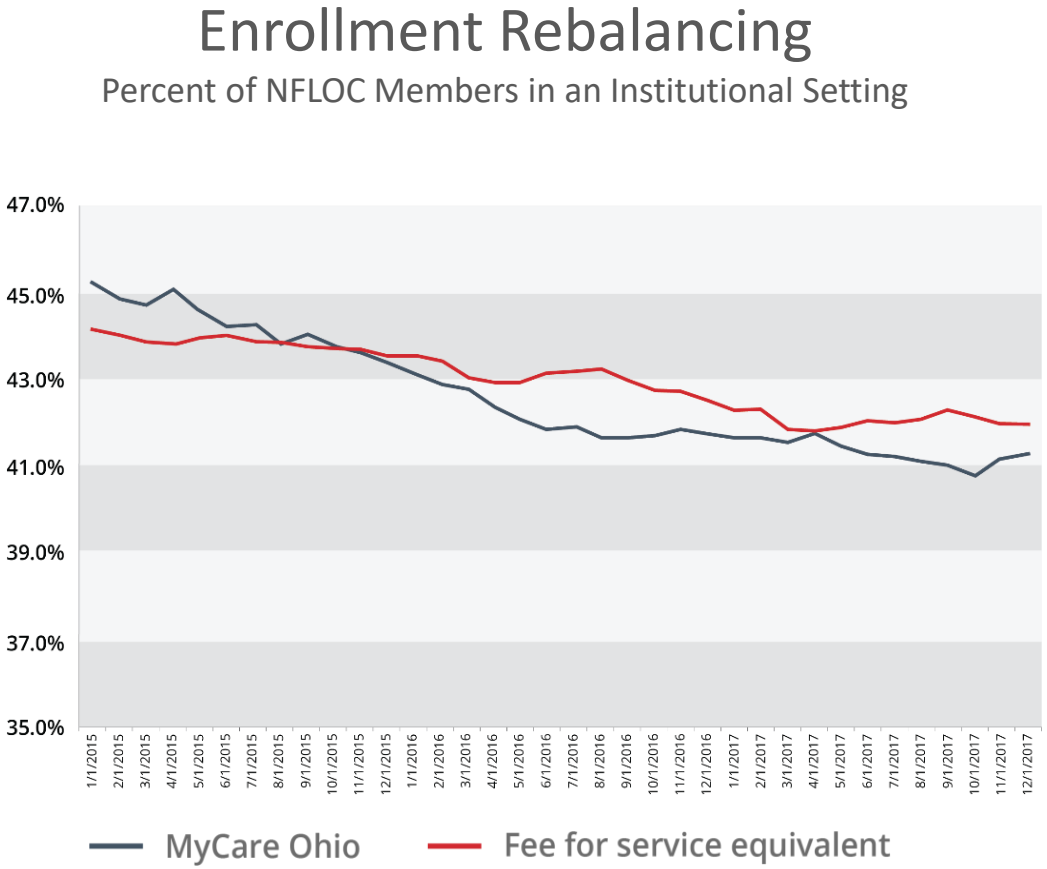
- 59% of MyCare Ohio statewide HEDIS results exceeded the 75th national NCQA Medicaid percentile
  - » Compared to other Medicaid health plans on a national level, 59% of MyCare Ohio plans' HEDIS results are in the top 25%
- 50% of the MyCare Ohio statewide HEDIS results exceeded the 90th national NCQA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

*MyCare Ohio HEDIS Survey Results for the "Opt-In" Population

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)

MyCare Ohio Enrollment Rebalancing



- This chart illustrates the percentage of NFLOC members in a nursing facility (NF) between the MyCare program and a FFS Equivalent population.
- Enrollment rebalancing in MyCare outpaced the FFS Equivalent population.
- **This implies that the MyCare program resulted in a 2.0% increase in the number of members transitioning to the community.**

MyCare Ohio Fiscal Impacts – Enrollment Rebalancing

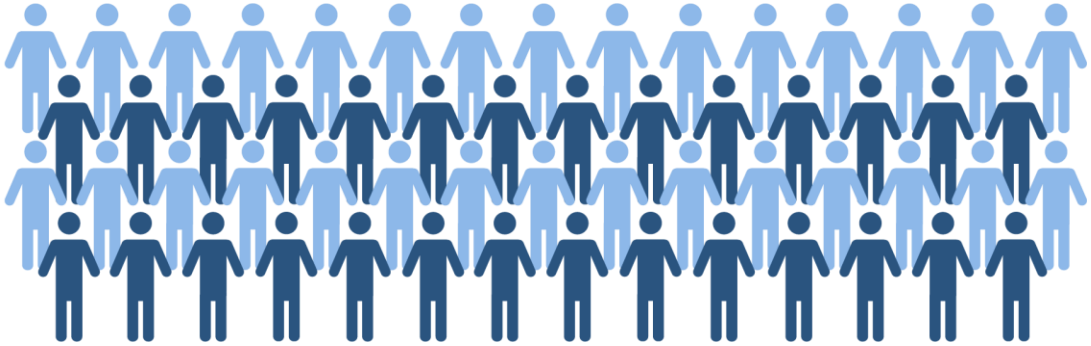
- For each individual receiving long-term services and supports* who moves from a nursing facility setting to a waiver setting, the average cost savings per member per month is approximately $3,000.**
- Based on an estimated 4% total rebalancing achieved by the MyCare Ohio managed care plans, there is an estimated annual savings of approximately $60 million for the program.
- Since the MyCare Ohio managed care plans have achieved an estimated 2% incremental rebalancing, there is an estimated annual savings of approximately $30 million above what would have been achieved under the traditional Medicaid fee-for-service program.

*Includes members in a nursing facility and those receiving waiver services
**Per July 2017 Effective MyCare Capitation Rates and Assumed Enrollment Mix

Improve Member Safety

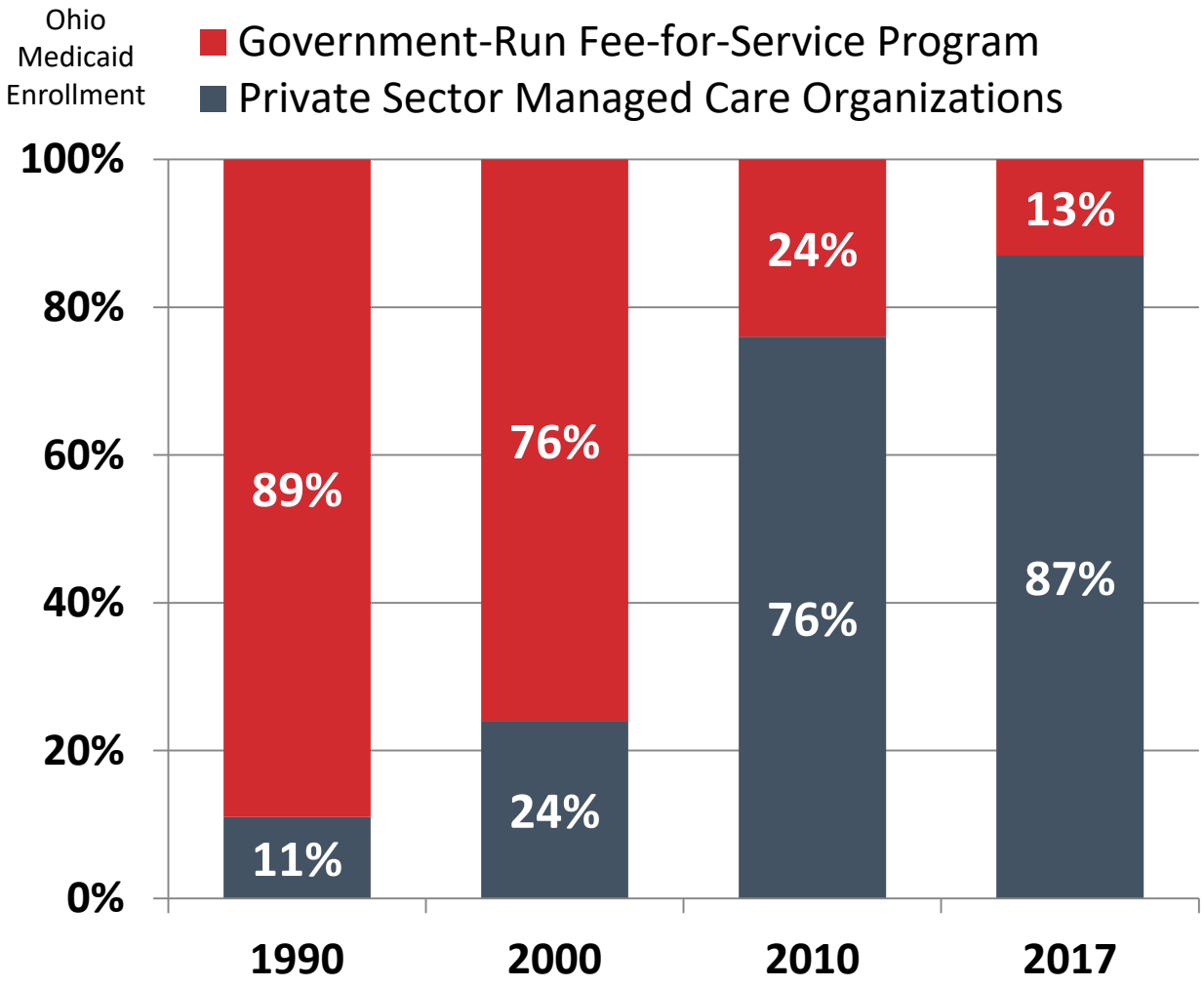
Since 2015, MyCare Ohio plans have been involved in the closure of nine poor-performing nursing facilities, assisting to safely move…

385 residents



The Future of MLTSS in Ohio

Benefits of Enrollment in Managed Care



The only Ohio Medicaid populations excluded from the benefits of care coordination are residents of nursing homes and recipients of home and community based services (HCBS) waivers*

* Behavioral health services will be included in the Ohio Medicaid managed care benefit package beginning July 1, 2018.

Source: Ohio Department of Medicaid (January 2018)

Advantages for individuals enrolled in MLTSS

Provide benefits of care coordination

Promote the health, safety and well-being of Medicaid individuals through care management

Give individuals more choice

Expand community LTSS options, and streamline and standardize the way people access them

Pay for value

Create a system that rewards providers for keeping patients as healthy as possible, and managing chronic conditions when necessary

Improve quality of care and achieve better outcomes

Strengthen the focus on quality measurement, including both quality of life and quality of care, in order to achieve better delivery systems and better outcomes

Increase accountability

Focus on the entire person and integrate services around the person's needs

Create a more sustainable program

Ensure long-term financial sustainability of the system

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

SOURCE: Ohio Governor's Office of Health Transformation (2011).

MyCare Ohio Lessons Learned	Considerations for Future Implementations
Waiver services	• 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	• Examination of prompt pay requirements to clarify state expectations for timely payment of provider claims and require penalties by provider type
Value-based contracting	• 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. Ohio is taking no immediate action to implement MLTSS.

- 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!

- Karla Warren
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- 614-752-2195

MLTSS Intensive: Dual Eligibles

Laura Finkelstein Chaise, Vice President of LTSS & MMP

NASUAD HCBS Conference, August 27, 2018

Centene Overview

CENTENE® Corporation

WHO WE ARE

St. Louis
based company founded in Milwaukee in 1984

41,200 employees

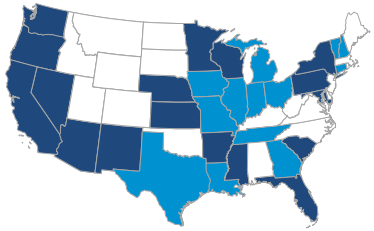
#61 Fortune 500

#43 on Forbes' **Global 2000: Growth Champions List**

#210 Fortune Global 500

#19 on Fortune's **Change the World List**

WHAT WE DO



31 states
with government sponsored healthcare programs

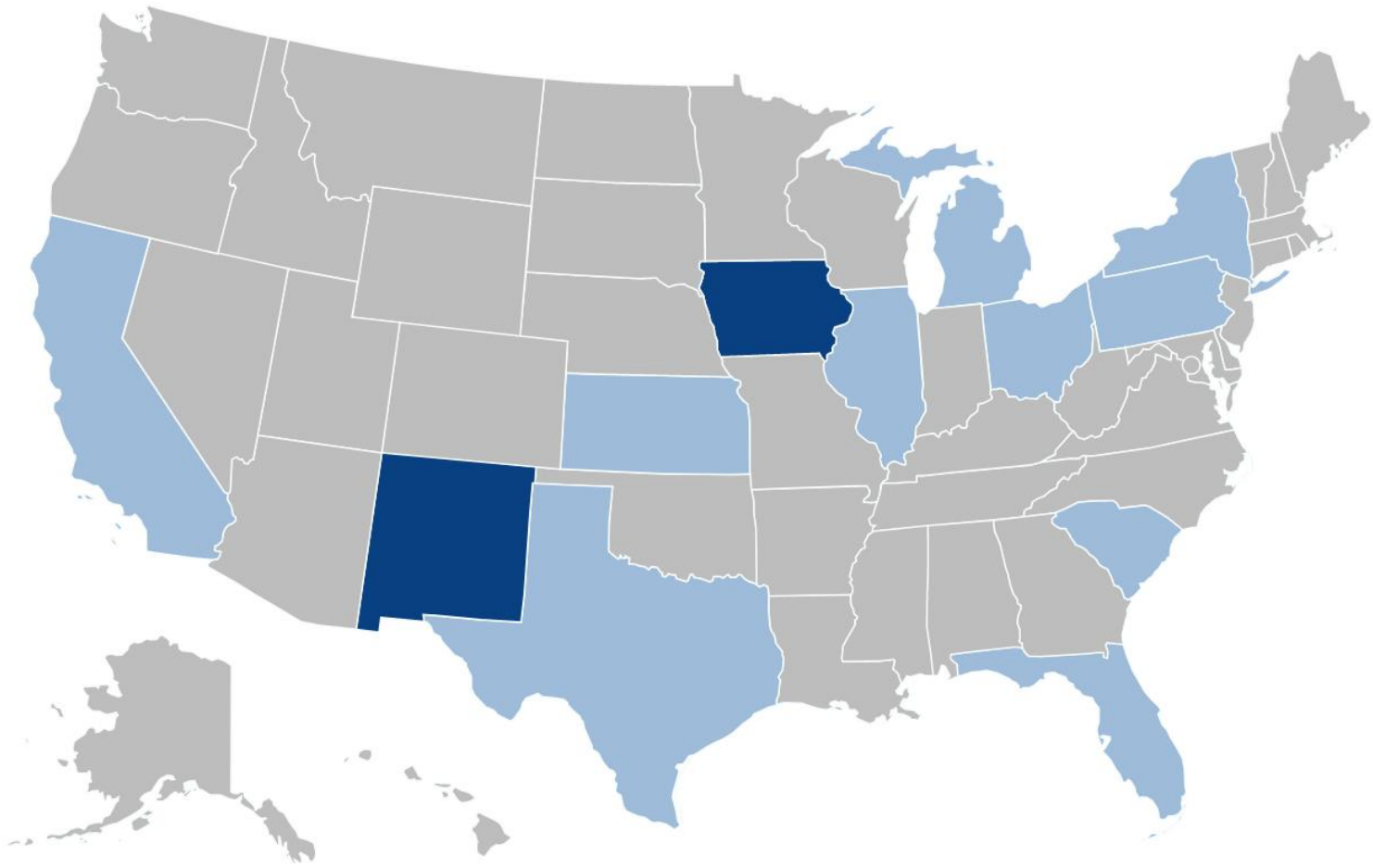
- **Medicaid** (25 states)
- **Marketplace** (16 States)
- **Medicare** (20 States)
- **Correctional** (12 States)

2 international markets

12.8 million members
includes 2.9 million TRICARE eligibles

~300 Product / Market Solutions

Centene's LTSS & MMP Footprint



- *10 States, with over 300,000 members*
- *Largest MLTSS health plan in the U.S. (per HMA)*

NM LTSS program starts 1/1/2019
IA LTSS program starts 7/1/2019

Duals: Quick Facts

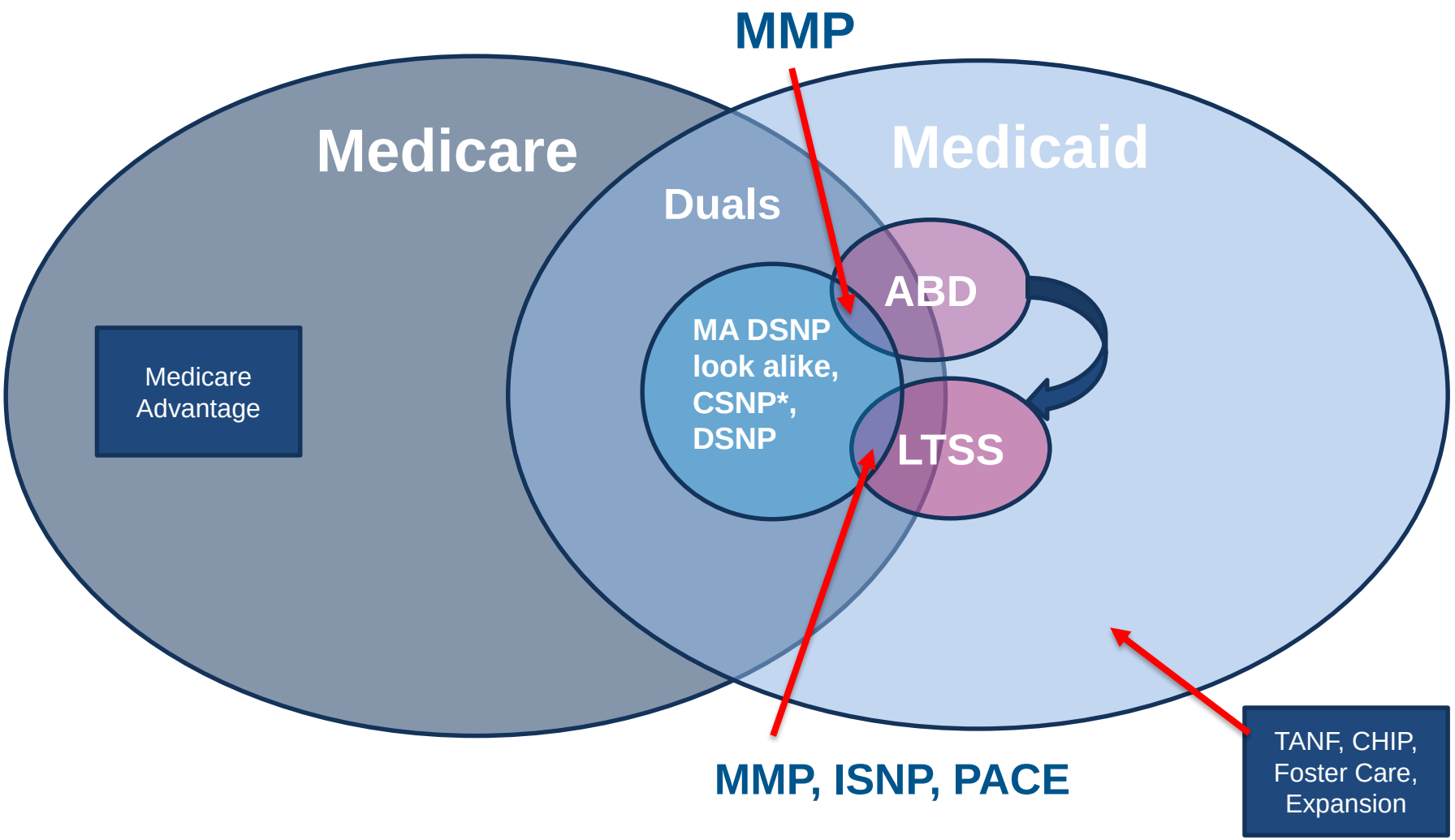
- 11.7 million dually eligible beneficiaries in the US
- Duals account for ~1/3 of all dollars spent by Medicare & Medicaid
- 68% have 3 or more chronic conditions
- 60% are women
- Most are over age 65, but 4 in 10 are younger

Sources: Medicare-Medicaid Coordination Office Fact Sheet, February 2018; MACPAC/MedPAC Data Book, January 2018

Challenges for Dually Eligible Beneficiaries

- Do I meet the eligibility rules? Is there anything I need to do to stay in each program? What if I miss a deadline?
- Am I supposed to pay this bill?
- When they ask for my ID card or ID number, which one should I give them?
- How do I know if my trusted doctor is “in the network”?
- Whose advice should I follow?
- Who am I supposed to call for help?

Dually eligible members are served under several products



**CSNP products can also exist in Medicare only*

Integration scenarios

- Member is enrolled in a health plan's Managed LTSS and Medicare Fee-For-Service
- Member is enrolled in a health plan's Managed LTSS and a different health plan's Medicare Advantage product
- Member is enrolled the same health plan's Managed LTSS and Medicare D-SNP products
- Member is enrolled the same health plan's Managed LTSS and Medicare FIDE-SNP products
- Member is enrolled a Medicare-Medicaid Plan (MMP)

Potential Benefits of Integrated Models

- Member has **one ID card**, one hotline to call
- Care Manager is true **“single point-of-contact”**
- Member has one **holistic, person-centered care plan**
- Providers send claims **one time for processing**
- Plan can leverage data to provide **real-time proactive supports**
- Savings can be **measured** and **captured**

MLTSS LESSONS LEADING TO INNOVATION

NASUAD CONFERENCE
August 27, 2018

Karen Kimsey, Chief Deputy
Virginia Department of
Medical Assistance Services

Agenda

- Virginia's Managed Care Platform
- Innovations (In-Place and In-Progress)
- On the Horizon
- Next Steps

Virginia's Managed Care Programs

96% of Medicaid members now in managed care

	Commonwealth Coordinated Care Plus (CCC Plus), including PACE	Medallion 4.0
Covered Groups 	▪ Serving older adults and people with disabilities ▪ PACE serves people 55 and older ▪ Medicaid-Medicare eligible	▪ Serving infants, children, pregnant women, parents
Covered Benefits 	▪ Long-term services and supports in the community and facility-based, acute care, pharmacy ▪ Incorporating community mental health	▪ Births, vaccinations, well visits, sick visits, acute care, pharmacy ▪ Incorporating community mental health

Virginia's Managed Care Organizations

Coverage is provided for most individuals through the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs

aetna®

Aetna Better Health® of Virginia

Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

Magellan COMPLETE CARE®

OptimaHealth Family Care

UnitedHealthcare® Community Plan

VirginiaPremier™
Powered by VCU Health

Medicaid's six health plans operate statewide in both Medallion 4 and CCC Plus

Innovations

Evolving Care Coordination

- Virginia's Financial Alignment Demonstration (**CCC**) served 30,000 dually eligible adults
- Voluntary participation program with limited geographic implementation
- No required ratios for Care Coordinators

- **CCC** produced great results and offered valuable experience and lessons learned
- **CCC Plus** was designed to build upon the successes
- **CCC Plus** established ratios for Care Coordinators
- Special care coordination unit created to monitor this critical component

- **CCC Plus** extends the benefits of care coordination, serves 216,000 individuals statewide through required participation
- Special program features of **CCC Plus** include:
  - "Common Core" Formulary
  - Nursing Facility Care
  - Community-Based Care
  - Enrollee Protections

CCC Plus builds on the success of CCC and expands care coordination strategies statewide

Making a Difference in People's Lives

Virginia's creative, targeted strategies to ensure seamless transition to managed care for those with complex care needs

DMAS recognized that Paul's transition to managed care needed **extra attention**.

DMAS's Care Coordinator **worked proactively** with Paul, his family and the MCO Care Coordinator to ensure a seamless transition.

During a **face-to-face visit**, both Care Coordinators, Paul, and his family discussed Paul's current status, care needs and developed a **comprehensive service plan**.

This **warm handoff** ensured a successful transition to managed care. We are excited to see Paul doing so well and fulfilling his personal mission to help others!

Inspired by son, family creates Virginia travel guide for people with disabilities

By Bill Lohmann
Jul 22, 2017

WOODFORD If he'd had the chance, Paul Duke knows he would have served in the Army.

"Tank commander," he said, his voice soft and almost inaudible compared with the ventilator that keeps air pumping through his lungs.

He is surrounded, in his room, by military paraphernalia: models of tanks, posters of war planes, videos of military documentaries and dramas, an autographed photo of Gen. Calvin Waller, second in command during Operation Desert Storm to Gen. Norman Schwarzkopf. He

Click here to learn more about how Paul is making a difference

Streamlining Accomplishments

NF

- Nursing Facility Admission Form-No preauth for custodial
- Care Coordination Notification to Nursing Facilities
- Claims Work Group: Agreement on RUGS codes

PC/PDN

- All plans use on Waiver Request Form
- Common codes and rates
- PDN workgroup to discuss processes

Hospice

- Common Forms
- Agreement on codes
- Common notification form

Community MH

- Care Coordinator/Case Mgmt. Responsibilities
- Common request Forms
- Identification of preauth requirements for each plan

"Common Core" Formulary

- The Common Core Formulary (CCF) is the DMAS list of "preferred" drugs on DMAS' Preferred Drug List (PDL)
- Medallion 4.0 and CCC Plus plans are required to cover all drugs on the CCF
  - The CCF includes 90 common drug classes
  - Some drugs are not on the CCF and health plans decide which drugs to include on their formularies
    - For example, drugs used to treat HIV, hemophilia & cancer are **not** on the CCF
  - **Health plans cannot require additional prior authorizations (PAs) or added restrictions on CCF drugs**
- Advantages
  - Increased continuity of care for patients
  - Decreases administrative burdens for prescribers

*The CCF does not apply to Medicare Part D plans

Care Management System – Coming Soon

Care management IT solution that will support data sharing between MCOs

Future Phase: support long term goal

Measure & Monitor: Health Plan Report Card that presents the quality of care a health plan is providing and track MCO Performance.

Phase 5: **APR 2020**
Member portal for assessments and screenings and 360 member view.

Stratify Population for Care Management and Compliance check: Apply logic to flag high risk and emerging risk patients to track compliance (*Ex. Track timeliness of assessments such as HRA, ICP etc.).* Ability to track gaps in care and care needs

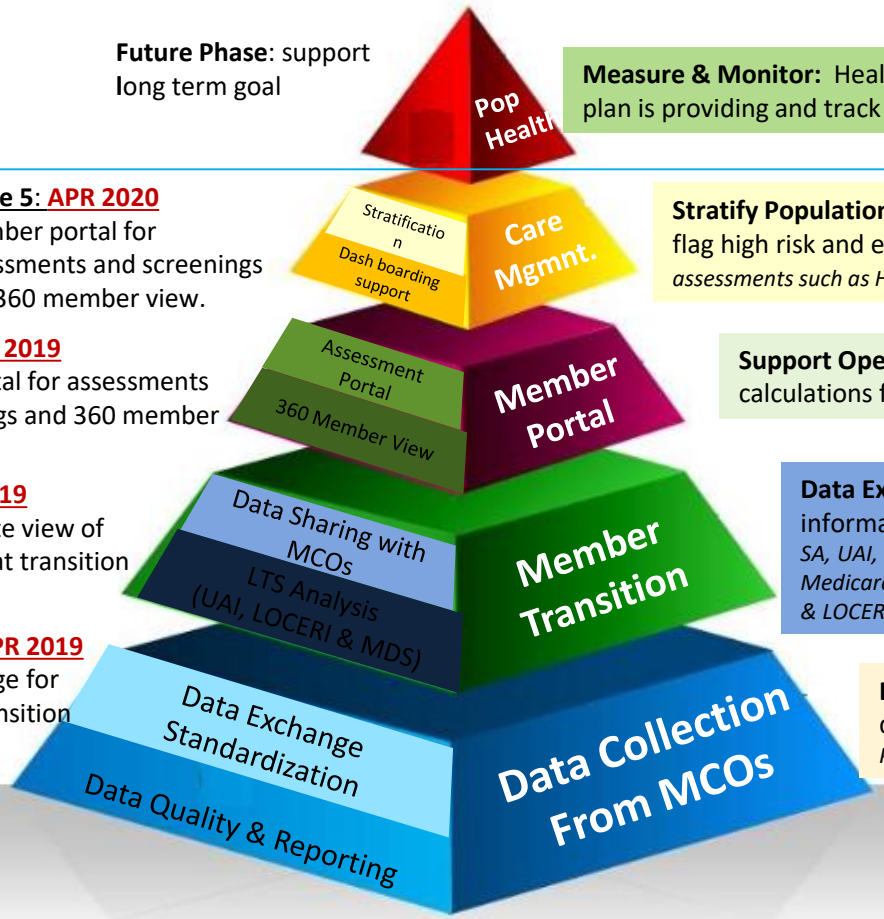
Phase 4: **DEC 2019**
Member portal for assessments and screenings and 360 member view.

Support Operations: Support UAI and LOCERI processing, and payment calculations for screenings. Provision a portal for member centric view.

Phase 3: AUG 2019
Create a complete view of member record at transition

Data Exchange with MCOs: Provide MCOs with seamless access to information for smooth member transition (*Comprehensive **MTR** including SA, UAI, LOCERI, MDS, PUMS, HRA, ICP, Carve out services, Medicaid and Medicare service utilization, immunization history, lab data etc.). Analysis of MDS & LOCERI Datasets*

Phase 1 & 2: **JAN/APR 2019**
Enable data exchange for smooth member transition



Define standards and collect data: Develop standards to collect data from MCOS *Phase #1 (Jan 2019): SA, PUMS, HRA; Phase #2 (Apr 2019): ICP and Demographic information*

Care Management System (Continued)

The care management system will help improve quality of care and health outcomes

- Enables smooth transition of member information to assist plans with timely proactive care planning
- Streamlines and standardizes data exchange between MCO's; both MCO deliverables and other State sourced information (carved out services, HRA, UAI and Level of Care information)
- Enables effective oversight, contract monitoring and surveillance

On the Horizon – Future Innovation

Medicaid Coverage for New Adults

Up to 400,000 more Virginia adults will enroll in quality, low-cost health coverage

www.coverva.org

for information and regular updates

“Medically Complex” Enrollees

“Medically Complex” includes individuals with a complex behavioral or medical condition and functional impairment, which may be established by:

Application Question

Applicant responds to a “Yes/No” question at time of the initial Medicaid application.

If Applicant marks “Yes,” then the member will receive a screening to validate.

Question on the Medicaid Application:

9. *Do you need help with everyday things like bathing, dressing, walking or using the bathroom to live safely in your home? Or Has a doctor or nurse told you that you have a physical disability or long term disease, mental or emotional illness, or addiction problem? Yes No*

“Medically Complex” members will be enrolled in the CCC Plus managed care program, which will provide enhanced care coordination services

Medically Complex Screening

Two Components (All Expansion Members)

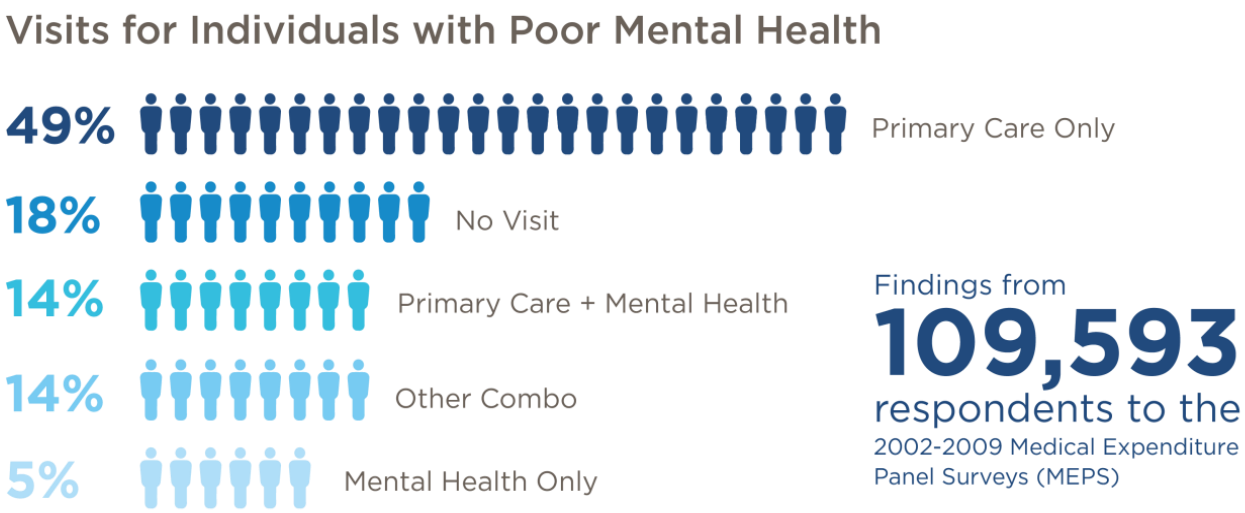
- Medical Diagnosis based
- CMO at managed care organizations can justify other conditions
- Includes serious mental illness and developmental disabilities
- Must have functional impact
- Social determinants of health
  - Housing
  - Access to food
  - Falls/ER Visits
  - Transportation
  - Caregiver Status (living situation)
  - Job status
  - Safety

Integrating Behavioral Health and Primary Care

"Health systems and communities are quickly realizing that an integrated behavioral health strategy is essential to achieve the Triple Aim, and that addressing behavioral health issues requires significant system changes to bring about meaningful improvement."

-Institute for Healthcare Improvement

MENTAL HEALTH TREATMENT PATHWAYS



Peterson, S., Miller, B., Payne-Murphy, J., & Phillips, R. (2014). Mental health treatment in the primary care setting: patterns and pathways. Family, Systems, & Health.

Managed Care Efforts and Integrating Primary Care/Behavioral Health

Enhanced Care Coordination

- MCO developed partnerships with Community Service Boards (CSBs) and select community Behavioral Health practices
  - Focused on members with severe mental illness (SMI) receiving targeted case management and having one or more chronic conditions.
  - Services are designed to improve access to primary and specialty care, reduce emergency room visits, reduce admission and readmission rates, reduce length of stay during hospital admissions, streamline prescription practices and pharmaceutical use, reduce high risk behavior, and improve patient satisfaction

Emergency Department Care Coordination Program

Virginia electronically links all of its emergency departments to improve care, trim costs

The ability to view information on a patient's 10 previous ED visits across different health systems saved on unneeded imaging tests and prevented the prescription of narcotics, one physician said.

By Bill Siwicki | July 31, 2018 | 03:00 PM

Virginia Governor Ralph Northam with Bruce Lo, MD, medical director of emergency medicine at Sentara Norfolk General Hospital.

https://www.healthcareitnews.com/news/virginia-electronically-links-all-its-emergency-departments-improve-care-trim-costs?platform=hootsuite

- Enables real-time communication and collaboration among healthcare providers, health plans, and clinical and care management personnel for patients receiving services in emergency departments.
- Provides physicians with vital information to increase effective and efficient care, avoid duplicative tests, and save valuable time.
- Provides real-time alerts to identify patient-specific risks
- Enables enhanced care coordination, and sharing of care plans and other information
- integration with the Prescription Monitoring Program and the Advance Health Care Directive Registry

ED Care Coordination Implementation

By June 30, 2018

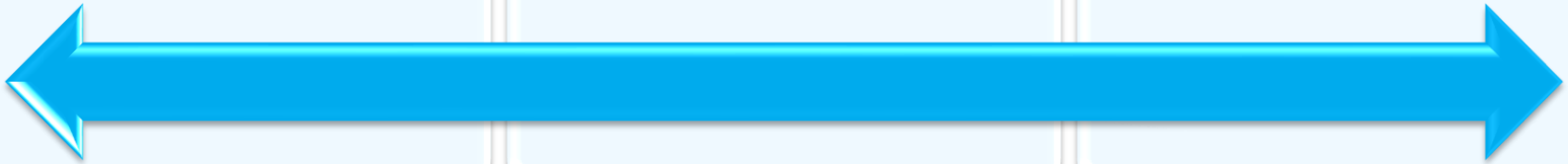
Phase 1: onboard **ALL** emergency departments & Medicaid Managed Care Organizations operating within Commonwealth

Starting July 1, 2018

Onboard downstream providers that include: primary care, case managers, long-term care, Community Service Boards, Behavioral Health, Federally Qualified Health Centers, specialty care, etc.

By June 30, 2019

Phase 2: onboard the State Employee Health Plan, all Medicare & Commercial health plans operating within Commonwealth (Excluding ERISA)



NASUAD MLTSS Intensive: Program Implementation Success and Challenges

HCBS Conference
August 27, 2018

Curtis Cunningham
Assistant Administrator of Long Term Care Benefits and Programs
Wisconsin Division of Medicaid Services

Agenda

- Wisconsin Waiver Programs
- Overview of Family Care & IRIS
- Incentives
- Process
- Current State
- Successes

Medicaid HCBS Waivers

- *"**Waives**" Medicaid rules that only pay for care in institutions to allow funding in the community*
- *Wisconsin has **several** waivers related to population served (Federal requirement that populations be separated)*
- ***1983 CIP 1A** established (serves DD relocating from institution)*
- ***1985 CIP II** established (serves elderly/physical disability)*
- ***1987 CIP 1B & COP-Waiver** established (first serves DD, 2nd serves elderly/phys dis: both as diversion to institutions).*
- ***1995 Brain Injury Waiver** (BIW) established*
- *But we still had long **waiting lists** .....*

Wisconsin Long Term Care Program Family Care

- Family Care established in 1998
- Partnership operated as a fully-capitated, dual Medicaid and Medicare program in 1999
- Both capitated long term care services
- Family Care benefit piloted in 5 counties:
  - Richland, La Crosse, Fond du Lac, Milwaukee (aging only), & Portage

WI LTC Care System Design

- Key Organizational Components
  - Aging and Disability Resource Centers (ADRCs)
  - Managed Care Organizations (MCOs)
- MCOs started as quasi-public entities formed by the counties
- Inclusion of state plan services for LTC and related with HCBS (15 state plan services)
- Comprehensive LTC waiver services (28 services)
- Includes all target groups (Elderly, Physically Disabled, and Intellectually and Developmentally disabled)

WI LTC Care System Design

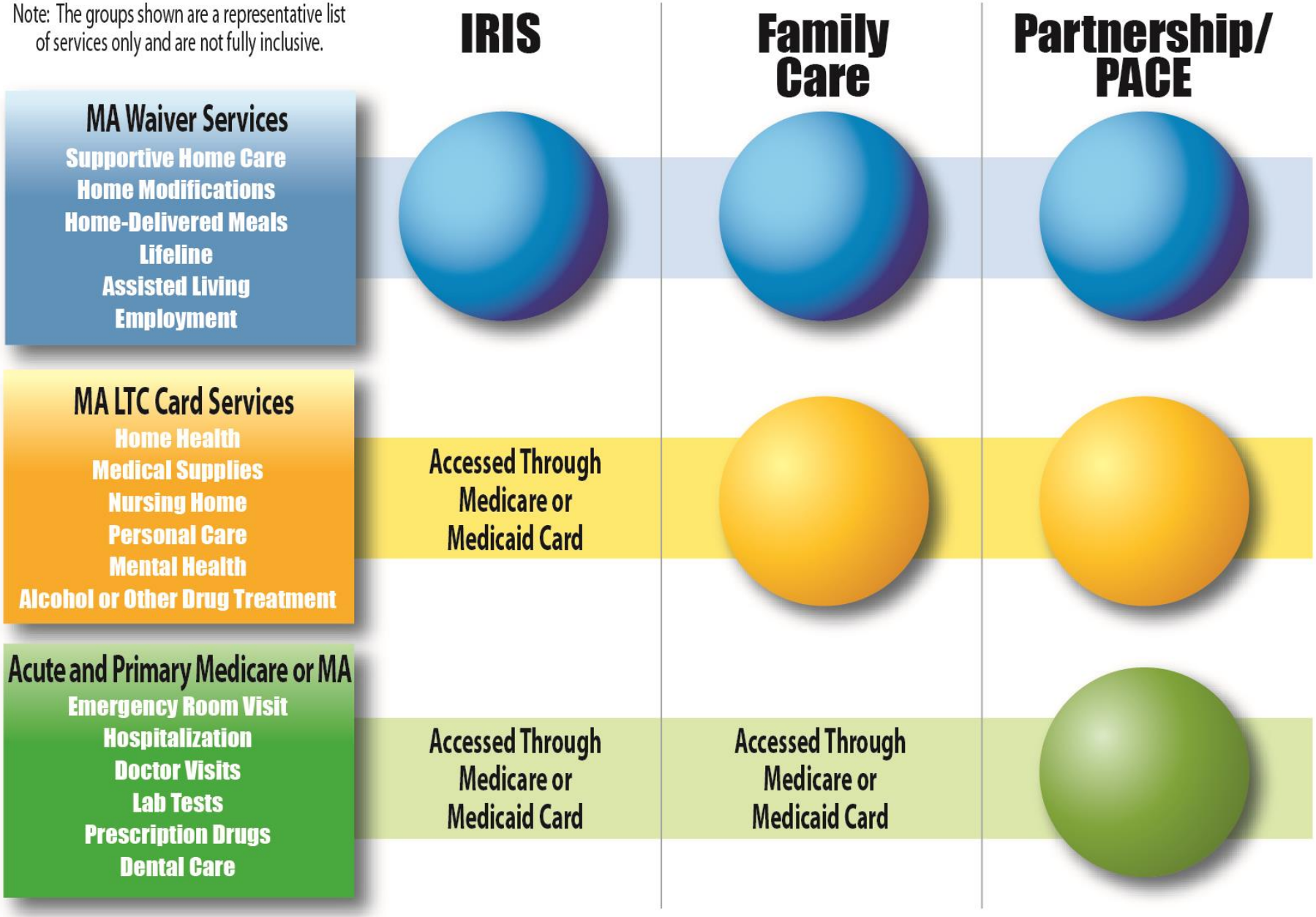
- Initial and annual functional screens for all members
- County financial contribution frozen at 22% of the counties 2006 spending amount
- Elimination of County waitlists for long term care services
- Entitlement for long term care services in the county 36 months after implementation
- A focus on natural supports and the vision that all people can live in the community

Family Care Program Design

- Model includes:
  - Strong contract outlining performance and quality expectations
  - Functional screen
  - Rate Model based on functional attributes
  - Resource Allocation Decision tool (RAD)
  - Person-centered approach that focusses on outcomes
  - High risk funding pool
  - Strong oversight model including contract monitoring, quality oversight, and best practice integration
  - Collaboration with MCOs, Advocates, and Counties

Examples of Wisconsin's LTC Program Services

Note: The groups shown are a representative list of services only and are not fully inclusive.



Enrollment Data 6/30/18

	I/DD #/%	FE #/%	PD #/%	TOTAL
Family Care	22,416 46.5%	17,547 36.4%	8,263 17.1%	48,226 69.4%
PACE, Partnership	876 22.3%	1,858 47.3%	1,193 30.3%	3,928 5.7%
IRIS Self-Directed Care	7,642 44.1%	3,465 20%	6,213 35.9%	17,320 24.9%
TOTAL	30,935 44.5%	22,870 32.9%	15,669 22.6%	69,493 100%

Long-Term Care Expenditures 6/30/18

Long Term Care expenditures as percent of total Medicaid budget = 42%

- SFY = State Fiscal Year
- ICF-IID = Intermediate Care Facilities for Individuals with Intellectual Disabilities

	SFY16 Actuals	SFY17 Actuals	SFY18 Projected
Nursing Homes/ICF-IID	$833.4 million	$816.3 million	$800.2 million
Family Care, PACE, Partnership	$1.6 billion	$1.8 billion	$1.9 billion
IRIS Self-Directed Care	$371.8 million	$430.7 million	$505.4 million
Adult Legacy Waivers	$117.8 Million	$104.1 Million	$86.4 Million
CLTS Waiver	$77.8 million	$67.4 million	$73.9 million
TOTAL	$3.0 billion	$3.2 billion	$3.3 Billion

Planning & Development Incentives

- Smooth and thoughtful transition
- Partnership with the counties as they changed to Districts.
- Planning Grants - Funds for expansion of Family Care. Provide planning grant dollars to new counties and their partners for the expansion of FC into additional counties. Emphasis is on development of fiscal and business operations for new MCOs

Process Milestones

- MCOs selected through competitive procurement process
- DHS/Counties/ADRCs/MCOs finalize the county implementation schedule including the number of months each county will take to transition waiver participants
- ADRC Readiness Training, Counseling, and Enrollment Training

Process Milestones

- MCO Certification
  - Develop provider network
  - Hire and train staff
  - Identify and procure office space, if needed
  - Establish Memorandums of Understanding with counties
- DHS holds informing sessions for consumers, guardians, providers and tribes
- ADRCs begin enrollment counseling

Process Milestones

- County/MCO/ICA will collaborate to transition waiver participant care plans
- Family Care MCOs and IRIS begin serving waiver participants
- Eligible individuals on waiting lists are served within 36 months of implementation as outlined in Wisconsin State Statute 46.286(3)(c)

Family Care/IRIS Expansion

- 2007 – Family Care's 1st expansion added 2 new counties
- 2008 - Self Direction Model added - IRIS (Include, Respect, I Self-Direct)
- 2008 – 19 counties added
- 2009 – 22 counties added
- 2010 – 7 counties added
- 2011 – 2 counties added
- 2015 – 7 counties added
- 2016 – 1 county added
- 2017 – 5 counties added
- 2018 – final 2 counties added

Entitlement for all target groups!!

Results of WI LTC Model

- In 2000, 49% of WI long term care population was in the community. In 2015, 80.2% live in the community.
- In 1998 there were 11,000 individuals on the waitlist. In July 2018 Family Care and IRIS are statewide.
- In 36 months or less all counties will have reached entitlement for long term care services.
- In 2015, at 65%, WI ranked 10th in nation for Medicaid HCBS expenditures as a percent of all long term care expenditures.
- In the AARP LTSS 2017 Scorecard Wisconsin ranked 6th overall in the nation and received the Pace Setter award for choice of setting and provider.

Observations

- Request For Proposals (RFPs) and MCO failures can lead to complicated transitions
- Integration with Medicare impacts State's ability to ensure regional stability
- Multiple MCOs with sufficient populations per MCO leads to stability.
- To many MCOs and to large of enrollment in each MCO complicates transitions and oversight monitoring.
- State must be staffed sufficiently with appropriate resources

Observations

- Long term care is a high cost low volume business
- Financial monitoring is important to ensure stability.
- MLTSS contracts must have an escalation process to address issues
- The contract must have a clear termination requirements
- Effective communication is critical
- Move slow to go fast – Advocate and member buy-in is key

In Summary

"It's all about communication and listening"

Anne Olson

Director, Office of Resource Center Development

Contact Information

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Early Lessons From Pennsylvania's Community HealthChoices (CHC) Program

Sharon Alexander
President, LTSS Solutions
AmeriHealth Caritas℠

August 27, 2018

AmeriHealth Caritas

CARE IS THE HEART OF OUR WORK℠

Delivering the Next **Generation** of Health Care

Today's Discussion

- About AmeriHealth Caritas.
- Background on Pennsylvania's Community Health Choices (CHC) Program.
- What Went Right and Our Focus Forward:
  - Care Delivery and Design.
  - Provider Engagement.
  - Measurement and Monitoring.
  - Transparency and Communication.

Leading a Managed Care Organization

AmeriHealth Caritas is part of the Independence Health Group in partnership with Blue Cross Blue Shield of Michigan.

Our mission:

We help people get care, stay well, and build healthy communities.

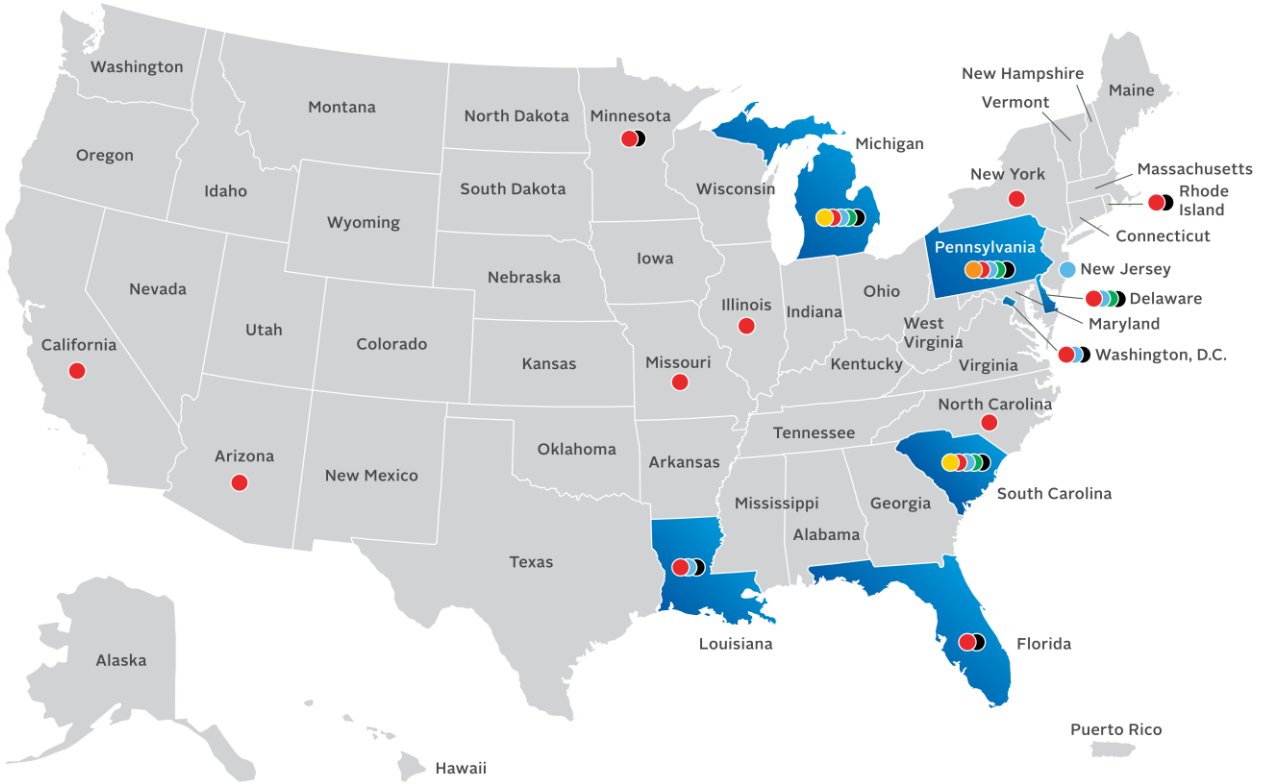
Our vision:

Leading America in health care solutions for the underserved.

States	Participants	Associates
15	**5.3M**	**6.2K**
+ the District of Columbia		

Our National Footprint

AmeriHealth Caritas is part of the Independence Health Group in partnership with Blue Cross Blue Shield of Michigan. AmeriHealth Caritas is one of the nation's leaders in health care solutions for those most in need.

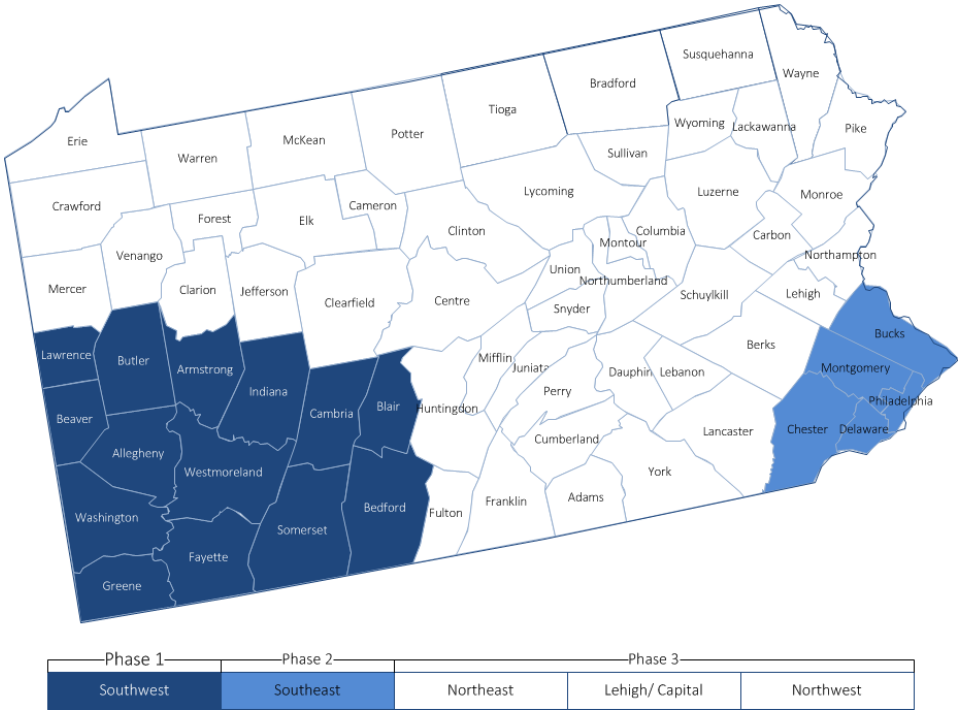


Blue states Existing AmeriHealth Caritas Medicaid health plan markets

- Dual eligible special needs plan (D-SNP)
- Medicare-Medicaid plan (MMP)
- Behavioral health managed care
- Specialty pharmacy
- Long-term services and supports (LTSS) experience
- Pharmacy benefit management

Pennsylvania's CHC Program Overview

Phased Roll-Out of CHC



Program overview

The CHC program is Pennsylvania's new managed long-term services and supports (MLTSS) program.

It targets two populations:

- Participants 21+ who require Medicaid LTSS because they meet nursing facility level-of-care criteria.
- Dual eligible participants 21+ ,whether or not they need or receive LTSS.

The intellectual developmental disability population is excluded and behavioral health services are carved out.

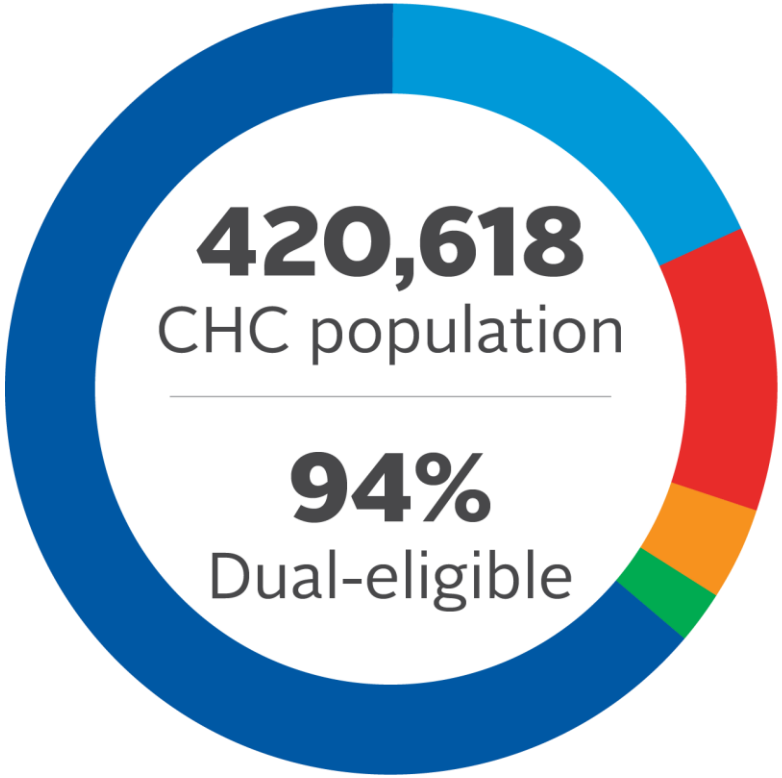
Three managed care organizations have been awarded: AmeriHealth Caritas (Pennsylvania and Keystone First), UPMC *for You*, and Pennsylvania Health and Wellness (Centene).

The program will be implemented in three phases:

- Southwest zone: January 1, 2018.
- Southeast zone: January 1, 2019.
- Remaining zones: January 1, 2020.

Awarded plans are required to operate a D-SNP plan statewide.

CHC Statewide Population Profile



64%
270,114
Healthy duals

18%
77,610
Duals in nursing facilities

12%
49,759
Duals in waivers

4%
15,821
Non-duals in waivers

2%
7,314
Non-duals in nursing facilities

16%
in waivers

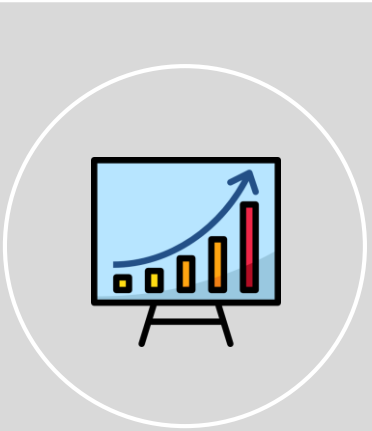
20%
in nursing facilities

Source: Commonwealth of Pennsylvania, Department of Human Services, 2018.

Early Lessons Learned:
What Went Right and What We're Focused on

Care delivery and design

Provider engagement



Meaningful measurement

Transparency and communication

Care Delivery and Design: What Went Right

Access to services

Consumers expressed concerns that:

- They would not receive their necessary services during the transition to MLTSS.
- At the end of the continuity of care period, prior services would be reduced.

Best practices

- The Pennsylvania Office of Long Term Living (OLTL) built in a six month continuity of care provision, where service plans approved at implementation will remain in place for six months.
- Service levels require careful monitoring during the transition process.
  - CHC plans report and monitor service plan changes to OLTL, to ensure service levels reflect the person-centered planning process.
- CHC plans also submit denial notices to OLTL for review.
  - State training for MCOs on denial notice process and language.

Care Delivery and Design: What Went Right

Enhanced Care Delivery Process

- Creating capacity to ensure the model of care supports a person-centered approach.
- Safeguarding nimbleness where indicated.

Best practices

Identifying participant risk factors:

- Screening and comprehensive standardized assessment tool that measures LTSS needs as well as other health and social needs, including behavioral health.
- Understanding Participants' social determinants of health

Targeting resources accordingly:

- Having a care team help address barriers for Participants living in their homes.
- Establishing feet on the street for greater Participant outreach and engagement.
- Caregiver services and supports.

Training:

- Robust training for service coordinators on person-centered practices to improve quality of service plans.
- Training collaboratives with Centers for Independent Living, Area Agencies on Aging, and other community-based organizations for member services and service coordination teams.

Care Delivery and Design: Our Forward Focus

Integration of care

Integrating care with unaligned D-SNP:

- Since a large portion of the Pennsylvania participants in CHC are Medicare-Medicaid enrollees who receive their primary and acute care services from Medicare, the state wanted to increase coordination with Medicare services.
- Contracting with D-SNPs enables the state to achieve greater coordination of services for their CHC Participants.
- Participants have a choice of Medicare D-SNP plans and can chose one unaffiliated with the CHC plan.

Promising practices

Working to close the gaps with unaligned DSNPs to better coordinate care:

- Mutual cooperation and coordination agreements between unaligned D-SNP and CHC plans.
- Focus is on coordination of care, exchange of information related to the administration of covered services to Participants, transition of services, and dispute resolution.
- Performance improvement project on strengthening transitions of care after an inpatient stay (acute or behavioral health inpatient stay).

Care Delivery and Design: Our Forward Focus

Coordination of care

Transition of service coordination:

- Service coordination becomes administrative responsibility of CHC plans after the continuity of care period.
- Complex landscape of community-based service coordination entities operating in the state.
- Moving toward a hybrid model approach to service coordination, where some responsibilities are delegated to designated community-based organizations and others are retained by plan.

Promising practices

- Service coordination entities (AAAs; Rehabilitation and Community Provider Organization) evolved to create two consortiums (sub-networks) of entities structured to support:
  - Single-signature authority for contracting.
  - Centralized data and reporting.
  - Credentialing.
  - Quality monitoring.
  - Training.
  - Movement to value-based purchasing.
  - Specific products and solutions.
- Delegated entities pursuing the National Committee for Quality Assurance Accreditation of Case Management for LTSS Programs.
- Leveraging proven expertise with community-based organizations such as nursing home transition teams.

Care Delivery and Design: Our Forward Focus

Service system innovation

Key state objective is to create a better LTSS system. Focused areas of innovation center on:

- **Increasing affordable and accessible community housing options:**
  - Housing expertise embedded at the care team level.
  - Creative benefit design to support crisis and short-term needs.
  - Federal/state/local community partnerships.
- **Enhancing the LTSS direct care workforce:**
  - Well-skilled workers through training and competencies development.
  - Incentive arrangements with providers to support knowledge building and career ladders.
- **Expanding the use of technology:**
  - Extending the reach of service coordination through biometric monitoring, change in condition management, and adaptive technology in Participants' homes to support independent living.
- **Expanding employment among Participants who have employment goals:**
  - Advancing opportunities for Participants through plan Employment Coordinators.

Provider Engagement: What Went Right

Participation and payment

- Most LTSS providers in Pennsylvania had limited experience with managed care, and their understanding, cooperation, and interaction was essential for successful CHC implementation.
- Active provider outreach and education was critical, as providers are often the first and most significant link between the Participant and the CHC plan.

Best practices

Robust provider communications:

- Dedicated provider forums — engage providers early and often; segmented by provider type (i.e., nursing home, home health) were formed to educate providers and discuss operational and programmatic issues.
- Plan focused webinars/online trainings for targeted providers (i.e., county nursing facilities, adult day care).

Contracting and Payment:

- Contract LTSS network as soon as feasible.
- Prompt and accurate payment.
- Rate floor in place for 36 months for nursing facility providers; Conduct claims testing before go-live to ensure payment accuracy.

Provider Engagement: Our Forward Focus

Value-based arrangements

Encourage accountable care by promoting value-based payment and delivery models.

- Many LTSS providers are not well positioned to enter into many forms of value-based payment.
  - Lack of understanding of value-based payment arrangements.
  - No contracting experience for value-based payment arrangements.
  - Small providers serving small number of Participants.
  - Limited data analytics capability.

Promising practices

- Establishing partnerships that tie payment of services based on quality of care for CHC LTSS Participants.
- Phased approach, beginning with pay-for-performance arrangement for nursing facilities and targeted home- and community-based service providers, moving over time to risk-based arrangements, including shared savings.
- Defining specific quality metrics and measurement sets.
  - LTSS measurement considers new domains that are difficult to measure, including quality of life, functional status, and independence.
  - Aligning with existing measures to enhance provider buy-in.
- Actionable data are vital to value-based payment development.

Measurement and Monitoring: What Went Right

Reporting and oversight to enhance the Participant experience

- Strong state monitoring and oversight post-implementation to oversee CHC plan operations and contracting adherence, which helps ensure Participants receive the care they need.
- Critical to addressing consumer and advocate stakeholder concerns.

Best practices

- Weekly "launch reports" prepared by CHC plans and submitted to the state to track and trend key metrics.
- Data provides an early indication of how program implementation is going before other data sources become available.
- Categories included:
  - Service continuity.
  - Service coordination continuity.
  - Provider network participation.
  - Critical Incidents/Grievance and Appeals.
- Comprehensive set of operations reports developed post-launch.

Measurement and Monitoring: Our Forward Focus

CHC quality measures

- Focus on refining and further developing the capacity to measure and improve quality.
- No national MLTSS quality standards.
- In the absence of national standards, state has developed a set of performance measures.

Promising practices

- Process of care and outcomes measures.
- The state is also requiring plans to gauge consumer satisfaction to measure performance.
  - CHC plans will be using HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for Pennsylvania.
  - A cross-disability survey of home- and community-based service experience from beneficiary's receiving LTSS.

Transparency and Communication: What Went Right

Strong stakeholder engagement

Best practices

Participants

- State produced general awareness flyers and has a robust website.
- Events hosted by community organizations (Aging Well, Jewish Healthcare Foundation).
- Comprehensive pre-transition materials.
- Service coordination entities and key providers (NF) held discussions with Participants.

Providers

- State sent out bi-weekly topical emails (i.e., billing, service coordination, continuity of care).
- State hosted provider forums in local communities to meet managed care organizations and understand the contracting process.
- Plans held provider one-on-ones, organized webinars and provider websites.

State partner

- Assigned a state liaison for each CHC plan.
- Established standing meetings through the readiness review process.
- Scheduled daily/weekly touchpoints during the launch.
- Conducted monthly “Third Thursdays” and MLTSS Sub-Medicaid Assistance Advisory Committee meetings.

Transparency and Communication: Our Focus Forward

Earlier stakeholder engagement

Promising practices

- Engaging stakeholders sooner and more often in southeastern Pennsylvania than in southwestern Pennsylvania, including providers and advocates.
- Enhanced Participant communication, education, and training related to several key areas, including Medicare and CHC, continuity of care period, provider network, and Participant rights.
- Longer enrollment timeline for southwestern Pennsylvania launch.
- Transparency is key — no one likes surprises.
- It is an iterative, developmental process — apply lessons learned from first phase to second phase to improve implementation.

More than

35 YEARS

of making

care the **heart**

of our **work.**

AmeriHealth Caritas®

Care is the heart of our work

MEDMGMT_18294840

The Arizona Health Care Cost Containment System's

Approach to:

Healthcare Workforce Development

Danielle Ashlock
ALTCS Project Manager

Starting 2.5 Years Ago AHCCCS…

- Established a Workforce Development Administrator
- Required all contracted Health Plans to hire a WFD Administrator/Specialist
- Included a WFD question in the ALTCS – EPD - Request For Proposals
- Implemented ACOM-407 a policy requiring Health Plans maintain a WFD operation

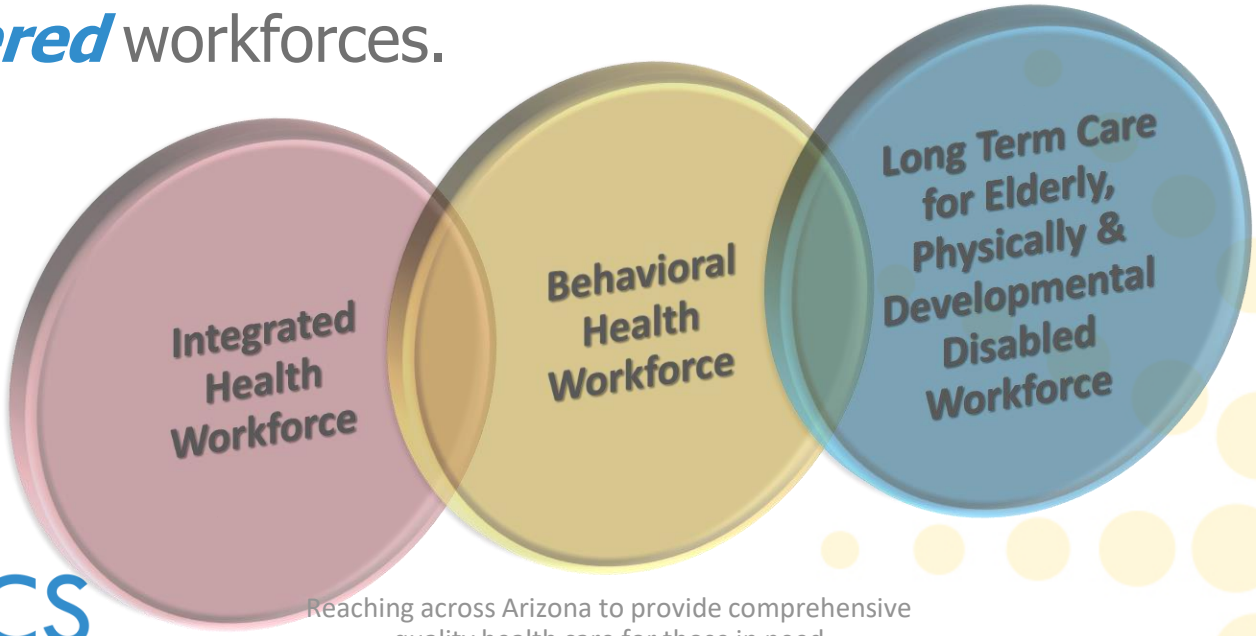
What Does AHCCCS Mean By WFD?

Policies, programs and processes to:

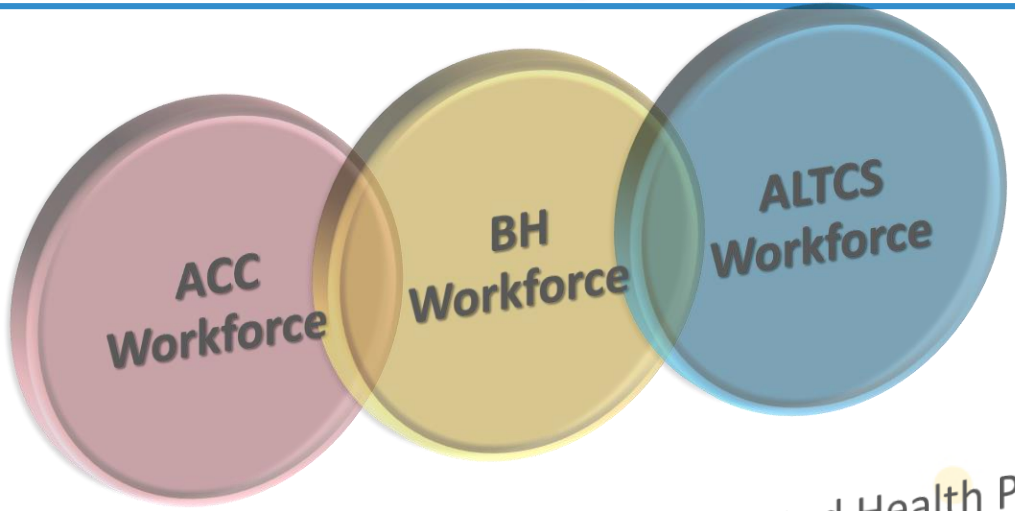
- ***Create***,
- ***Sustain and***
- ***Retain*** a viable workforce.

Mission of the Office of WFD

- Ensure AHCCCS Members are engaged by the most ***interpersonally, clinically, culturally & technically*** capable healthcare workforce in the US,
- By ***coordinating*** the efforts of ***8 contracted Health Plans*** to support the development of ***3 population centered*** workforces.



Current WFD "Goals"



5. Commitment
4. **Culture** — Shared Vision of Integrated Health Process
3. **Capability** — Practitioner Competency
2. Connectivity
1. **Capacity** — Double the "N" of Direct Care Workers by 2030

ACOM 407 – WFD Policy

- Goes into effect October 1, 2018
- Requires Health Plans establish a WFD operation.
- WFD Operation has to:
  - Have a WFD Administrator / Specialist
  - Develop a *WFD Plan* with and for its provider network
  - Monitor the networks workforce
  - Collect information about the 5C's of the workforce
  - Provide Technical Assistance and Training to network providers in WFD.

https://www.azahcccs.gov/shared/Downloads/ACOM/NotEffective/400/407.pdf

WFD Plan Requirement

- Produce a Workforce Development Plan (WFD) in collaboration with providers, AHCCCS members, families and stakeholders
- The WFD Plan describes the goals, objectives, tasks and timelines to develop the workforce.
- The WFD Plan includes:
  - Short and long term strategic WFD capacity and capability requirements
  - Forecast of anticipated workforce capacity (size, job types, etc.) and capability (skills and workplace support) needs,
  - Description of the actions to be taken to implement WFD initiatives, such as programs to recruit AHCCCS members to seek employment in various roles within the AHCCCS healthcare system, and
  - Description of how stakeholders, members, families and the general public will be involved in the development and implementation of the WFD Plan.
  - Commitments made in the RFP Response

Ensuring Sustainable Capacity

- Formed a Statewide Long Term Care Advisory Group
- Developed Standard WF Metrics
- Exploring "Universal Worker"
- Health Plans - Planning & Investing in WFD
- AZ Dept. of Ed – Implementing DCW program in high schools
- DCW Industry
  - revising the DCW Curriculum and
  - community collaborative to recruit and train individuals with developmental disabilities to be part of the workforce

Future Considerations

- Performance Improvement Project
- Differential Adjusted payment

Questions?

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Thank You!

MLTSS Symposium

Michael Simone

Director of Clinical Growth Strategy

UnitedHealthcare
COMMUNITY & STATE

National Advisory Board Representation

UnitedHealthcare
COMMUNITY & STATE

Family Caregivers

UnitedHealthcare COMMUNITY & STATE

Challenges:

- Caregivers Themselves Are Aging
- Emotional & Financial Difficulties
- Lack of Respite Opportunities
- Demand Increasing While Supply Decreases

Opportunities:

- Education, Training & Research
- Peer-To-Peer Networking & Respite
- Targeted Pilots
- Telehealth and Remote Patient Monitoring

@UHCCS

Direct Service Workers

UnitedHealthcare COMMUNITY & STATE

Challenges:

- More Desirable Work Alternatives
- Recruitment, Vacancies & Turnover,
- Wages
- Shortage of Workers

Opportunities

- Tiered Competency Based Training
- Better Health Plan Alignment
- Peer Supports
- Improved Wages and Clearer Career Pathways
- Enhanced Consumer Facing Directories

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STAR+PLUS Pilot

UnitedHealthcare COMMUNITY & STATE

The STAR+PLUS pilot is intended to utilize and leverage the PAS services in the home to improve overall member outcomes, integrating the roles of personal care attendants with the broader care team

- Reduction ER and Hospitalization in pilot group
- Improved member outcome
- Real time intervention
  - ✓ Case Management (**Quality/Compliance)**
  - ✓ Integrating the PAS role with coordinated process & tools **(Quality)**
  - ✓ Reducing Hospital admissions & ER visit (**Affordability**)
  - ✓ Reduce fraud and waste (**Affordability**)
  - ✓ Close the gap to access/interventions to care (**Quality**)
  - ✓ Enhance Member Experience (**CHAPS**)
  - ✓ Expand on UHC / Optum “whole person” approach (**Growth)**

@UHCCS

Thank you!

Michael Simone
Director of Clinical Growth Strategy
UnitedHealthcare Community & State

@UHCCS

You don’t join us, we join you.SM

aetna®

Nicole Sunder

August 2018

HCBS Workforce Development in MLTSS

Nicole Sunder, Director Integrated Care Transformation

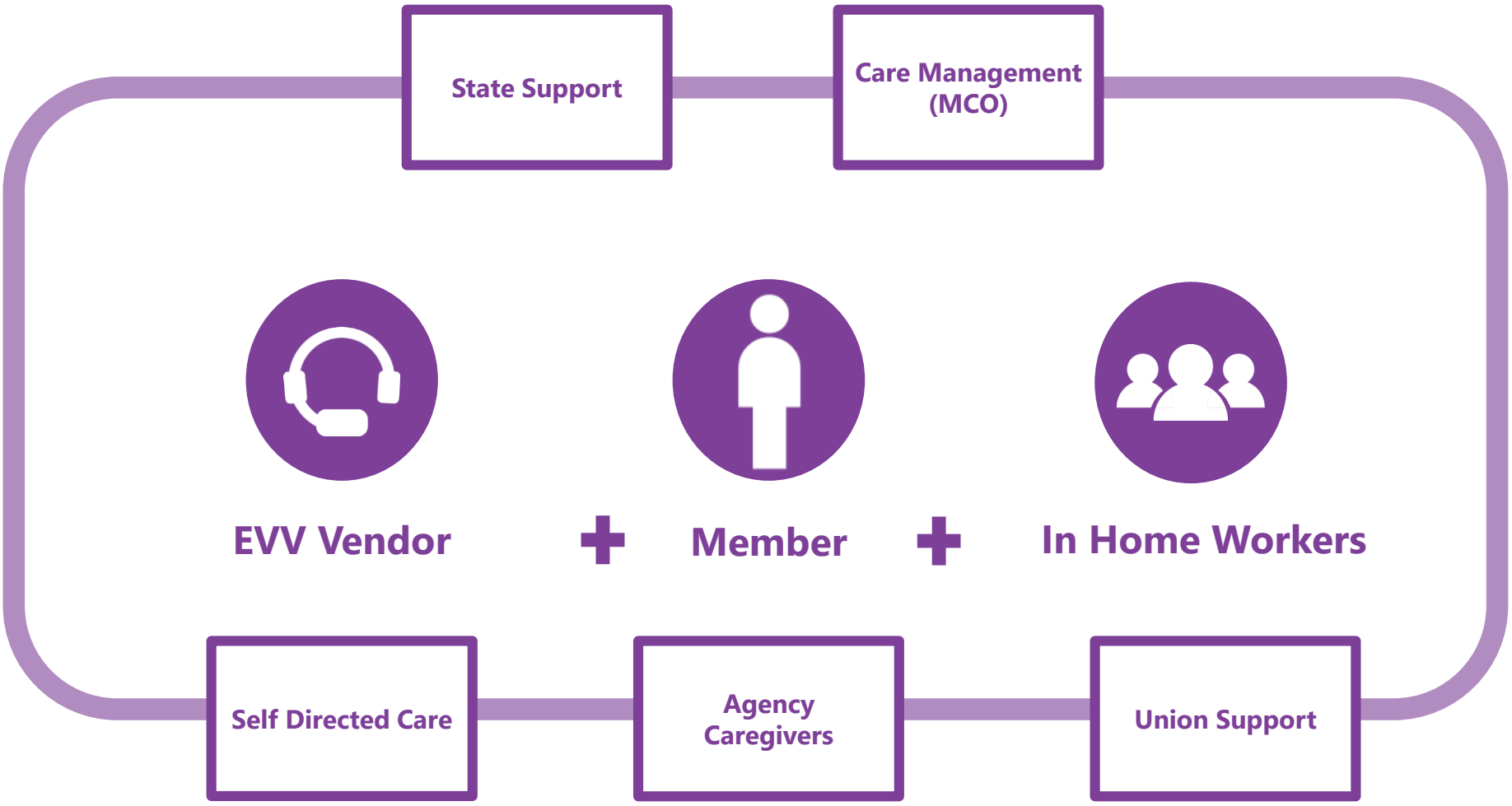
aetna®

Our members are at the center of everything we do

We believe in improving every life we touch as good stewards to those we serve

Electronic Visit Verification & Workforce

Integrated Workforce Opportunities…



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Putting this in practice…

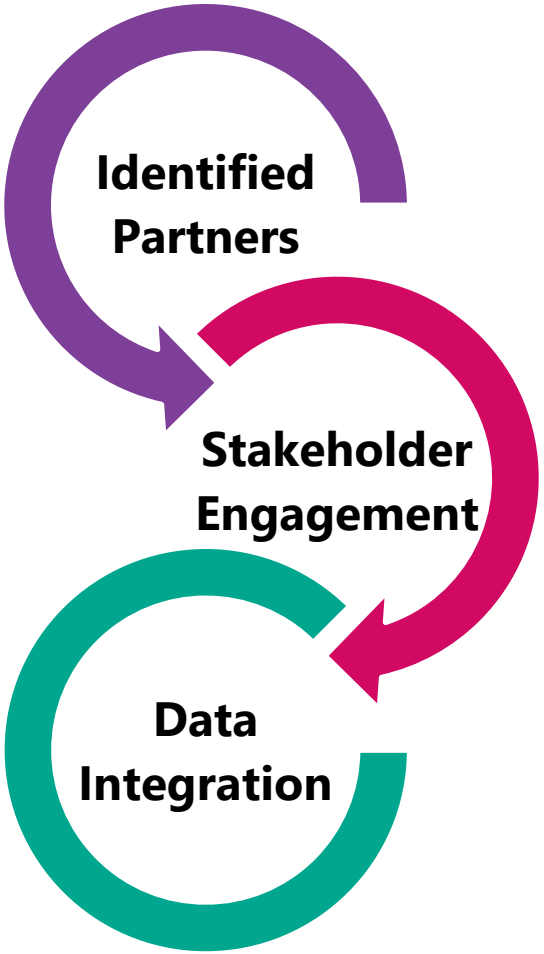
We believe that fundamental change requires increased collaboration

Identifying the way the State is going to help support putting EVV in place and the impact to the current caregiver model

Selecting who is responsible for each part of the communication plan and training for participants and caregivers

Offering ongoing oversight, technical support and education with cultural humility

Leveraging this technology to ensure people get the services they need while reducing fraud, waste and abuse



NASDDDS

NASUAD
National Association of States United for Aging and Disabilities

MLTSS FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES: STRATEGIES FOR SUCCESS

Camille Dobson, NASUAD Deputy Executive Director

Laura Vegas, NASDDDS Director of MCO Business Acumen

Need for Paper

NASUAD
National Association of States United for Aging and Disabilities
NASDDDS

- Programs serving people with intellectual/developmental disabilities (I/DD) in managed care programs are few in the country
- States with MLTSS programs for older adults and people with physical disabilities express interest in expanding/creating programs for people with I/DD
- There is significant concern from participants and their families about the impact of managed care on their services

Need for Paper

- Little written about this topic
- States, health plans, participants and other stakeholders can use promising practices from states operating MLTSS I/DD programs
- Approach:
  - NASUAD partnered with Ari Ne'eman and NASDDDS (subject matter experts on serving individuals with I/DD)
  - Conducted lit search and interviewed states and plans

History of I/DD Advocacy

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- Late 1940s to mid 1950s - Parent Movement
  - Families across the US began asserting a different vision, different lifestyle and different future
  - Question wisdom of institutionalization
- 1950
  - Isolated independent small groups of parents coalesced
  - Demanded services for their sons and daughters outside of an institutional setting
  - Advocacy groups sprang up across the country
  - National Association for Retarded Children – The Arc

History of I/DD Advocacy

- 1970's – 1980's
  - Alternatives to large institutions
  - Education for all Handicapped Children Act (IDEA)
  - Section 1915c of the Social Security Act
  - Oregon was first state to receive approval for HCBS waiver

- Mid 1980's – mid 1990's
  - Day Habilitation/Supported Employment
  - Deinstitutionalization/Balancing

History of I/DD Advocacy

- Parents and Families as Pioneers for Progress
  - People with I/DD live in their homes and communities
  - Closing institutions
  - Supports in the family home
  - Person-centered services and supports
  - Self-determination
  - Employment
  - In all states, have been instrumental in the development of publically financed human services system
  - Expertise, passion, experience and love

MLTSS Delivery Systems

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NASDDDS

- In 23 states as of April 2018
- Almost all cover LTSS services for older adults and people with disabilities
- States seeking to increase community living; simplify administrative processes; and use health plans to drive quality improvements and innovation
- Only 8 states include waiver services for people with I/DD in their MLTSS programs:

Arizona	Iowa	Kansas
Michigan *	New York #	North Carolina *
Tennessee	Wisconsin	

* I/DD and MH populations only
\# Financial Alignment Demonstration

MLTSS Program Lifecycle

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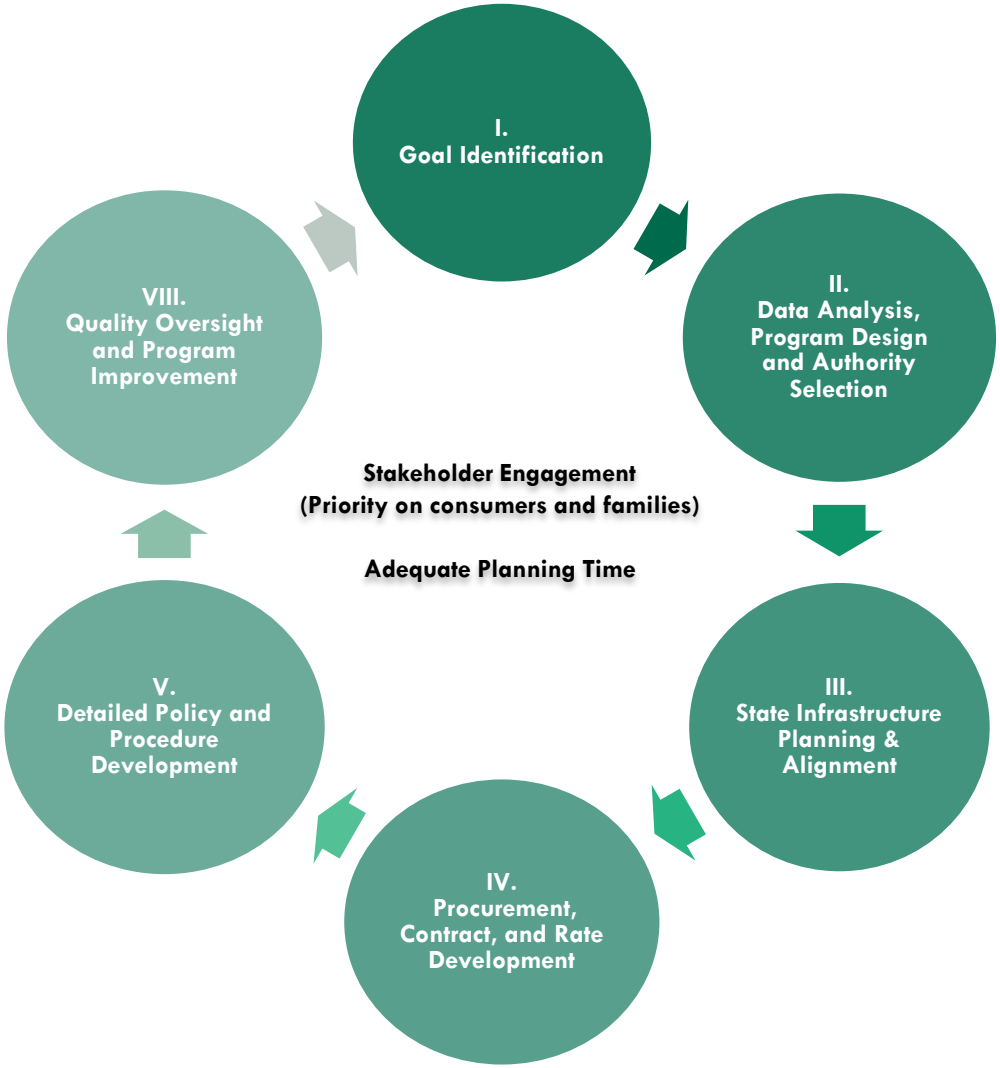

MLTSS Program Lifecycle

- Broad stakeholder engagement
  - Advocates
  - Providers
  - Health plans
  - Community-based organizations
  - Parents/families (more to come)
- Two-way street
  - Incorporate stakeholder recommendations into program design
  - Providing TA to self-advocates, families, providers
- Health plans must have process for stakeholder engagement

MLTSS Program Lifecycle

- Stakeholder engagement – families/caregivers should get particular attention
  - Meaningful roles in the design and implementation of managed care for people with I/DD and their families
  - States and managed care partners must have strong transparent systems for meaningful stakeholder engagement
  - Opportunities for input and response to stakeholders
  - Adequate time for engagement and review of successes and challenges of implementation
  - Ongoing, not just during design and implementation

MLTSS Program Lifecycle

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- Adequate planning time
  - CMS recommends two year planning process, minimum
  - Thoughtful planning and design
  - Incorporate stakeholder input
  - Safeguards to insure smooth transition
  - Education about MLTSS for people with I/DD and their families
  - Health plans familiarize themselves with LTSS for people with I/DD and their local provider network

Goal Identification

- State system goals should also incorporate goals for participants including person centeredness, employment choices, and self-determination
- I/DD system is typically 'rebalanced' so other goals will be predominant
  - Increased access to preventive and acute services
  - Comprehensive care/service coordination
  - Budget predictability and stability

Michigan includes specific goals for all participants to pursue competitive employment

Program Design

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- Data on FFS costs, utilization and provider distribution critical
  - Set capitation rates
  - Identify network capacity/gaps
- Populations, benefit package, geographic reach all need to be identified
- Managed care authority/modifications to service authority
- Maintaining historical quality infrastructure (ie. NCI)

Kansas continues to administer NCI survey and requires MCOs to use data in their QI activities

State Infrastructure

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- Close collaboration with I/DD operating agency/unit to access experience for design and implementation plans
  - Voc rehab and education play important role as well
- If feasible, transition waiver oversight staff to contract/quality monitoring; specific focus on critical incident reporting and monitoring
- Ensure beneficiary support system staff have training/experience with I/DD participants and services

Tennessee's Medicaid and VR agencies signed MOU for efficient employment services

Procurement/Rates

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- RFP should make state expectations and priorities clear
  - Include program requirements specific to I/DD populations
  - Seek demonstrated expertise/philosophy about I/DD populations
- Establish minimum standards for provider ‘credentials’ and other I/DD program-specific elements
- Adequate rates are essential, and should support goals of program
  - Encourage innovation but maintain stability of system

Contracts

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- MCO staff composition and skill set (different from other populations)
- Minimize burden on providers (standardized processes across plans)
- Expectations for addressing informal support network, esp. family members
- Collect and submit data to show progress to goals (ie. competitive employment achieved and maintained)

Tennessee developed 'preferred contracting standards' for I/DD program network

Policies and Procedures

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- The devil is in the details
- Contract cannot enumerate the operational aspects of program implementation
- The more information the state can transmit increases likelihood of health plans implementing the program design with fidelity
- Transparent communication is critical
- Educate and train, and educate and train some more

3 plans in North Carolina collaborate to deliver web-based PCP training to providers using DirectCourse

Quality Improvement

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NASDDDS

- Important to establish quality measures that will assess success in meeting program goals
- Participant input critical to defining 'success'
  - Clinical quality secondary to meeting participants goals for their lives
- Ensuring health and welfare a key quality outcome
- Wealth of NCI historical data can be instrumental in comparing experiences under MLTSS

The I/DD agency in Tennessee conducts on-site MCO performance reviews

Key Takeaways

- MLTSS programs for people with I/DD hold great promise for expanding employment and improving health status
- Deliberate and thoughtful design, procurement and implementation plans will increase likelihood of success
- Slow and steady wins the race!
- States and MCOs should work collaboratively to support providers and achieve program goals
- Regular and bidirectional engagement with participants and their families will provide important feedback loop
- Measuring quality in meaningful ways will support program success

NASDDDS

NASUAD
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United for Aging and Disabilities

NASUAD
National Association of States United for Aging and Disabilities

Improving Quality in MLTSS

MLTSS Pre-Conference Intensive

August 287, 2017

Quality Measurement

- Quality measures provide a framework around which stakeholders can collaborate around shared goals:
  - Assist in ensuring collective accountability throughout a system, by various stakeholders:
    - Payers (state governments)
    - Providers
    - Purchasers (managed care organizations)
    - Beneficiaries and their informal caregivers
    - Advocacy groups
  - Used to incentivize quality and reward sustained levels of high performance
  - Identify progress towards goals

Challenges to Effective MLTSS Quality Measurement

- HCBS does not have widely adopted or evidence-based guidelines, protocols or training standards
  - There are few professional norms, education, and bodies of knowledge
- State-specific HCBS measures:
  - Address common HCBS domains
  - But may be imprecise, poorly specified, or not thoroughly tested
  - Cannot be used for cross-state comparisons

Challenges to Effective HCBS Quality Measurement

- States tend to use almost all structure and process measures, for example:
  - # of providers trained
  - # of assessments completed
  - % of care plans completed timely
  - # of critical incidents reported and remediated
- Outcome measures are highly desirable for beneficiaries, but outcomes can vary based on consumer needs and goals
- States must navigate the push and pull between person-level outcomes and system performance

Importance of Quality Frameworks

- They are a useful way to organize thinking about the different aspect of a HCBS program which are a priority for the state and stakeholders

- Several organizations have published HCBS frameworks that states can adopt – wholly or in part – for their HCBS quality measurement program
  - The National Quality Forum (NQF)
  - United Healthcare
  - The National MLTSS Health Plan Association

Frameworks Comparison At-a-Glance

NQF Quality Framework	United Healthcare Quality Framework	National MLTSS Health Plan Association Framework
Service Delivery and Effectiveness	P (Service/Care Coordination)	N
Person-Centered Planning and Coordination	P (Service/Care Coordination)	Y
Choice and Control	P (Living Independently/Choice and Decision-making)	P (Quality of Life)
Community Inclusion	P (Community Integration)	N
Caregiver Support	N	N
Workforce	N	N
Human and Legal Rights *	N	N
Equity *	N	N
Holistic Health and Functioning	P (Health Status/Medical Care)	P (Integration Risk Factors)
System Performance and Accountability *	N	N
Consumer Leadership in System Development *	N	N
	Access #	Transition to Most Integrated Setting #
		Satisfaction #

*Key: * NQF domains measure system performance and as such, are elements a health plan cannot measure or be held accountable for; # there are no corresponding domains in NQF Framework; Y – domain is identical to NQF; P – domain shares some of the same elements; N – domain is not addressed*

Considerations for MLTSS Measures

- Should be defined relative to the ultimate goals of or outcomes of LTSS
- Must be as applicable as possible to as many populations as possible
- Should be valid and reliable (ie. audited or otherwise vetted)
- Must address waiver assurances (if appropriate) or 1115 requirements
- Should address both quality of life and service delivery
- Need to be 'doable' for health plans, and focus on what the health plans can control
- Minimize case/record review to the maximum extent possible; focus on administrative data

Considerations for MLTSS Measures

- While HCBS waiver PMs are important, they do not necessarily lead to quality/performance improvement
- "Easiest" measures focus on improved health outcomes
  - ↓ ED visits
  - ↓ Inpatient admits
  - ↑ Preventative services
- Consumer and advocacy groups – especially disability communities – want to see outcome measures
- About half of MLTSS states are using quality of life surveys to assess quality

National Efforts to "Move the Needle"

- NQF issued HCBS measurement framework /domains in 2016
  - Committee spent 2 years sifting through measures, developing domain definitions and identifying needed next steps

  (http://www.qualityforum.org/Projects/h/Home_and_CommunityBased_Services_Quality/Final_Report.aspx)

- CMS contracted with Mathematica Policy Research/NCQA to develop and test MLTSS-specific measures in areas of care coordination and rebalancing

- University of Minnesota using NQF Framework to test domains with consumers and develop new measures to fill measurement gaps (https://ici.umn.edu/index.php?projects/view/189)

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An Anthem Company

Amerigroup of Tennessee

Raising the Bar: Achieving LTSS Distinction

Today's Presentation

- Amerigroup and Anthem Overview
- Why Pursue LTSS Distinction?
- Gaps Identified and Systems Developed
- Lessons Learned

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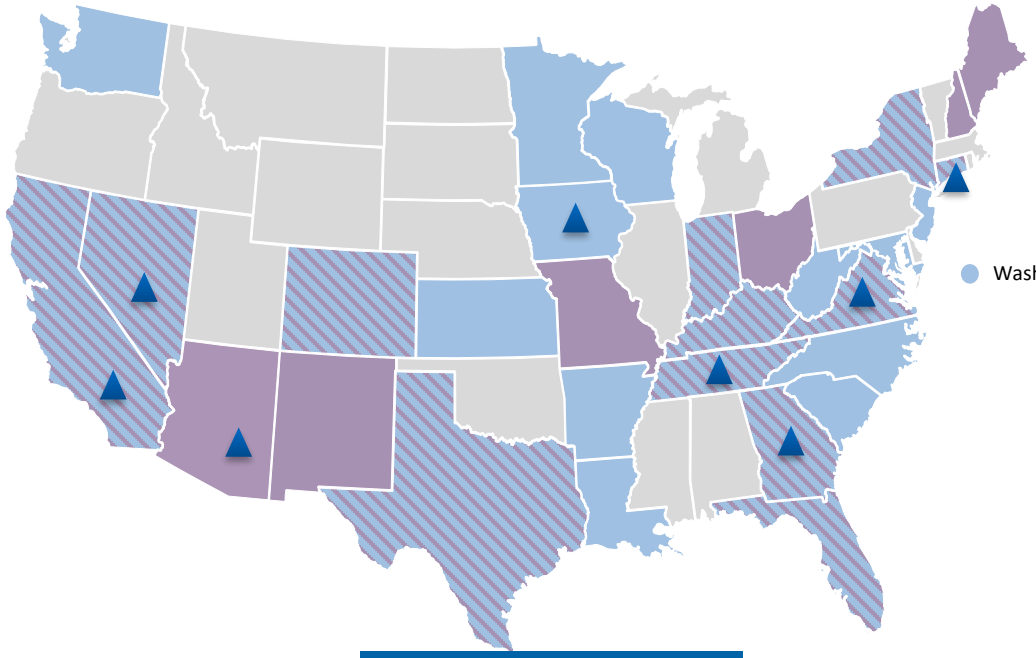
Government Business Division (GBD)



$48.3B
OPERATING REVENUE

9.6M
MEDICAL MEMBERS

Four lines of business

Medicaid
(24 states + DC)

Medicare
(21 states)

CareMore
(8 states)

Federal Government Solutions
- Federal Employee Program (FEP)
- National Government Services (CMS Medicare Administrative Contractor)
- WellPoint Military Care

*CareMore Health Plan membership is included with Medicare / functional management of the program is within DBG.

Amerigroup of Tennessee

2007-Initial Launch-TANF, ABD/SSI and Medicare
- Current Membership-Medicaid: ~390K

2010-March- LTSS or CHOICES Program Launched
- CHOICES Total: ~9000
- 90+% are Dual Eligible

2015-September; Seamless Conversion
- Auto assigns Medicaid members newly Medicare eligible into Medicare plan aligned with current Medicaid enrollment

2016-July; Employment Community First (ECF)-I/DD
- CHOICES Groups 4, 5, 6-~600

Why Pursue LTSS Distinction

NCQA's Standards

Provide a framework to **deliver efficient, effective, person-centered care**.

Offer a roadmap for improvement—can **conduct a gap analysis to identify areas where it can improve**.

Align with the needs of states and MCOs to help support contracting requirements.

Focus on coordinated care, training and measurement to **become more efficient and reduce errors and duplicated services.**

Improve communication among individuals, caregivers and community service providers.

Focus on person-centered services, which can lead to **better care planning and monitoring**.

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Why Pursue LTSS Distinction?, Cont.

NCQA Accreditation of Case Management for LTSS evaluates organizations in eight standard areas. They include:

★	**Program description.** Organizations use up-to-date evidence and professional standards to develop their case management programs, and regularly update programs with emerging findings and information.		**Measurement and quality improvement.** Organizations measure and work to improve participant experience, program effectiveness and active participation rates.
	Assessment process. Organizations systematically assess the populations they serve and have a process for conducting comprehensive assessments.		**Staffing, training and verification.** Organizations define staffing needs, verify staff credentials, when applicable, and provide ongoing staff training and oversight.
★	**Person-centered care planning and monitoring.** Organizations have a process for developing individualized care plans that incorporate personal preferences, prioritized goals and self-management plans, and monitor progress against those plans.		**Rights and responsibilities.** Organizations communicate the rights and responsibilities of participants in a case management program.
	Care transitions. Organizations have a process for managing transitions, identifying problems that could cause unplanned care transitions and, when possible, preventing unplanned transitions.		**Delegation.** Organizations document and monitor functions performed for them by other organizations.

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★ Critical Factor – organization must meet to score higher than 20% on this element

Why Pursue LTSS Distinction?, Cont.

NCQA/Industry

A means to define core components of an LTSS Program and allow clients to "comparison shop" and monitor effectiveness

Local Health Plan

Strengthen your contract rebid

A means to obtain resource support

A means to improve operational efficiency

Enterprise

Strengthen RFP submissions

Strengthen public policy input

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Our Path

2013 Stakeholder Development Meetings

2015 LTSS Standards Development Advisory Group

2016 CMS/NCQA LTSS Measurement – Technical Evaluation Panel (TEP)

2016 Early Adopter

2017 Survey

Gaps Identified and Systems Developed

NCQA/Industry	Local Health Plan	Enterprise
A means to define core components of an LTSS Program and allow clients to “comparison shop” and monitor effectiveness	Strengthen your contract rebid A means to obtain resource support A means to improve operational efficiency	Strengthen RFP submissions Strengthen public policy input

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Gaps Identified and Systems Developed

Existing Structures

- Integrated LTSS and Quality Programming
- Member /Provider Advisory Committees
- Annual Performance Improvement Project (PIP)
- Annual HEDIS goals and metrics lead by dedicated QI PI resource
- LTSS Dedicated Medical Director
- HCBS credentialing and Quality monitoring
- Critical Incident Management
- Person-centered Organization Certification, already in-process

New Structures Needed

- Add Home and Community-based (HCBS) providers to Medical Advisory Committee and Credentialing Committee
- Add dedicated LTSS Program Manager in Quality
- LTSS Program Description
- Leverage existing NCQA Quality Improvement Templates
- Leverage existing clinical reporting and create new P&P for population risk assessment process
- Leverage existing Case Management P&P for assessment process
- Create “note templates” in Care Compass to improve documentation
- Implement NCQA Case Management Audit process to support ongoing intensive staff training and feedback

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Lessons Learned

Strengths

- Experience is Key-Operational since 2010, TN has many years of LTSS experience.
- Operational Leadership Support-Knowledgeable, experienced and a highly dedicated team that understands the value of achieving NCQA LTSS Distinction.
- Integrated model-Integration of LTSS and Quality Management activities and Amerigroup's vision for person centered care.

Critical Issues

- Early Implementation of Systems- Implementation of the New PCSP(Person Centered Support Plan) by April 1 to meet 6 month look back period.
- Strong Audit Feedback-Implementation of internal audits against NCQA LTSS CM file review requirements. Current audits focus on state TATs and contract compliance.
- Ongoing Training-Continuing care coordinator staff training to recognize that conducting and completing comprehensive assessments does lead to the development of tangible plans of care, potential concrete actions and will not count for NCQA unless documented in the member's file.

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Questions?

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Division of TennCare

Quality that Matters

Tennessee's Approach to Measuring and Improving Quality

Measuring Quality

- **Why** do we **measure quality?** What's the point?
  - Understand **and improve** performance and outcomes
- Statutory commitment to **measuring** quality from the perspective of people who receive LTSS and their families
  - What's matters most to the people we support?
  - What has the greatest impact on their day-to-day lives?
  - How can we use that data to help improve the supports we provide **and** their impact on people's quality of life?
- Policy/program commitment to **valuing** quality in the same way – aligning payment for LTSS with the outcomes that most impact people's day-to-day lives
- **"Measure what we value"**, not "value what we measure"

It doesn't matter how well we can measure
things that don't matter—
that don't make a difference in people's lives.

—Lisa Mills, PhD

TN

Quality Improvement in LTSS (QuILTSS)

- A TennCare initiative to **promote the delivery of high quality LTSS** for TennCare members (NF and HCBS) **through payment reform (at the provider level) and workforce development**
- Part of the State's broader payment reform strategy (episodes of care and primary care transformation—patient centered medical homes and behavioral health homes)
- **Quality is defined from the perspective of the person receiving services and their family/caregivers**
- **Creates a new payment system (aligning payment with quality)** for **NFs and** certain **HCBS** based on performance on measures most important to members and their family/caregivers
- **Transform the system** by aligning incentives around the things that most impact the member's experience of care and day-to-day living
- **Includes workforce development** as a core foundational aspect of building capacity to deliver high quality LTSS

TN

Long-Term Services and Supports (LTSS) Overview

Value-Based Purchasing Initiatives for Nursing Facilities

- Medicaid reimbursement for Nursing Facility (NF) services based in part on resident acuity and quality outcomes that most impact residents' experience of care
- Goal to reward providers that improve quality of care and quality of life by promoting a person-centered care delivery model
- Revised reimbursement approach for Enhanced Respiratory Care (ERC) services in a NF based on the facility's performance on key quality outcome and technology indicators

Value-Based Purchasing Initiatives for Home and Community Based Services (HCBS)

- Align incentives with person-centered individual and program outcomes across HCBS programs and populations including:
  - Employment and Community First CHOICES MLTSS Program
  - Section 1915(c) waivers
  - CHOICES MLTSS Program
  - Behavioral Health Crisis Prevention, Intervention and Stabilization Services for Individuals with I/DD

Workforce Development

- Invest in the development of a comprehensive competency-based workforce development program and credentialing registry for individuals paid to deliver LTSS
- Value-based incentives for providers employing better trained and qualified staff

NCI-AD

- Indicators, outcomes, and approach align with Tennessee's member focus—measure satisfaction, quality of life, choice and control, community engagement, etc. from the perspective of person supported
- Transition to NCI-AD (from previous tool used to conduct an annual survey of satisfaction and quality of life) allowed TN to measure quality in the program, among its MCOs, as well as across health plans and programs in other states
- Objective measure of compliance with HCBS Settings Rule
- Identify opportunities for improvement for the state and MCOs
  - TennCare and each MCO review survey results, identify strengths and opportunities, develop an action plan that outlines program/process improvements to improve member-focused outcomes

TN

Using NCI-AD to Drive Payment

- How can we collect data at the provider level and leverage that data for value-based payment in order to drive quality improvement?
- Need a “mini” version of the NCI/NCI-AD (or comparable tool)
- Ideally, accessible as a web-based self-assessment tool that will make it practical and affordable to:
  - Implement across the entire population of individuals receiving HCBS
  - Aggregate results by provider
  - Use to inform value-based payment for certain services
- Initial conversations with NASUAD, NASDDDS, and HSRI
  - Would require a new tool (must be validated)
  - Could potentially be another resource for states to use in assessing/improving quality, driving value-based payment

TN

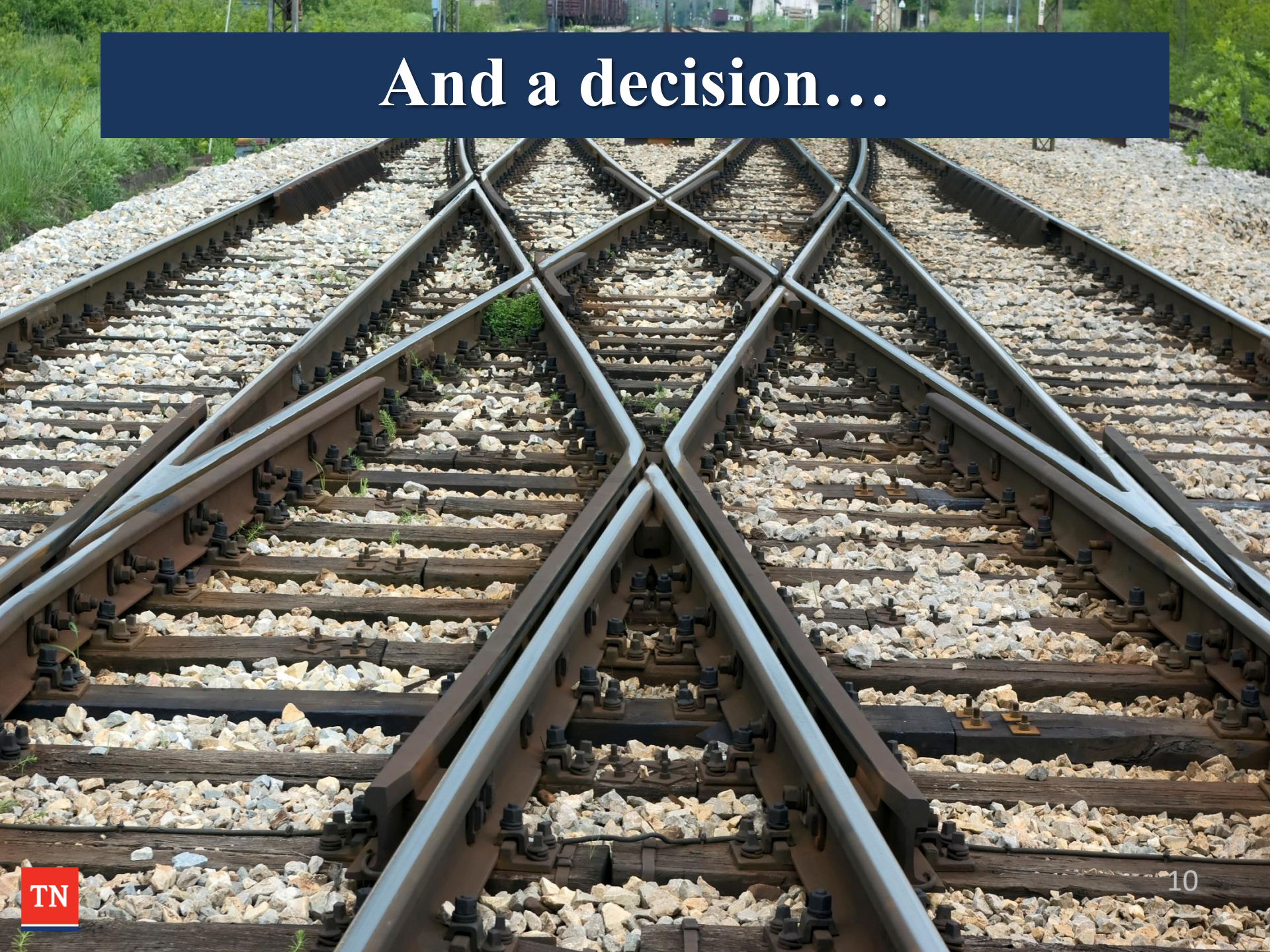
But then…

The train we didn't see coming

The Challenge of Workforce Development

- Escalating challenges with recruitment and retention in longstanding Section 1915(c) waivers
  - 51% based on 2018 Staff Stability Survey (NCI)
- Most significant factor impacting implementation of MTLSS program for people with I/DD
- To provide high quality services and supports, must have competent staff to deliver them
  - Recruitment
  - Retention
  - Consistent assignment
  - Training and competency
  - Wages and benefits
  - Satisfaction of workforce and people receiving services and supports

And a decision…



Leveraging VBP for Workforce Development

- **Phase I**
  - One-time payment to establish ongoing workforce data reporting/use
  - Financial incentives (rate enhancements) for adopting evidence-based and best practices to improve workforce recruitment/retention
    - Include wage tiers that reward advanced training/certification and tenure;
      align incentives at the worker level
  - Non-recurring investment in building provider capacity through:
    - Subject Matter Expert consultation
    - Training, train the trainer
    - Technical assistance
    - Community of practice
    - Peer mentoring
    - Verifying adoption of required practices
- **Phase II**
  - Transition to sustaining financial incentives (enhanced rates) for specific workforce and quality of life outcomes once practices expected to result in the outcomes have been effectively adopted

And ultimately…

Comparing the Quality of Managed Long-Term Services and Supports (MLTSS) Plans: New Quality Measures

National HCBS Conference
Baltimore, MD
MLTSS Intensive -- August 27, 2018

This work was conducted under a contract with the Centers for Medicare & Medicaid Services (CMS) Measure Instrument Development and Support, #HHSM-500-2013-13011, Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees, #HHSM-500-T0004

Overview

- Goals of MLTSS measure development and testing
- Overview of MLTSS measures
  - Assessment and Care Planning measures (4)
  - Falls Risk Reduction (1)
  - Institutional Admissions and Transitions to the Community – LTSS System Rebalancing (3)
- Measure roll-out, implementation, and use

State Contract Requirements for MLTSS Plans

- State contracts require MLTSS plans to conduct assessments and create care plans:
  - For new enrollees, within a specified timeframe after enrollment
  - For continuing enrollees, updated annually
- MLTSS plans arrange for needed services and supports based on assessments and care plans
- However, state contracts generally do not specify the content of the assessments or care plans

CMS Goals for MLTSS Quality Measures

Create nationally standardized measures for use across MLTSS plans and state Medicaid programs

1. **Fill key gaps in MLTSS measure domains**
2. **Develop and test measures that could be included in a broader set of MLTSS measures, including:**
   - Person-centered assessment and care planning
   - Rebalancing/Reducing unnecessary institutional stays
   - Quality of life
   - Choice and control
3. **Avoid duplicating concurrent LTSS measure development efforts, such as measures based on HCBS CAHPS (experience of care) and National Core Indicator surveys**

CMS & NQF Measure Evaluation Criteria*

- **Importance – meaningful process or outcome, performance gap & evidence of effective improvement techniques**
- **Scientific acceptability – primary focus of testing to determine if measure properties are:**
  - **Reliable**
  - **Valid**
- **Feasibility**
- **Usability**
- **Harmonization**

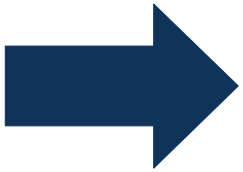
** CMS Measures Management System Blueprint (May 2017) and National Quality Forum (NQF) Measure Evaluation Criteria and Guidance for Evaluating Measures for Endorsement (August 2017)*

Critical Processes that Lead to Key Outcomes

Improved LTSS Processes:

Comprehensive Assessment and Care Planning

(4 measures)



Improved LTSS Outcomes:

Reduction of risks and adverse health outcomes (1 measure)

Reduction of unnecessary institutional stays (3 measures)

Improvement in quality of life

MLTSS Measures Deep Dive

LTSS Comprehensive Assessment and Update

The percentage of MLTSS plan members who have documentation of an in-home, comprehensive assessment covering core elements, within 90 days of enrollment or annually

Rate 1: 9 Core elements

Rate 2: 9 Core elements + at least 12 supplemental elements

Nine Core Elements of Comprehensive Assessment		
Activities of Daily Living (ADLs)	Cognitive function	Living arrangement
Current medications	Mental health status	Availability of friend/family caregiver support
Acute and chronic conditions	Home safety risk	Current providers

LTSS Comprehensive Care Plan and Update

The percentage of MLTSS plan members who have documentation of a comprehensive LTSS care plan, covering core elements, within 120 days of enrollment or annually with documentation of caregiver involvement and beneficiary consent

Rate 1: 9 Core elements
Rate 2: 9 Core elements + at least 4 supplemental elements

(9) Core Elements of Comprehensive Care Plan	
Beneficiary goal	Follow-up & communication
Plan for medical needs	Emergency need plan
Plan for functional needs	Caregiver involvement
Plan for cognitive needs	Member agreement to plan
List of all LTSS services	

LTSS Shared Care Plan with Primary Care Practitioner

The percentage of MLTSS plan members with a care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner identified by the plan member within 30 days of its development

Evidence of a Transmitted Care Plan	
Who the plan was submitted to	Date of Transmittal
A copy of the transmitted care plan or plan sections	The entire care plan does not need to be transmitted – only the most relevant parts

LTSS Reassessment/Care Plan Update After Inpatient Discharge

The percentage of inpatient discharges of MLTSS plan members resulting in updates to the assessment and care plan within 30 days of discharge

Rate 1: Re-Assessment after inpatient discharge

Rate 2: Re-Assessment and care plan update after inpatient discharge

Elements

(9) Core Elements of Comprehensive Assessment
(9) Core Elements of Comprehensive Care Plan

Screening, Risk Assessment, and Plan of Care to Prevent Future Falls

Falls Part 1: Screening

The percentage of MLTSS plan members 18 years of age and older who have documentation of screening for history of falls and/or problems with balance or gait

Falls Part 2: Risk Assessment and Plan of Care

The percentage of MLTSS plan members 18 years of age and older with a documented history of falls (at least two falls or one fall with injury in the past year), who have documentation of a falls risk assessment and plan of care to prevent future falls

Rate 1: Falls Risk Assessment	Balance/gait assessment AND one other assessment
Rate 2: Plan of Care for Falls	Exercise therapy or referral to exercise

Admission to an Institution from the Community

The number of MLTSS plan member admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) from the community per 1,000 member months

Rate 1: Admissions resulting in a short-term (1 to 20 days) stay
Rate 2: Admissions resulting in a medium-term (21 to100 days) stay
Rate 3: Admissions resulting in a long-term (101+ days) stay

Stratified by Age	
Age Categories	Ages 18 - 64
	Ages 65 - 74
	Ages 75 - 84
	Ages 85+

Minimizing Institutional Length of Stay

The proportion of admissions to an institutional facility (e.g., nursing facility, ICF/IID) for MLTSS plan members that result in successful discharge to the community (community residence for 60 or more days) within 100 days of admission

- Observed Rate
- Risked-Adjusted Rate

Risk-Adjustment Factors		
Age	Gender	Dual Eligibility
Condition Categories	Number of Hospital Stays	Days of Enrollment in MLTSS Plan

Successful Transition After Long-Term Institutional Stay

The proportion of MLTSS plan members who are long-term residents (101 days or more) of institutional facilities (e.g., nursing facility, ICD/IID) who are successfully transitioned to the community (community residence for 60 or more days)

- Observed Rate
- Risked-Adjusted Rate

Risk-Adjustment Factors		
Age	Gender	Dual Eligibility
Condition Categories	Number of Hospital Stays	Days of Enrollment in MLTSS Plan

Measure roll-out, implementation, and use

- Complete technical specifications manual for all 8 MLTSS measures posted on Medicaid.gov:

  https://www.medicaid.gov/medicaid/managed-care/ltss/index.html

- Questions and TA

  MLTSSMeasures@cms.hhs.gov.

Measure roll-out, implementation, and use

NQF/HEDIS

- 4 assessment and care planning measures and specifications will be included in HEDIS 2019*
- 3 institutional use/rebalancing measures submitted to NQF for potential endorsement – Fall 2018
- Falls risk reduction measure to be submitted to NQF for review later in the year

*Now available at: https://www.medicaid.gov/medicaid/managed-care/ltss/index.html

Measure roll-out, implementation, and use

- **Results of first year of HEDIS reporting:**
  - Compare scores across plans, identify anomalies and potential reasons
  - Revise specifications to help MLTSS plans report measures accurately
- **State questions and TA requests to CMS:**
  - Assist in creating FAQs
  - Identify strategies to overcome problems in collecting data or validating measures reported by plans

For more information

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NCI-AD

NATIONAL CORE INDICATORS-
Aging and Disabilities

NCI-AD Overview

MLTSS Intensive
August 28, 2018

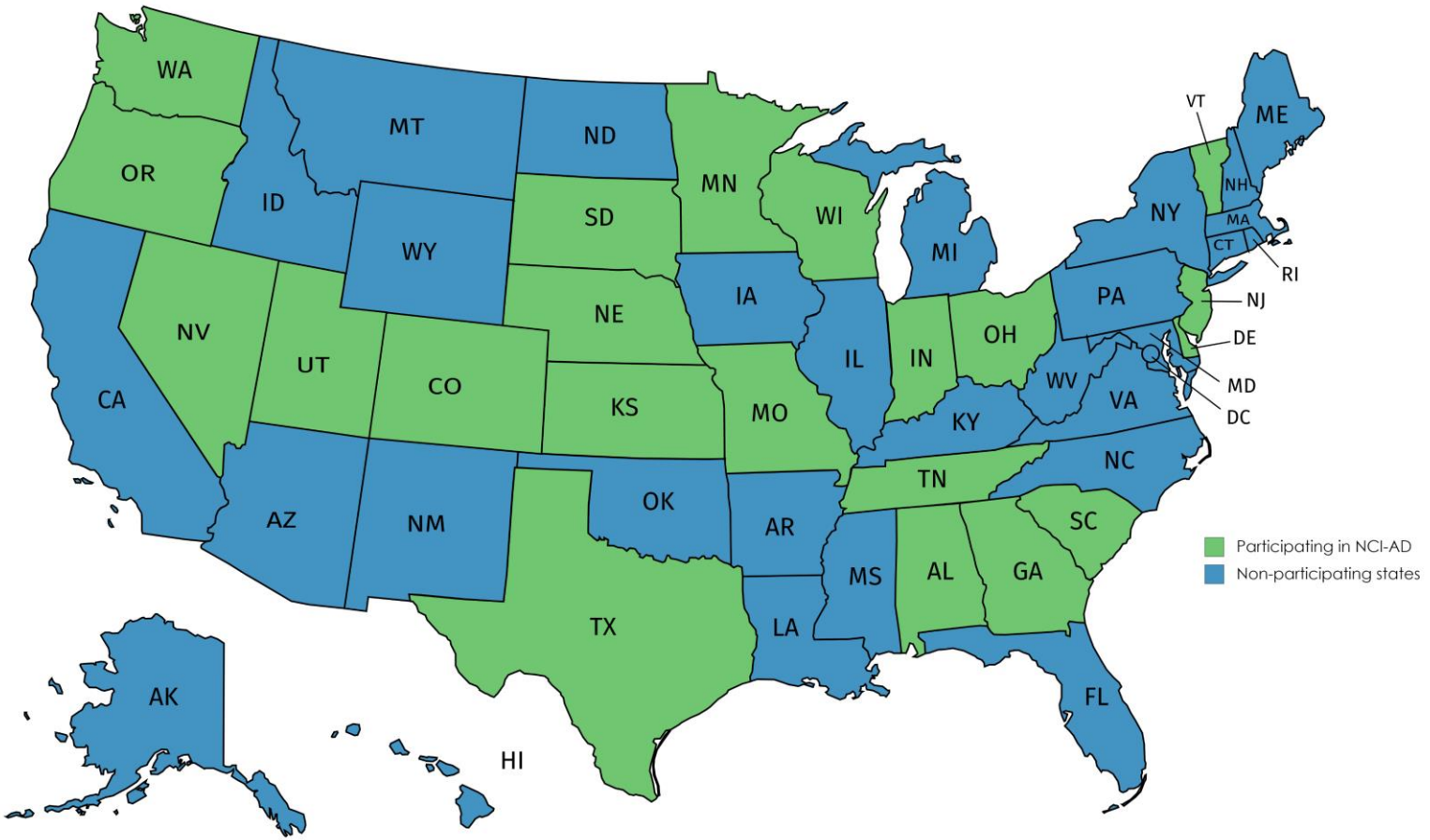
Overview and Background

- Collaboration between the National Association of States United for Aging and Disabilities (NASUAD) and Human Services Research Institute (HSRI)
- Supported by participating states and funding from the Administration for Community Living
- Face-to-face survey
- Focused on older adults and adults with physical disabilities being served by state LTSS systems

Medicaid waivers	Skilled nursing facilities
Medicaid state plans	PACE programs
MLTSS populations	Money Follows the Person
Older Americans Act programs	State-funded programs

NCI-AD

State Participation 2018-2019



How does NCI-AD Work?

- Commit to technical assistance (TA) year and 1 year of surveying
- Develop a project team and contact state agency partners
- Begin monthly TA calls with NASUAD and HSRI
- Design a sample of at least 400 LTSS recipients
- Hire a vendor or develop an internal team to conduct interviews
- Gather pre-survey and background information from state administrative records
- Hold 1 - 2 day in-person interviewer training in state
- Conduct in-person NCI-AD interviews with survey participants
- Enter data into ODESA to share with HSRI
- Receive state-specific report and state-to-state comparison report
- All data are published on www.NCI-AD.org

NCI-AD

What Sets NCI-AD Apart?

- State owns—and has immediate access to—their own data
- Can be used across settings and funding sources
- Optional state-specific questions
- Optional Person Centered Planning Module
- Can provide state, program, and regional comparisons
  - Crosswalks to NCI (ID/DD) measures
- Focuses on consumer outcomes and how services impact quality of life
  - Goes beyond service satisfaction
- Transparency and accountability
  - State and National reports are publicly available online

NCI-AD

How States Use NCI-AD Data

- Identify areas for service improvement
- Communicate with service recipients, families, and advocates
- Identify issues states can flag for deeper analysis
- Communicate with lawmakers and state legislature
- Compare programs within the state
- Compare state programs nationally
- Track changes over time

NCI-AD

NCI-AD Website

www.nci-ad.org

Houses:

- Project overview
- State and National Reports
- Webinars
- Presentations
- Staff contacts
- State-specific project information

NCI-AD