



Hot Topics in MLTSS

MLTSS Intensive
2016 HCBS Conference

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www.nasuad.org

What is Managed Long-Term Services and Supports (MLTSS)?

- MLTSS is the delivery of long term services and supports (state plan, waiver or both) through capitated Medicaid managed care plans
- Plans can be a managed care organization, pre-paid inpatient health plan, or a pre-paid ambulatory health plan (depending on scope of benefits provided)
- In many cases, plans are covering medical services as well, which provides a comprehensive delivery system for beneficiaries

Why are states pursuing MLTSS?

- In FFY 2014, LTSS expenditures represented about 34% of all Medicaid expenditures (~\$146B) ¹
 - These services constitute the largest group of Medicaid services remaining in traditional fee-for-service system
 - Fragmented approach to the ‘whole person’
 - Of note: managed care expenditures have DOUBLED since FY 2012 (to almost 15% of all LTSS expenditures)
- In FFY 2013, total LTSS expenditures were spent on fewer than 10% of all Medicaid beneficiaries ²

¹ Truven Health Analytics, June 2016

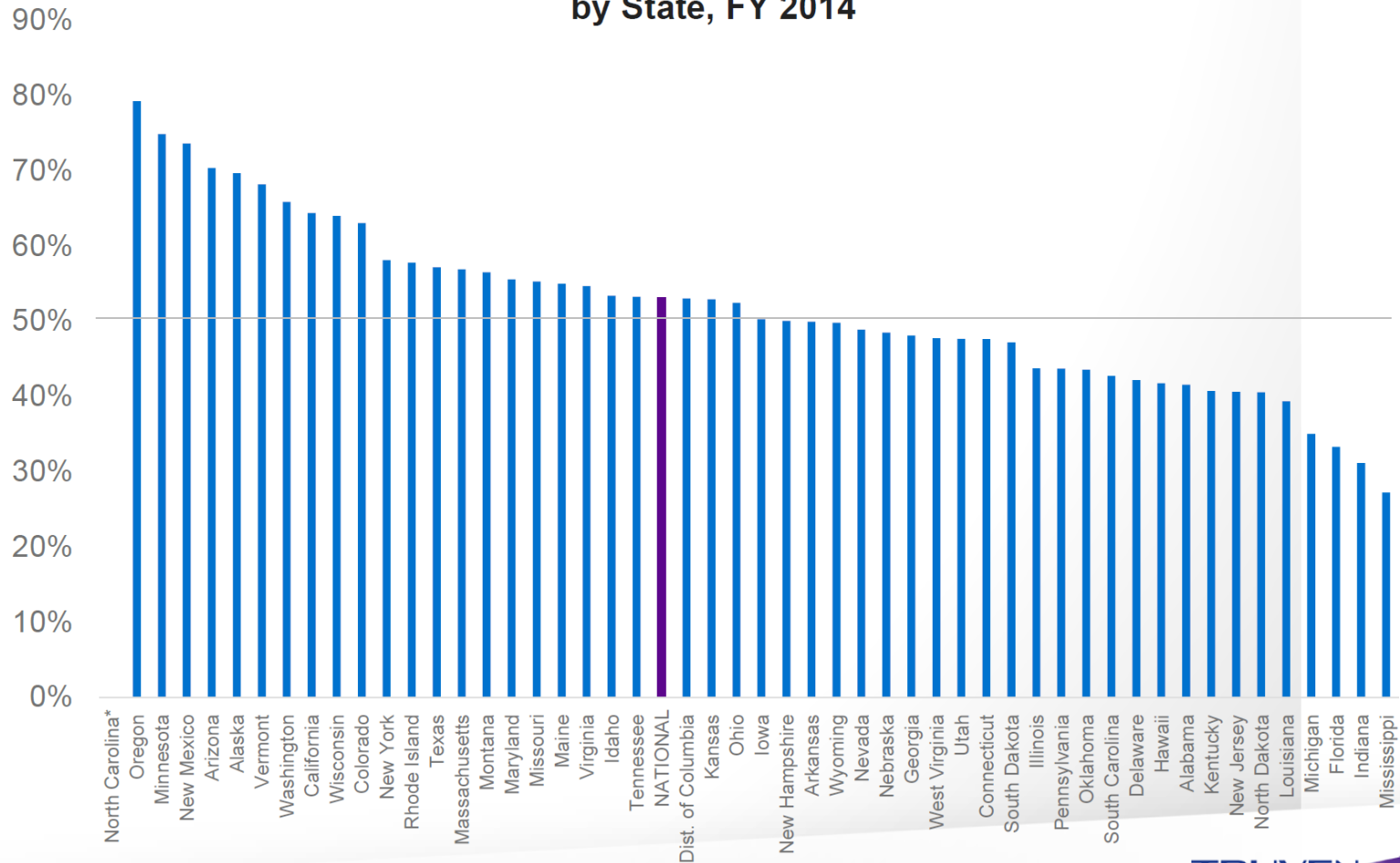
² MACPAC, June 2014 Report, Chapter 2

Why are states pursuing MLTSS?

- Accountability rests with a single entity
- Capitation payments (monthly PMPM x # of enrollees) provide budget predictability for states
- Bending the cost curve
- Rebalance system

Why are states pursuing MLTSS?

Medicaid HCBS Expenditures as a Percent of Total Medicaid LTSS Expenditures, by State, FY 2014



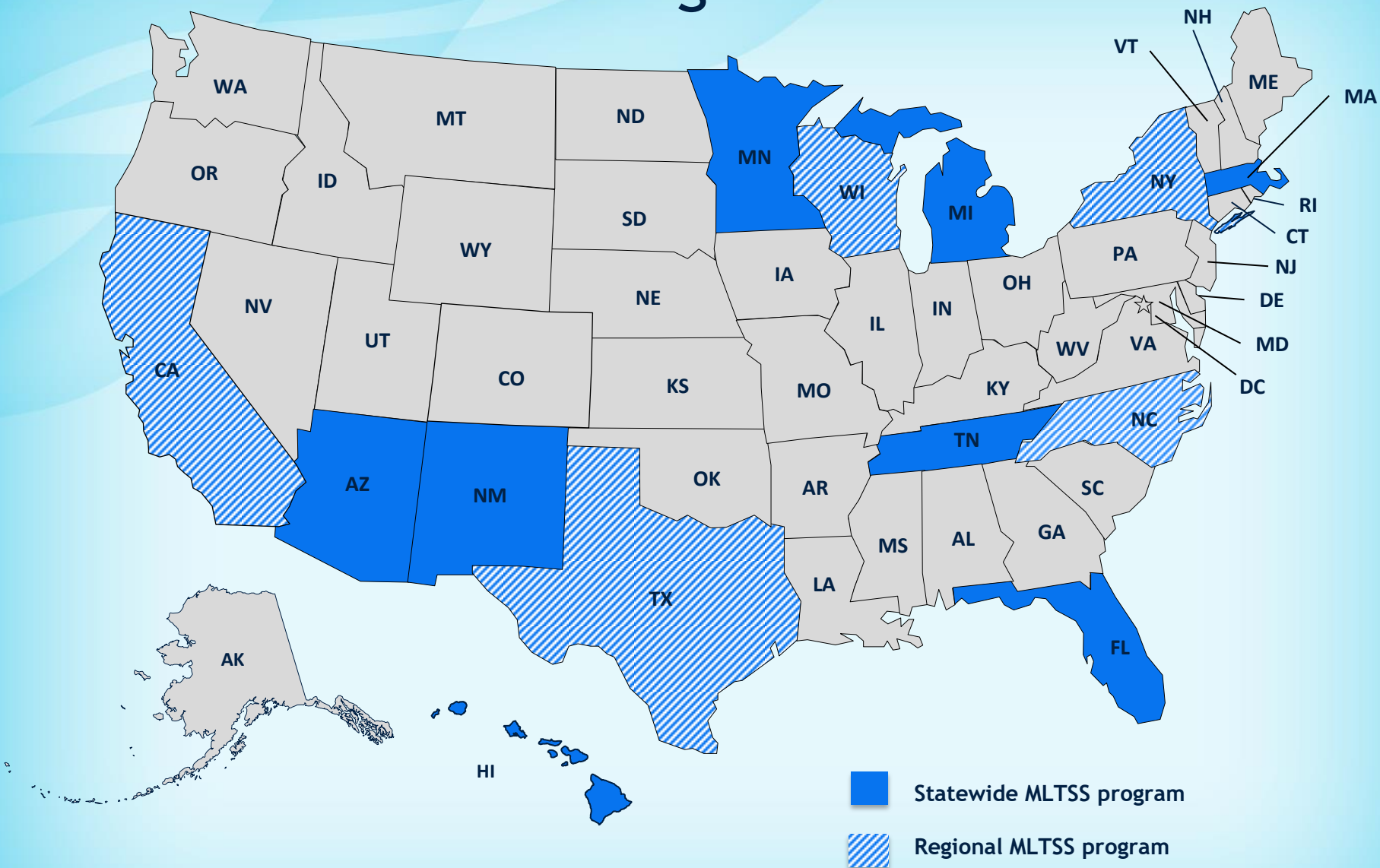
* North Carolina was not included because a high proportion of data were not reported.

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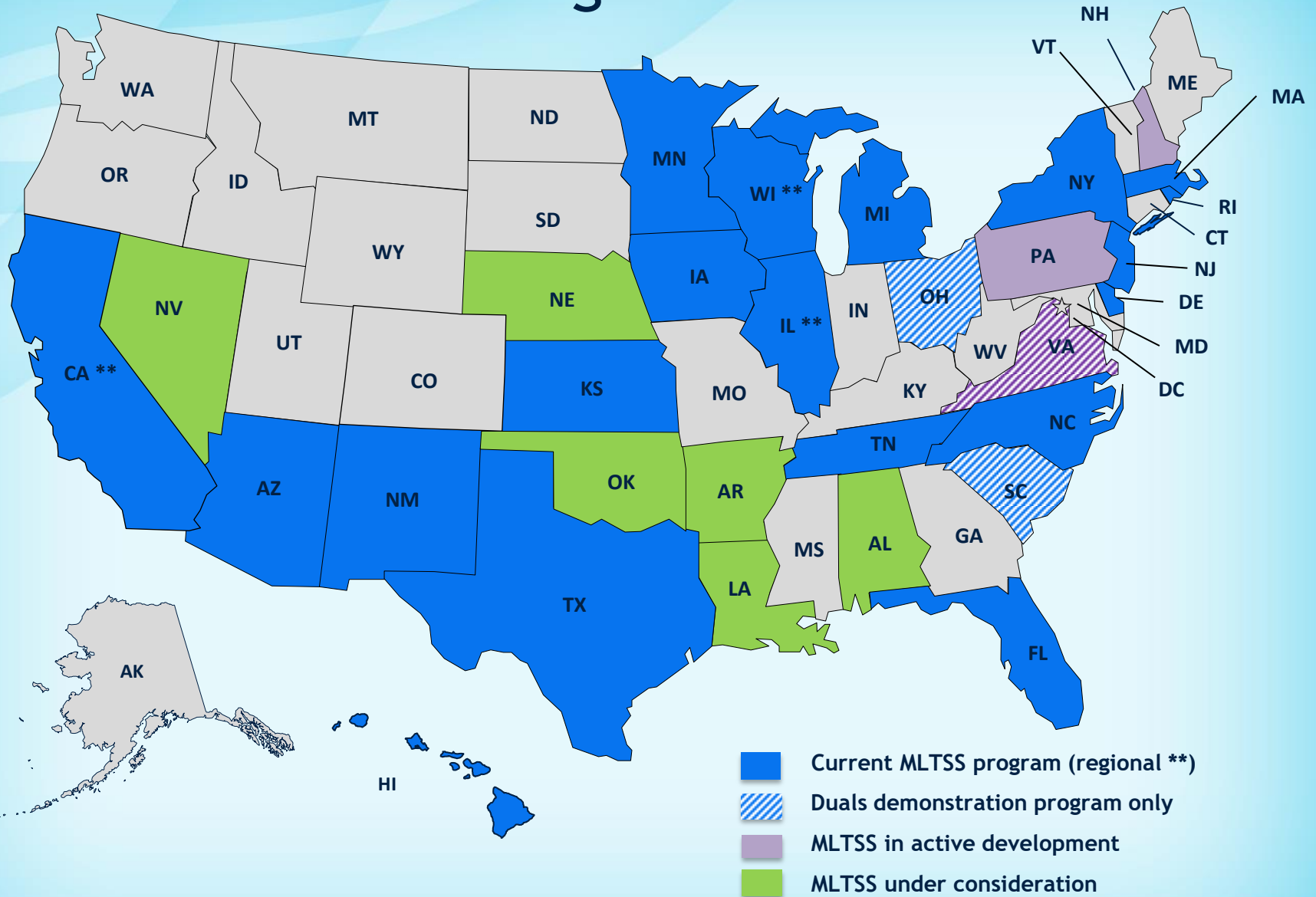
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MLTSS Programs - 2010



Source: Truven Health Analytics, 2012

MLTSS Programs - 2016



Source: NASUAD survey; CMS data

Context for today's intensive

- Programs evolve but some issues remain front and center for both new and more established programs
 - Measuring MLTSS quality continues to be a challenge
 - Aligning payment with policy goals yet maintaining sustainable program is complicated
 - New regulations = new framework for program design
 - MLTSS for consumers with I/DD requires new skills and sensitivities to ensure 'success'

Context for today's intensive

- Goal for intensive: Share learnings on 'hot topics' that continue to challenge states, health plans, providers and consumers
- Outcome of intensive: Leave with greater understanding of body of knowledge in each area and how that knowledge could improve and/or inform MLTSS programs in your state.

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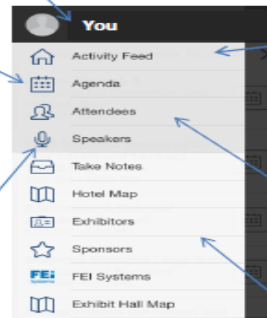
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NCI-AD: Quality in MLTSS

Kelsey Walter, NCI-AD Director
National Association of States United for Aging and Disabilities

What is NCI-AD?

- Quality of life survey for older adults and adults with physical disabilities
- Assess outcomes of state LTSS systems
 - Skilled nursing facilities
 - Medicaid waivers
 - Medicaid state plans
 - PACE
 - MLTSS populations
 - State-funded programs, and
 - Older Americans Act programs
 - Money Follows the Person
- Gathers information directly from consumers through face-to-face interviews
- State-developed initiative
- Relative of the ID/DD systems National Core Indicators (NCI)

Adult Consumer Survey

■ Pre-survey Form

- Used to setup interviews, for use by the interviewers only

■ Background Information (21 questions)

- Demographics and personal characteristics: gathers data about the consumer from agency records and/or the individual

■ Consumer Survey (86 (51 proxy) questions + 2 optional)

- Includes subjective satisfaction-related questions that can only be answered by the consumer, and objective questions that can be answered by the consumer or, if needed, their proxy

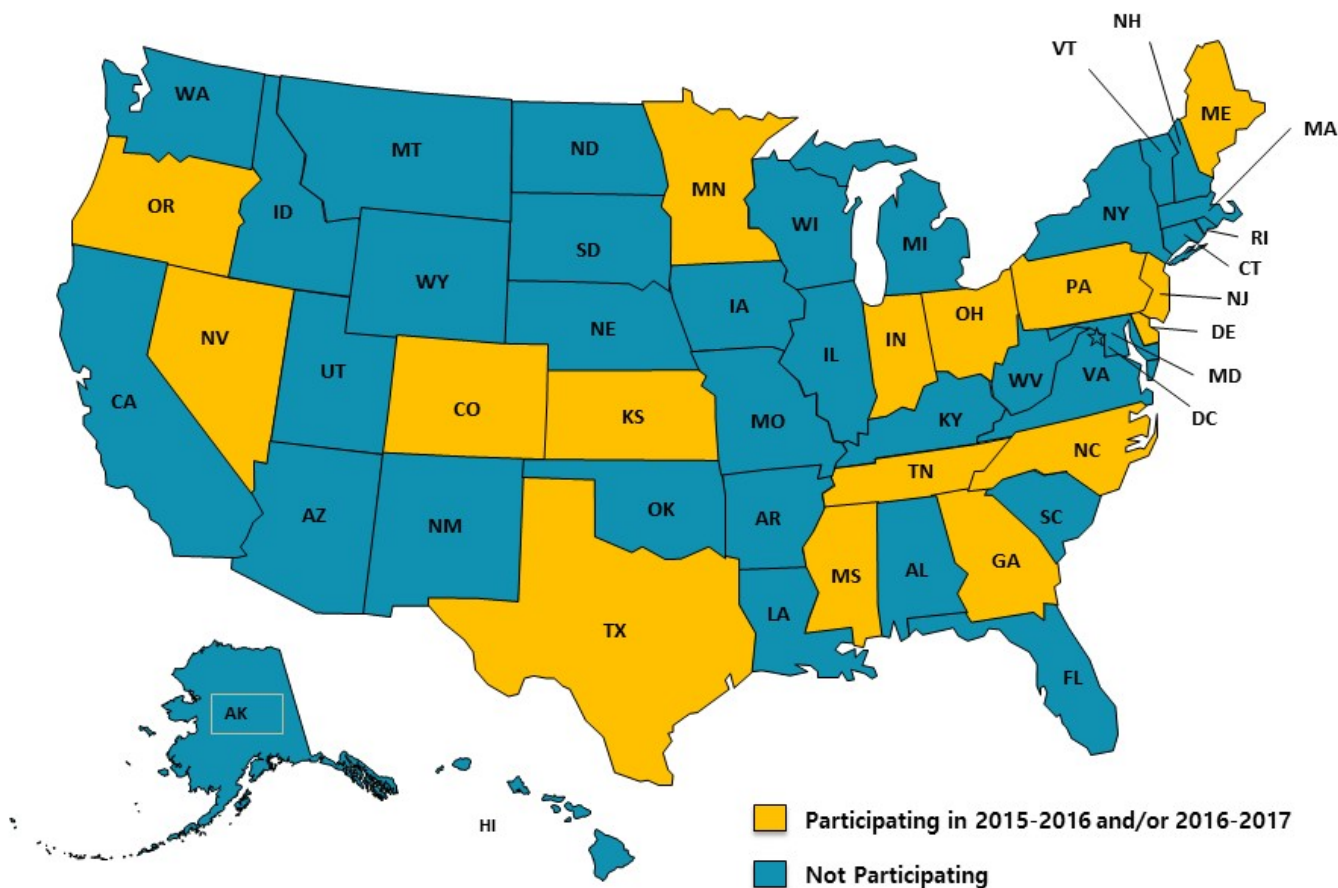
■ Interviewer Feedback Sheet

- Asks interviewer to evaluate the survey experience and flag concerns

Consumer Outcomes:

- Community Participation
- Choice and Decision-making
- Relationships
- Satisfaction
- Service and Care Coordination
- Access
- Self-Direction of Care
- Work/Employment
- Rights and Respect
- Health Care
- Medications
- Safety and Wellness
- Everyday Living and Affordability
- Planning for the Future
- Control

State Participation 2016-2017





Mid-Year Results 2015-2016

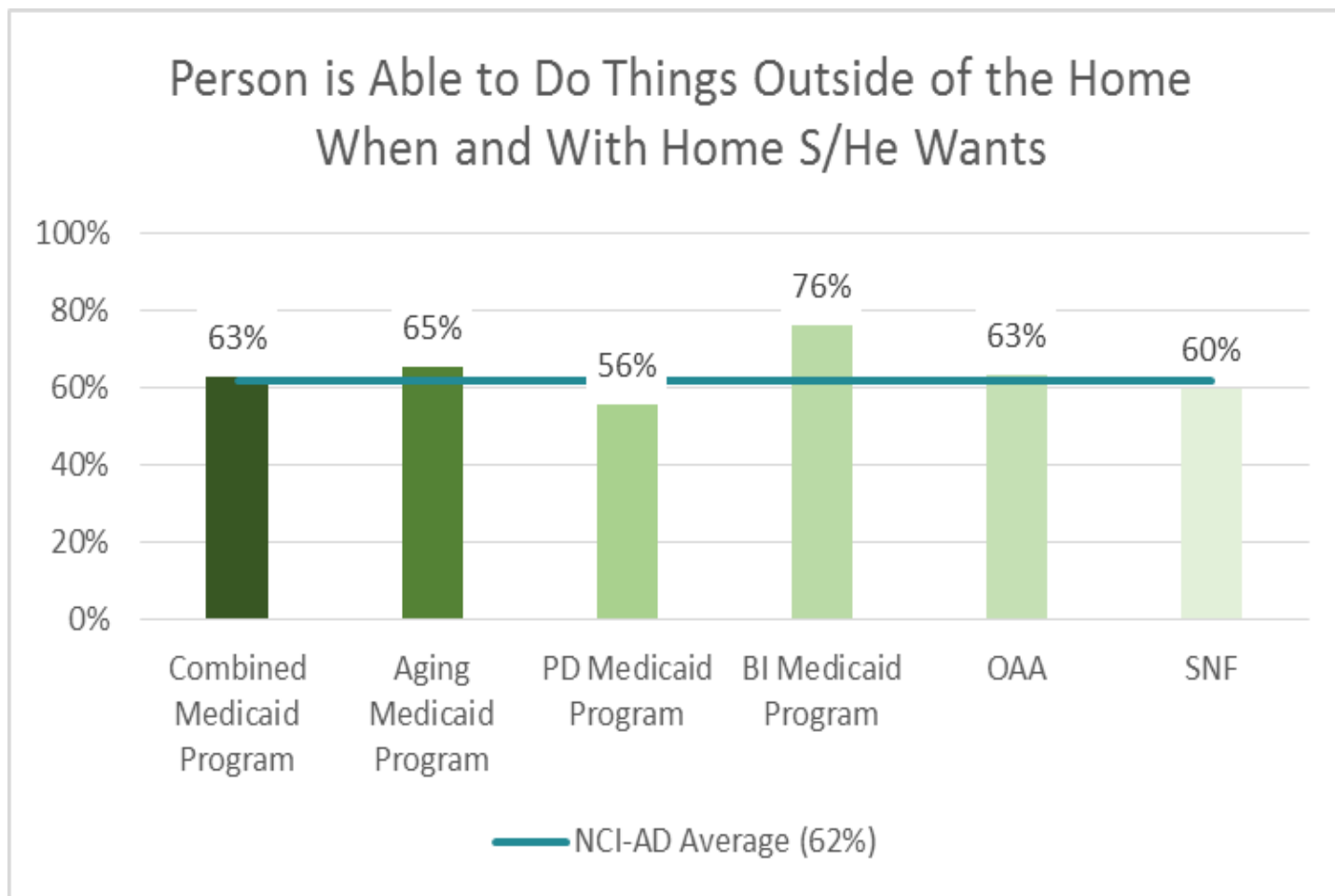
Six State Report

National Report Categories for State Samples

State	Combined Medicaid program		Aging Medicaid program	PD Medicaid program	BI Medicaid program	OAA	SNF
Colorado	EBD Waiver (N=312)		N/A	N/A	N/A*	OAA (N=88)	N/A
Georgia	CCSP Waiver (N=331)		N/A	N/A	N/A	HCBS (N=470)	N/A
Maine**	Consumer Directed PC Services; Elder and Adults with Disabilities Waiver; Private Duty Nursing; MaineCare Day Health	(N = 261)	N/A	N/A	N/A	OAA (N=90)	N/A
Mississippi	Assisted Living Waiver; Elderly and Disabled Waiver	(N=529)	N/A	IL Waiver (N=293)	TBI/SCI Waiver (N=113)	N/A	N/A
North Carolina	MFP (N=56)		PACE (N=57)	CAP/DA (N=224)	N/A	HCCBG (N=296)	SNF (N=331)
New Jersey	NJ Family Care (4 MCOs) (N=415)		PACE (N=101)	N/A	N/A	OAA (N=104)	SNF FFS (N=104)
Total N	1904		158	517	113	1048	435

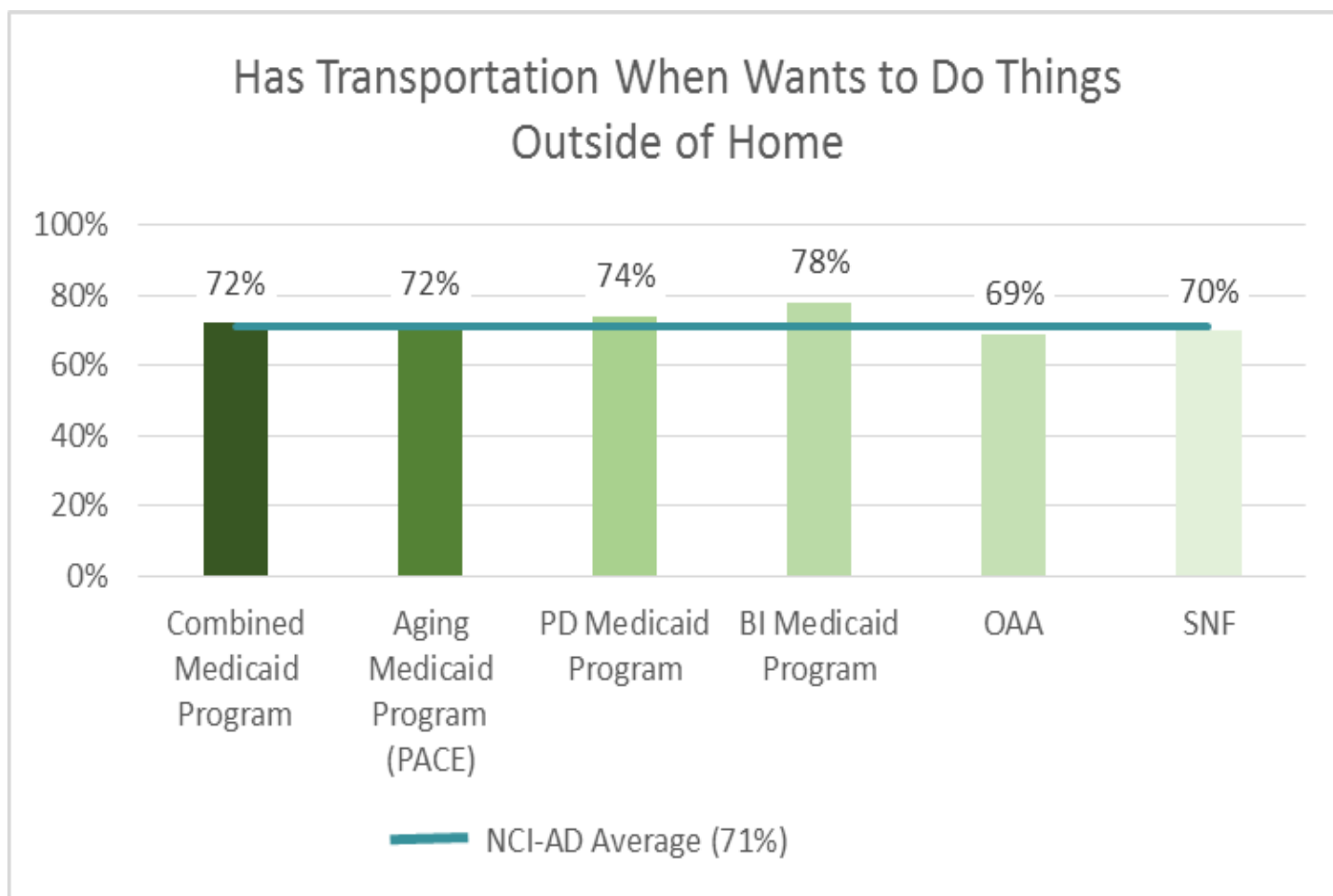
Community Participation

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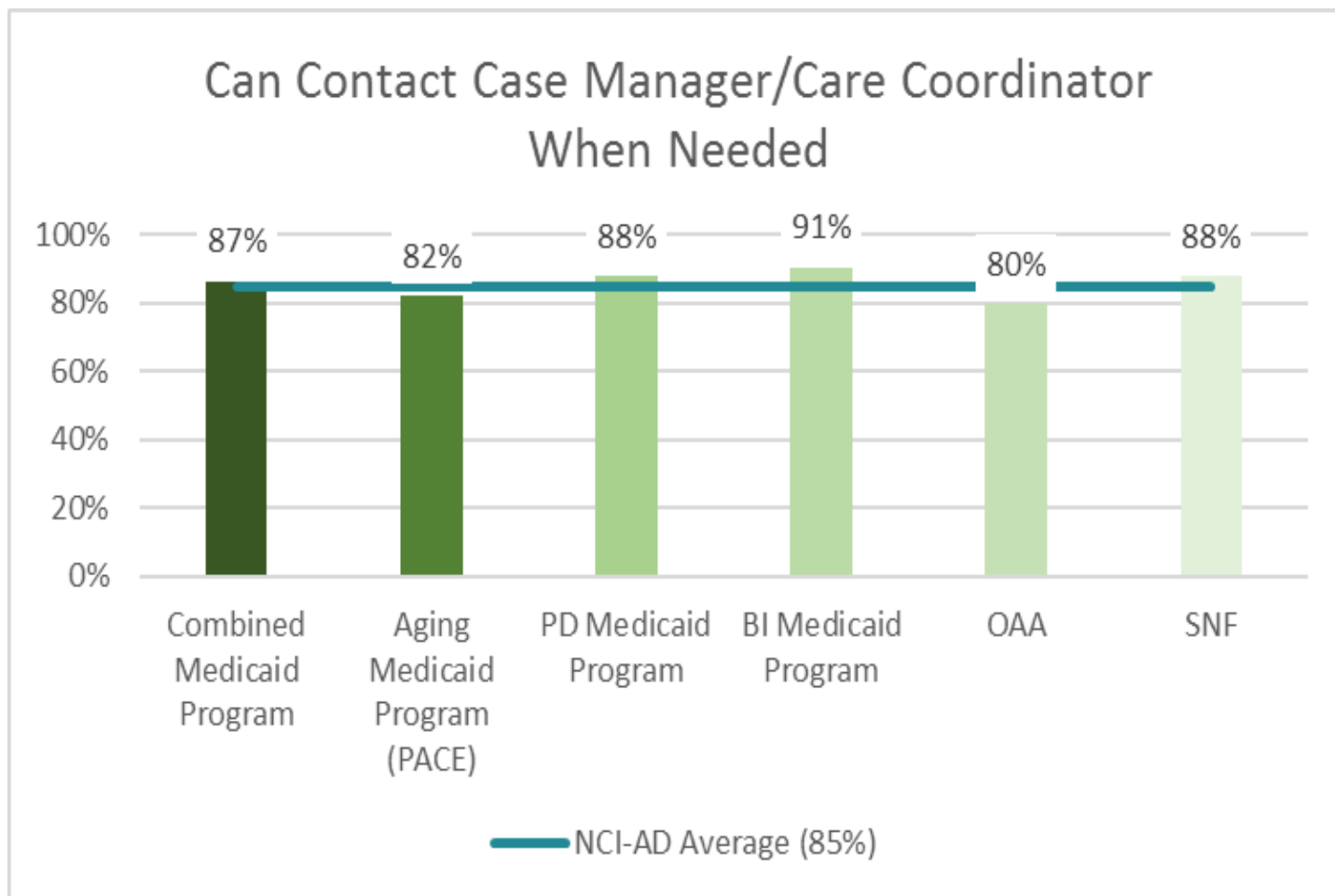
Transportation

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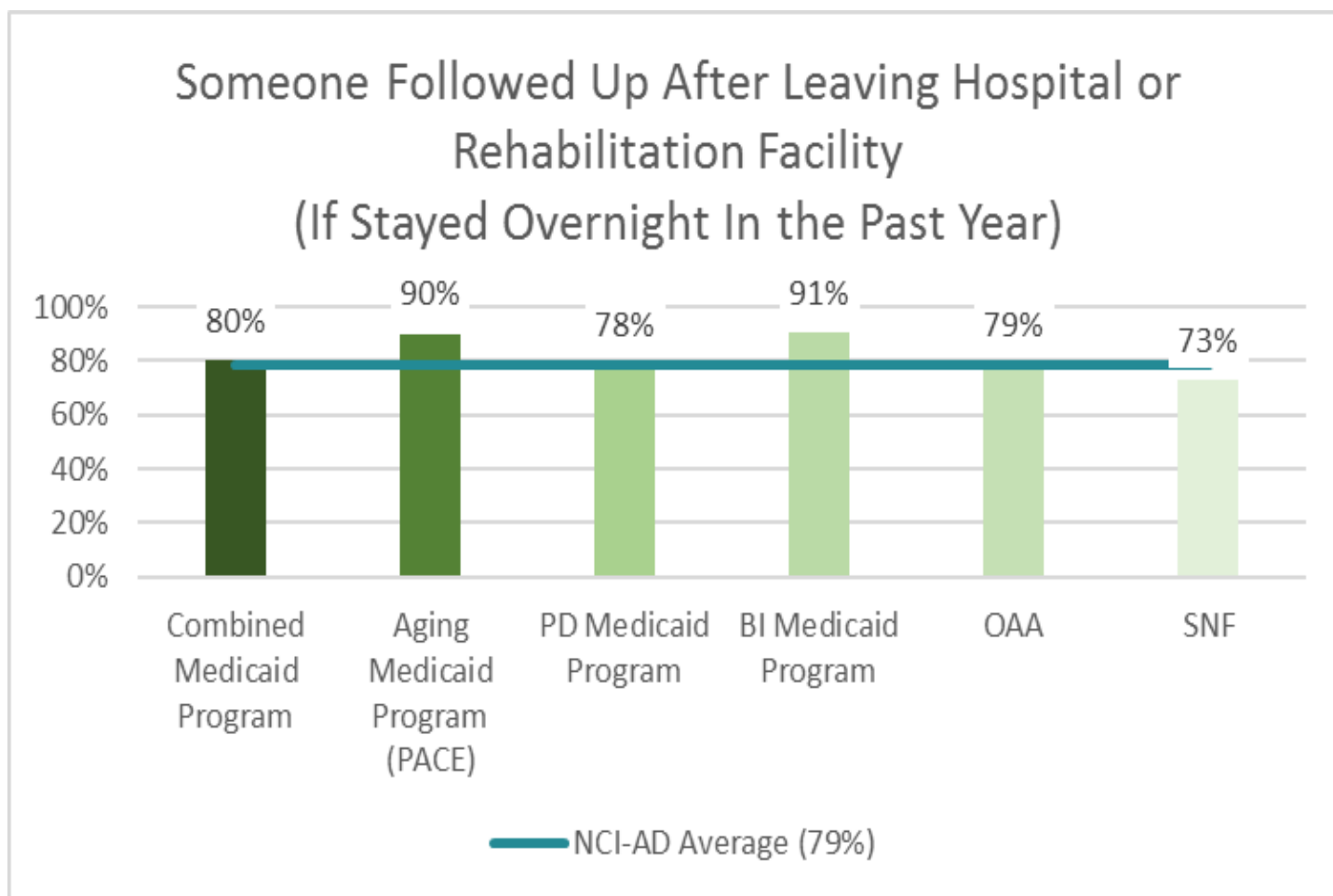
Service Coordination

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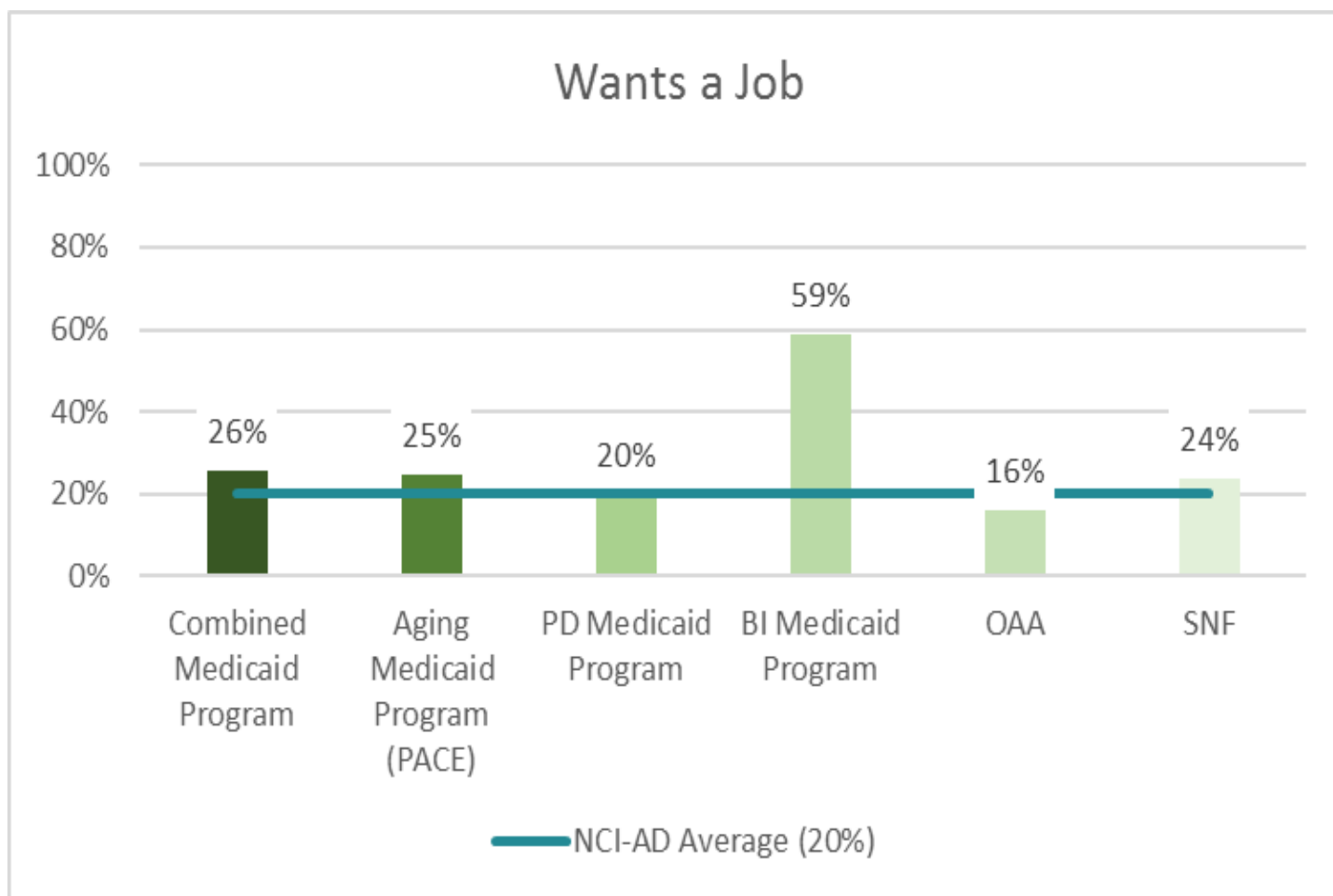
Care Coordination

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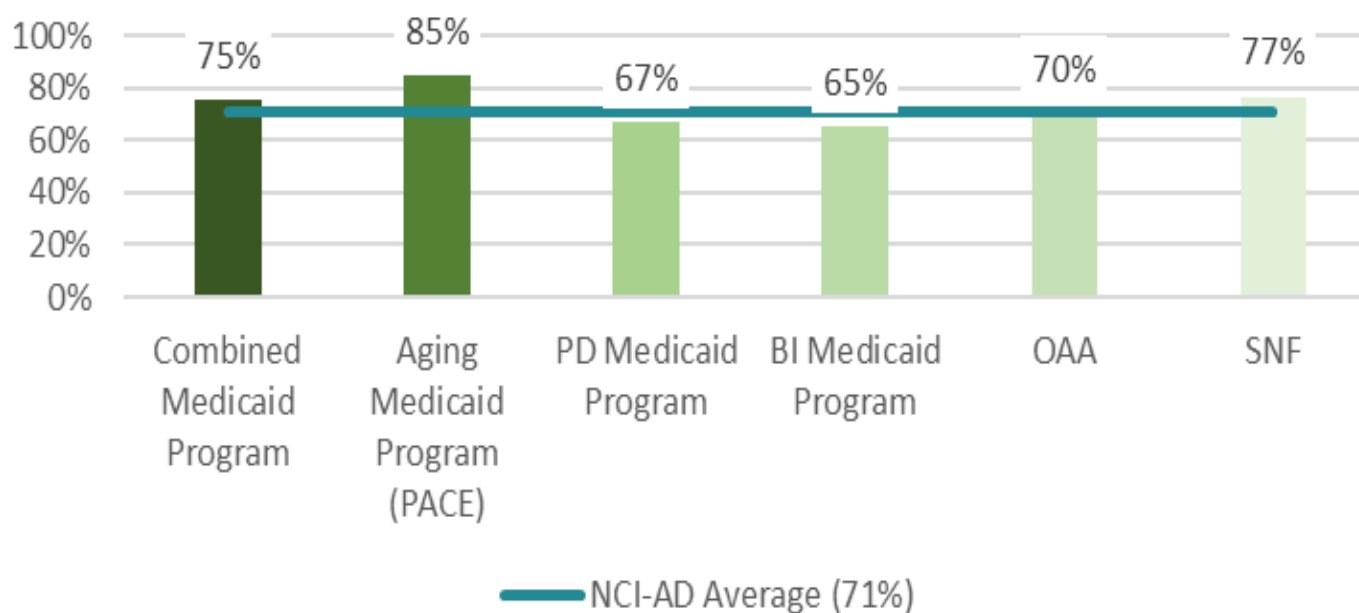


Employment

12



Someone Talked or Worked With Person to Reduce Risk of Falling (If There Were Concerns About Person's Stability)



How States are Using NCI-AD Data

- Quality improvement efforts (CQI framework)
- Incentivizing quality outcomes in MLTSS
 - Process measures for accountability: care coordination, transitions, choice/control, access to community
 - MCOs may assess quality: [United Healthcare's MLTSS Proposed Framework](#)
 - Data useful for pre/post MLTSS comparisons
- Compliance
 - Olmstead planning, BIP, MFP, HCBS Settings Regulations
- Benchmarking and comparing data nationally
- Identifying service needs and gaps
- Allocating services

QUALITY MEASURE DEVELOPMENT: Medicaid Managed Long-term Services and Supports (MLTSS) Programs

National HCBS Conference **MLTSS Intensive**

Debra J. Lipson, Senior Fellow, Mathematica
Erin Giovannetti, Senior Research Scientist, NCQA

August 29, 2016

Outline

- **MLTSS quality measure gaps and needs**
- **Project history, sponsors, and goals**
- **MLTSS measures undergoing testing**
 - **Institutional use**
 - **Assessment and care planning**
- **Preliminary test findings**
- **Next Steps**

Existing MLTSS Quality Measures

- **Standard national measures are medically oriented**
 - HEDIS Medicare Advantage measures
 - Hospitalization for Ambulatory Care Sensitive Conditions (ACSCs) among HCBS users
 - Necessary but insufficient
- **State-specific LTSS measures:**
 - Address some LTSS domains
 - But imprecise, poorly specified, or not thoroughly tested
 - Cannot be used for cross-state comparisons
- **Gaps remain for key domains**

Key MLTSS Quality Domains

- **Rebalancing – greater use of HCBS and avoidance of unnecessary institutional care**
- **Comprehensive, timely assessment**
- **Comprehensive, person-focused care planning**
- **Quality of life**
- **Community integration (employment, socialization)**
- **HCBS Experience of Care**
- **Integration of medical care and LTSS**

Quality Measure Development for MLTSS – Project Overview

History

- **Medicaid Managed Care TA & Oversight, 2012-2013**
 - CMCS, Division of Managed Care Plans (DMCP)
 - Mathematica and NCQA
 - Literature Review, Measure Scan, Technical Expert Panel
 - Development of preliminary measure specifications
- **Quality Measure Development (QMD) for MLTSS, 2015-2017**
 - Multiple CMS Sponsors (CCSQ, MMCO, CMCS DQ & DMCP)
 - Mathematica and NCQA
 - Measure testing and refinement of specifications
 - TEP review and feedback (QMD Duals and LTSS TEP)
 - Seek NQF endorsement, propose implementation plan

QMD Project Goals

- **Conduct field testing on a set of MLTSS measures to assess:**
 - **Feasibility:** Are the measure specifications are easy to understand and can measure elements can be identified in claims or records?
 - **Validity:** Do the measures accurately capture the intended care processes or outcomes (construct validity)? Do the measure scores correlate with other measures of quality (convergent validity)?
 - **Reliability:** For chart or record-based measures, is there high agreement when different individuals report results? Are the measures scores precise with minimal random error?
 - **Meaningful variation:** Are there statistically or clinically meaningful differences in results across reporting entities or different subpopulations?

Project Goals (continued)

- **Avoid duplication of related measure development and testing efforts that could be used for MLTSS**
 - For example, HCBS Experience of Care Survey
- **Align MLTSS with measures for FFS LTSS users to the extent possible, to allow comparisons**
- **Obtain public comment on proposed measures**
- **Provide technical support to steer measures through the NQF endorsement process**
- **Follow CMS Measure Management System Blueprint guidelines, while adapting to Medicaid program requirements as appropriate**

MLTSS Measures

Identification of Measure Concepts

- **Under the previous contract, CMS directed NCQA and Mathematica to identify potential domains of measurement**
 - Desire for measures which address key activities of MLTSS plans
 - Decided not to pursue domains best addressed via person-reported outcomes measures, due to concurrent efforts in this area
- **Identified three primary domains**
 - Institution Utilization (rebalancing indicator)
 - Assessment
 - Care Planning
- **Conducted environmental scan for each domain of measurement and identified potential measure concepts**
- **Convened TEP to discuss and refine measure concepts and definitions**

Admission to an Institution from the Community

- **Description: Number of admissions to an institution among MLTSS enrollees residing in the community per 1,000 enrollee months.**
- **Rates:**
 1. Short-stay admissions (<100 days)
 2. Long-stay admissions (100+ days)
 3. Total admissions
- **Exploring feasibility of:**
 - Separate rates for nursing facility and ICF-IID
 - Risk-adjustment for clinical conditions

Successful Discharge after Short-Term Stay

- **Description: Percentage of admissions to an institution that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission.**
- **Exploring feasibility of:**
 - **Separate rates for nursing facility and ICF-IID**
 - **Risk-adjustment for clinical conditions**

Successful Transition after Long-Term Stay

- **Description: The percentage of long-term stay (101 days or more) institutional residents who are successfully transitioned to the community (community residence for 30 or more days).**
- **Exploring feasibility of:**
 - **Separate rates for nursing facility and ICF-IID**
 - **Risk-adjustment for clinical conditions**

Comprehensive Assessment Composite

- **Description: The percentage of MLTSS enrollees who have documentation of a comprehensive assessment within the appropriate time frame, including the following components:**
 - **Core domains:** Physical functioning and disability, medical conditions, mental and behavioral health, needs and risks, social support, preferences and use of services
 - **Timeframe:** Within 90 days of initial enrollment or within 13 months of a previous assessment
 - **Documentation of involvement** of family member, caregiver, guardian, or power of attorney in assessment (with beneficiary consent)
 - Exclude beneficiaries who refuse assessment

Comprehensive Care Plan Composite

- **Description: The percentage of MLTSS enrollees who have documentation of a completed comprehensive care plan developed within the appropriate time frame.**
 - **Core domains:**
 - Beneficiary needs in core domains
 - Beneficiary goals of care and identified barriers to meeting goals
 - Service plan and providers of services addressing needs including frequency and duration of service
 - **Timeframe:** Within 120 days of initial enrollment or 13 months of a previous care plan
 - **Beneficiary signature** or that of their guardian or power of attorney (POA)
 - **Signature of family member or caregiver** (if applicable and with beneficiary consent)
-

Shared Care Plan

- **Description: The percentage MLTSS beneficiaries with a care plan for whom all or part of the care plan was transmitted to key LTSS providers and the primary care provider within 30 days of development or update.**
- **Draft definition of key providers:**
 - PCP should always receive
 - LTSS included: physical or occupational therapy, skilled nursing, or personal care in the home
 - LTSS excluded: meal delivery, medical supplies, homemaker and other services not providing hands-on care

Re-assessment and Care Plan Update After Discharge

- **Description: The percentage of MLTSS beneficiaries whose care plan was updated within 30 days of discharge from an acute care facility, nursing home, or other institution.**
 - Same elements as re-assessment and care plan update composites
 - Exclusion for planned readmissions and pregnancy related hospitalizations

Falls Screening, Assessment and Plan of Care

- **Description: Percentage of MLTSS enrollees age 18+ who had the following:**
 - **Screening:** screened for fall risk
 - **Assessment:** at risk for future falls and received a fall risk assessment
 - **Plan of Care:** at risk of future falls and received a plan of care to address falls, including recommendations for exercise and vitamin D therapy
- **Revision to a PQRS measure**
 - Revised denominator (ages 18-64)
 - Test measure using record review
 - Test measure in health plan setting

Preliminary Test Findings

- **Interviews with 12 MLTSS health plans held to solicit views on the feasibility, usability and importance of assessment, care plan and falls measures.**
- **All or most data elements are available, but in different locations in health plan data management systems, or in separate locations.**
 - Especially in “delegated models”: health plan contracts with case management agencies to conduct assessment, care planning, and care coordination
- **Reporting burden for chart-based measures**
 - Testing an approach to combine related measures and focus on timeliness of assessment and care plans, regardless of length of enrollment

MLTSS Measure Test Timeline

- **Interviews with health plan managers- spring 2016**
 - Results used to refine measure specifications, lower burden
- **Field testing and analysis – July-December 2016**
 - Testing of 5 chart-based and 3 institutional use measures
- **Public Comment on measure specifications – September 2016**
- **Summary Report – January 2017**
- **Seek NQF endorsement for valid, reliable measures – 2017**
- **If appropriate, develop implementation plan**

CMS Sponsors and Project Team

CMS

CMCS, Division of Quality and Health Outcomes

CMCS, Division of Managed Care Plans

CMCS, Medicaid Innovation Accelerator Program Office

CMS, Medicare-Medicaid Coordination Office

Center for Clinical Standards and Quality

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- **Announcements and links:**
<https://www.mathematica-mpr.com/our-publications-and-findings/projects/quality-measure-development-dual-enrollees-long-term-services-and-support>

Measuring Quality in Long-Term Services and Supports

Catherine Anderson

VP, State Programs

UnitedHealthcare Community & State

National Advisory Board Members



NATIONAL ALLIANCE *for* CAREGIVING
Advancing Family Caregiving Through Research, Innovation, and Advocacy



Texas Parent to Parent



National Quality Conversation

- Shifting quality of care to focus on outcomes, particularly within Medicaid, has become a **focus area for regulators** at the state and federal levels.
- Recent examples include the **Core Quality Measure Collaborative**, led by the America's Health Insurance Plans, CMS, and the National Quality Forum.
- Such efforts are primarily focused on developing quality **measure sets for clinical domains** (e.g., cardiology, gastroenterology, etc.).
- The **non-clinical supports** and services that comprise the majority of MLTSS have largely not been addressed.
- National Quality Forum is leading an effort to develop quality frameworks for **home and community-based services**.

Consistent Quality Measurement Across States is Critical

- There is **no national framework** for quality measurement for MLTSS.
- Absent a framework states are developing their own measures, which often **change year-to-year and differ state-to-state**.
- This creates **significant, inherent challenges** in evaluating the quality of these services across states and over time.
- Adopting a consistent quality framework is beneficial for **consumers, advocates, policymakers, and managed care organizations (MCOs)**.

The Benefits of a Consistent Quality Framework

Consumers

- Using a consistent framework will pave the way for improved support and quality of life, and more informed decision-making by individuals and their caregivers.

Advocates

- Consistent frameworks offer information to guide advocacy efforts and assurances that the complex needs of constituents are being uniformly and meaningfully addressed.

State Policymakers

- Medicaid agencies will have an important tool for advancing the well-being of their aging and disabled citizens.
- A consistent framework provides a benchmark for performance against other states and over time.

MCOs

- A consistent framework will offer a meaningful blueprint for monitoring and improving the services delivered to members using MLTSS.

Challenges in Developing a Consistent Framework

- The needs of the aged and disabled populations can exist on a continuum, which brings about challenges ensuring that quality measures uphold a **person-centered approach**.
- Individuals and interested parties (e.g., advocacy groups) may advance **competing initiatives**, making consensus difficult.
- Monitoring and regulatory requirements across states and settings impact the development of quality measures that address **quality of life vs. traditional provider performance**.
- Numerous factors (e.g., age, disorder/diagnosis, co-morbid/co-occurring conditions, placement or setting, and gender) impact the specific quality measures **appropriate for sub-populations** within the broad population accessing LTSS.

Framework Development Process



The Value of the National Advisory Board's Quality Framework

Person-centered

The quality frameworks consider individual goals and needs and the social, functional, behavioral and clinical supports uniquely meaningful to individuals accessing MLTSS.

Outcome-focused

The measures go beyond quantifying the need for and use of services to assessing the effect on health status, employment, routine tasks and quality of life.

Developed by experts

An independent panel of leading aging and disability experts, advocates and consumer representatives developed the frameworks over the course of a year.

Practical

The measures included in the framework can be instituted by states and managed care organizations with the data systems and tools they already have in place.

The MLTSS Quality Framework

Domains	Example Measure
Access	<ul style="list-style-type: none">• Proportion of individuals who indicate that their service plan includes things that are important to them (HCBS Experience Survey).
Health Status / Medical Care	<ul style="list-style-type: none">• Percentage of MLTSS members who transitioned from nursing facility to the community (State Measure).
Living Independently / Choice and Decision-Making	<ul style="list-style-type: none">• Proportion of people who have adequate support to perform activities of daily living and IADLs (NCI-AD).
Service / Care Coordination	<ul style="list-style-type: none">• Proportion of people who know how to manage their chronic conditions (NCI-AD).
Community Integration	<ul style="list-style-type: none">• Proportion of individuals who report they can see or talk with family as often as they want to (NCI-AD).

State Implementation

- **Review the framework** and determine what if any steps need to be made to implement the quality framework.
- Share with **stakeholders** the rationale for a consistent quality framework.
- Seek participation from and work with the local provider, health plan, consumer, and advocacy communities to evaluate any **state-specific measures** that the state should track in addition to (not in lieu of) the baseline framework.
- In upcoming requests for proposals, require that bidding health plans **leverage a specific set of universal quality measures** as a condition for being selected as the MLTSS plan.

Questions?

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An Overview of National Quality Forum HCBS Quality Measurement Committee Work

MLTSS Intensive - HCBS Conference
August 29, 2016

Camille Dobson
Deputy Executive Director

The State of Quality Measurement for HCBS

- “A thousand flowers blooming”
- States generally on their own to develop
- The National Quality Forum (NQF), along with HHS, saw need for coherent approach to home and community based services (HCBS) quality measurement
- NQF is finishing up a 2-year HCBS Quality Measurement project
- Goal is to guide efforts to develop a broad spectrum of quality measures that have been tested and validated for all populations using HCBS
- Will provide consistency and comparability across states and programs

Purpose of HCBS Quality Measurement Committee

- Provide multi-stakeholder guidance on the highest priorities for measuring HCBS that support high-quality community living.
- NQF also endorses quality measures. However, the purpose of this committee is NOT TO ENDORSE specific measures but to provide a framework that will lead to measure development.

Specific Tasks of Committee



Done

- 1) Create a conceptual framework for measurement, including a definition for HCBS



Done

- 2) Gather information about measures and measure concepts that are currently in use (environmental scan)



Done

- 3) Identify gaps in HCBS measures based on the framework and environmental scan



Sept.
2016

- 4) Make recommendations for HCBS measure development

Why is NQF's Work Important?

- NQF work is first strategic attempt to organize existing HCBS measures into a coherent framework
- May provide a menu of PMs that have been reviewed and “vetted” from which states can select for their program
- Will help stakeholder pushback against lack of standardized measures for HCBS

Working HCBS Operational Definition

- For purposes of measuring quality only!
- Recognize CMS has regulatory definition of HCBS for Medicaid-funded services
- HCBS refers to an array of services and supports that promote the independence, well-being, self-determination, and community inclusion of an individual of any age who has significant, long-term physical, cognitive, and/or behavioral health needs and that are delivered in the home or other integrated community setting

Draft HCBS Conceptual Framework

Consists of 11 major domains 

- Multiple subdomains
- Numerous comments were received after publication of 3rd interim report in June
- Committee still tweaking

Choice and Control

Community Inclusion

Caregiver Support

Workforce

Human and Legal Rights

Equity

System Performance & Accountability

Consumer Leadership in System Development

Person-Centered Service Planning and Coordination

Service Delivery & Effectiveness

Holistic Health & Functioning

Draft HCBS Conceptual Framework

(NOTE: language continues to be refined)

Choice and Control

- The level to which individuals who use HCBS, on their own or with support, make life choices, choose their services and control how those services are delivered

Community Inclusion

- The level to which people who use HCBS are integrated into their communities and socially connected, in accordance with personal preferences

Caregiver Support

- The level of support (e.g., financial, emotional, technical) available to and received by family caregivers or natural supports of individuals who use HCBS

Draft HCBS Conceptual Framework

(NOTE: language continues to be refined)

Workforce

- The adequacy, availability, and appropriateness of the provider network and HCBS workforce

Human and Legal Rights

- The level to which the human and legal rights of individuals who use HCBS are promoted and protected.

Equity

- The level to which HCBS are equitably available to all individuals who need long-term services and supports

Draft HCBS Conceptual Framework

(NOTE: language continues to be refined)

System Performance & Accountability

- The extent to the system operates efficiently, ethically, transparently and effectively in achieving desired outcomes

Consumer Leadership in System Development

- The level to which individuals who use HCBS are well supported to actively participate in the design, implementation, and evaluation of the system at all levels

Person-Centered Service Planning and Coordination

- The processes by which the HCBS system identifies personal goals, preferences, and needs, and coordinates services and supports across providers and systems

Draft HCBS Conceptual Framework

(NOTE: language continues to be refined)

Service Delivery & Effectiveness

- The level to which services are provided in a manner consistent with a person's needs, goals, and preferences that help the person to achieve desired outcomes

Holistic Health & Functioning

- The extent to which all dimensions of holistic health are assessed and supported

Recommendations for Measure Development

- Committee is planning to identify promising measures in each domain as a starting point
- Will also make recommendations for additional development, refinement and testing in each domain
- Based on results of environmental scans and gaps:
 - Short-Term
 - Intermediate
 - Long-Term
- Recommendations are intended to guide future investment in HCBS measure development with goal of securing NQF endorsement

Next Steps and More Information

- Final Report (September 23)
- For more information on the NQF Measuring HCBS Quality project, including interim reports, and more detail on the draft domains and sub-domains
 - http://www.qualityforum.org/Measuring_HCBS_Quality.aspx



For more information, please visit: www.nasuad.org

Or call us at: **202-898-2583**

MLTSS Rate Setting Best Practices - A Health Plan Perspective

NASUAD MLTSS Intensive

Washington, DC

8/29/2016

Centene Overview

WHO WE ARE



St. Louis

based company founded in
Wisconsin in 1984

28,000 employees

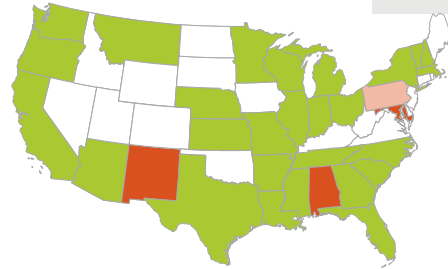
#124

on the
Fortune 500 list

\$39.4 – 40.0 billion

Expected revenue for 2016

WHAT WE DO



28 states

with government sponsored
healthcare programs &
implementations, including:

Medicaid
(24 states)

MLTSS & MMP
(9 States)

MA SNP
(8 States)

ABD Non-Dual
(17 States)

11.5 million members includes

210,000 MLTSS Members

248,000 & 2,300

Physicians

Hospitals

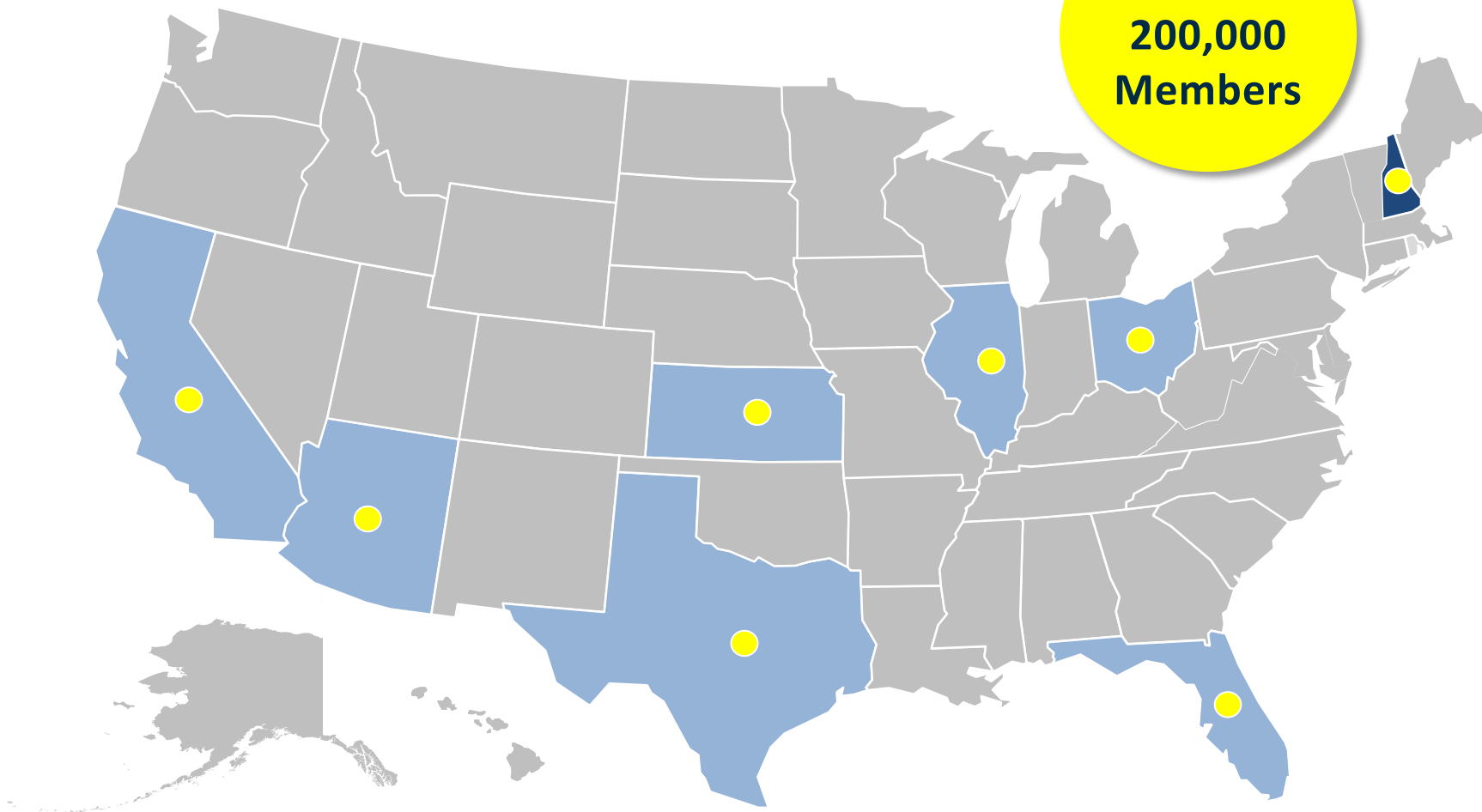
In our provider networks

Long-Term Services and Supports



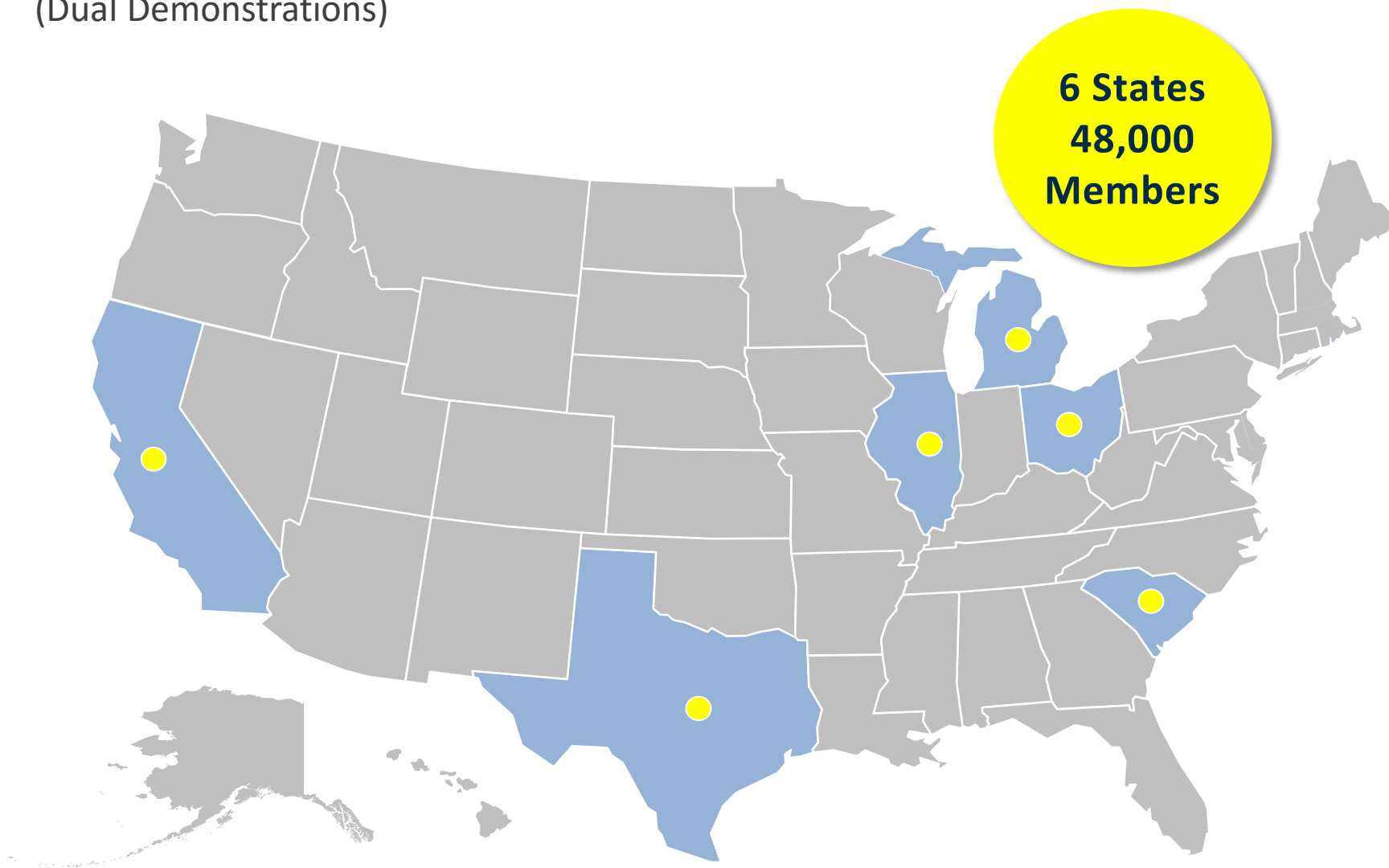
*Waiver HCBS services and nursing facility services are anticipated to go-live
July 1, 2017*

**7 States
200,000
Members**



Medicare Medicaid Plans

(Dual Demonstrations)



Rate structures come in many forms

Core

- Blended rate
- Cells based on location
- Dual/non-dual

Alignment with policy goals

- Blended rate/Cells based on location with transition incentive
- Withholds
- Bonuses

Risk mitigation

- Risk corridors
- Functional based risk adjustment
- Acuity based risk adjustment

Key inputs to rate development & pitfalls

Inputs

Cost of services
provided to
beneficiary

MCO savings
assumptions

Institutional
transitions

Pitfalls

- Composition of rate cells change as populations transition; doesn't account for functional needs
- Provider payments mandated but averages paid to plans
- Institutional limited savings unless levels of care
- HCBS savings requires paid service reductions
- Physical health limited to copays/coinsurance on Duals
- Starting point for rebalancing differs by state
- Different populations will have different transition expectations
- Only institutional members can transition out; maturity of HCBS market and housing limit transitions
- Count based on member months not people
- Timing of rate reset too short to incent behavior/allow for shared savings with providers

Challenges with the blended rate

Does not minimize complexity of rate development

Lack of transparency on policy goal of transition expectations

More likely to mistakenly set the transition expectation on the whole population instead of institutional

Creates incentives for gaming/rewards plans who may not achieve policy goal

Treats all plans as if have same mix of institutional/HCBS members

If not the blend, then what can we do in the short run?

Component

- Separate rate cells based on location (e.g., institution, HCBS)
- Rate cell holds for 6-12 months after transitions
- Assign specific *net* transition targets to various institutionalized populations and bake into NF rates
- Reassign targets annually based on prior year performance
- Utilize risk corridors until program is stable

Rationale

- Provides transparency on policy goal of transitions
- Ensures members *actually* transitioned
- Provides plans sufficient financial incentive to move members with ability to share with providers
- Targets can be realigned to match prior year performance
- Allows for program to stabilize



What's the right answer in the long run?

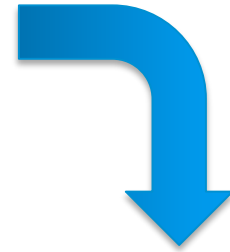
Identify key cost drivers

- Functional status
- Medical acuity (for some populations)
- Setting (institutional rent)



Leverage assessment data

- Mandate common assessment
- Audit assessments to ensure accuracy



Develop individual scores from assessments

- Eliminate rate cells
- Assign each member risk score



Build off of actual experience

- Compute rates based on actual provider encounters
- Reset on regular periodicity
- Provide enhancement for rent in institutions



Drive policy goals directly

- Set transition assumptions
- Utilize withhold or bonuses to incent MCO behavior

Better alignment of actual experience with rates paid to MCOs and policy



Division of
**Health Care
Finance & Administration**

The Road Less Traveled
**to Value Based Purchasing
for HCBS**

The Road Less Traveled



**“Two roads diverged in a wood,
and I - I took the one less traveled by,
and that has made all the difference.”**

Robert Frost

Why Value Based Purchasing for LTSS?



“It’s my hope that we can provide quality health care for more Tennesseans while transforming the relationship among health care users, providers and payers.
If Tennessee can do that, we all win.”

— Governor Haslam’s address
to a joint session of the state Legislature
March 2013

We are **deeply committed** to reforming the way we pay for healthcare in Tennessee

Our goal is to **pay for outcomes and for quality care**

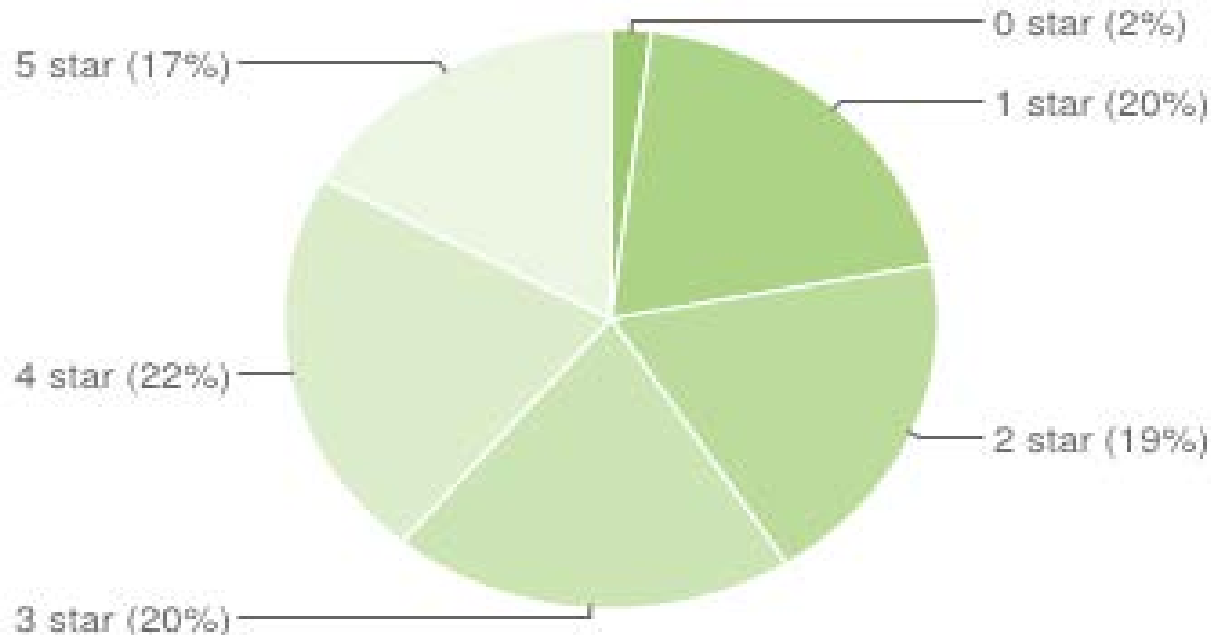
We plan to have value-based payment account for the **majority of healthcare spend** within the next three to five years

By **aligning on common approaches** we will see greater impact and ease the transition for providers

By working together, we can make significant progress toward **sustainable medical costs and improving care**

Why Value Based Purchasing for LTSS?

- Poor NF quality performance
 - The overall average Five-Star rating for Tennessee skilled nursing homes was 2.9 –ranked 48th nationally.



- Low level of engagement in AEC, QAPI

Why Value Based Purchasing for LTSS?

- Statutory commitment to change NF reimbursement methodology
- Statutory commitment to quality—from the perspective of the individuals receiving HCBS

*The long-term care system shall include **a comprehensive quality approach across the entire continuum of long-term care services and settings** that promotes continuous quality improvement and that **focuses on customer perceptions of quality**, with mechanisms to ensure ongoing feedback from persons receiving care and their families in order to immediately identify and resolve issues, and to improve the overall quality of services and the system.*

—The Long Term Care Community Choices Act of 2008

- Member satisfaction surveys identified significant opportunities for improvement in quality of care and quality of life (across services and settings)
- Transform the system by aligning incentives around the things that most impact the member's experience of care and day-to-day living

What is QuILTSS

- A TennCare initiative to promote the delivery of high quality LTSS for TennCare members (NF and HCBS) through payment reform and workforce development
- Part of the State's broader payment reform strategy
- 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
- Includes creation of a comprehensive competency-based workforce development program and credentialing registry for direct support professionals, including coaching and mentoring to support continued recruitment, learning, development and retention

QuILTSS Development

Process Included:

- Survey of Federal & State Landscape
- Literature Review
- Key Informant Interviews with Other States
- **Stakeholder Input Processes**
 - “What does quality look like from the perspective of those receiving services and supports and the people who are important to them”
 - 18 community forums in 9 cities (over 1,200 participants)
 - Online survey process to gather input from consumers, families and providers
 - One-on-one meetings with key stakeholders
- Data Analysis
- Comprehensive Technical Assistance Report available at <http://www.lipscomb.edu/transforming/tareport>
- Facilitation of **ongoing stakeholder processes** to develop and implement *Quality Framework* and payment approach

The Road Less Traveled: Choosing a pathway

- CMS 5-STAR rating system
- Other standardized “clinical” measures/approaches
- Develop an approach around the member experience
 - Must be comfortable with blazing a trail
 - Measures may not be as “valid” or “reliable”
 - Will have to develop the capacity of the system to measure and improve quality

*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

Strategic Policy Decisions

- Focus on the member experience to define, measure and pay for quality
 - Other systems measure clinical quality and regulatory compliance
- Develop a statewide payment reform approach
(Versus allowing MCOs to develop their own)
 - Reduces administrative burden for providers
 - Aligns efforts around key values/metrics across the system
- Collaborative stakeholder process
 - Ongoing stakeholder input
 - Design, implementation, reconsideration
- Iterative, developmental process
 - Develop infrastructure, processes and capacity—set providers up for success (for improvement)
 - Provide ongoing feedback to improve quality
- Transparent
 - Clear expectations, training and feedback to providers

From TA Report to *Quality Framework*

- Leveraged TA report with stakeholders
 - Brought the voice of consumers into discussions
- Twelve weeks of stakeholder meetings, facilitated by Lipscomb University
 - Homework assignments, shuttle diplomacy
- End of three month period yielded agreement on a *Quality Framework* for NF services
- Intend to apply across LTSS and settings, where appropriate
 - Some measures will be different for HCBS

Quality Framework for NF QuILTSS

- **Threshold Measures**
 - Current with NF Assessment
 - Not provide false information
- Must meet these standards to participate

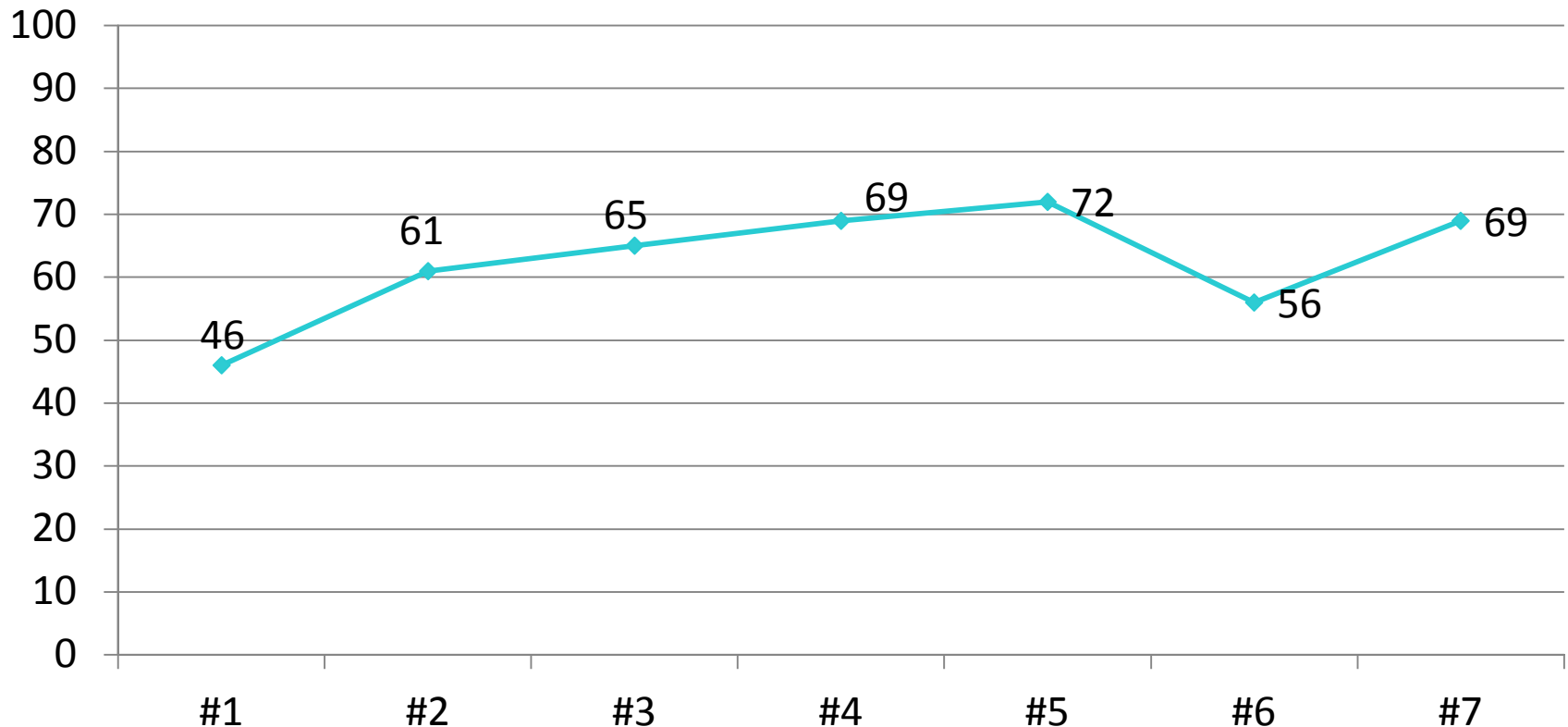
- **Quality Measures**
 - Satisfaction
 - Resident
 - Family
 - Staff35 Points
 - 15 points
 - 10 points
 - 10 points
 - Culture Change/Quality of Life
 - Respectful Treatment
 - Resident Choice
 - Member/Resident and Family Input
 - Meaningful Activities30 Points
 - 10 points
 - 10 Points
 - 5 Points
 - 5 Points
 - Staffing/Staff Competency
 - RN hours per day
 - CNA hours per day
 - Staff Retention
 - Consistent Staff Assignment
 - Staff Training25 Points
 - 5 points
 - 5 points
 - 5 points
 - 5 points
 - 5 points
 - Clinical Performance
 - Antipsychotic Medication
 - Urinary Tract Infections10 Points
 - 5 points
 - 5 points
 - Bonus Points
 - 10 Points
- Point values are aligned with member, family and stakeholder feedback

Implementing NF QuILTSS

- Implemented August 2014
- Provided detailed guidance to NFs including written instructions and video trainings
- NFs submit quality data through a web-based application
 - Supporting documentation and evidence
- Have completed 7 submissions
- 291 NFs have made quality submissions (293 current Medicaid NFs)
- Each NF submission is reviewed at least twice, often 3 times
- NFs are provided with a summary score sheet that outlines where points were earned and provides explanation for why points were not earned
- NFs have the opportunity to request reconsideration of individual items
 - Not submission of new materials, but reconsideration of original material
- TennCare has a Reconsideration Committee of external stakeholders that reviews denials of reconsideration requests
- TennCare provides feedback and guidance to the industry as each new submission period begins
- MCOs have distributed over \$45.2 million in payments for quality-based rate adjustments

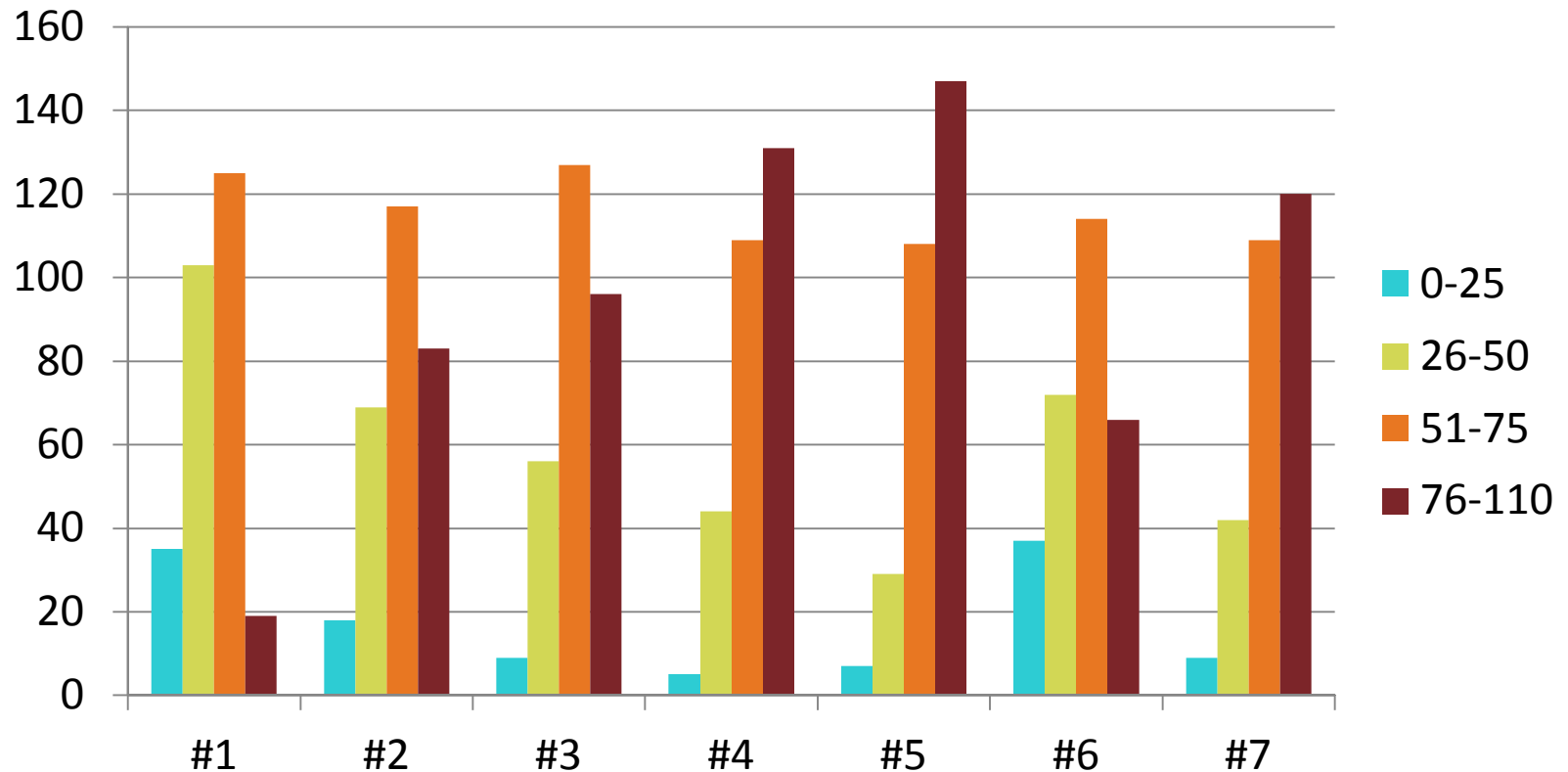
NF Performance

NFs receiving QuILTSS points (standards raised in #6)



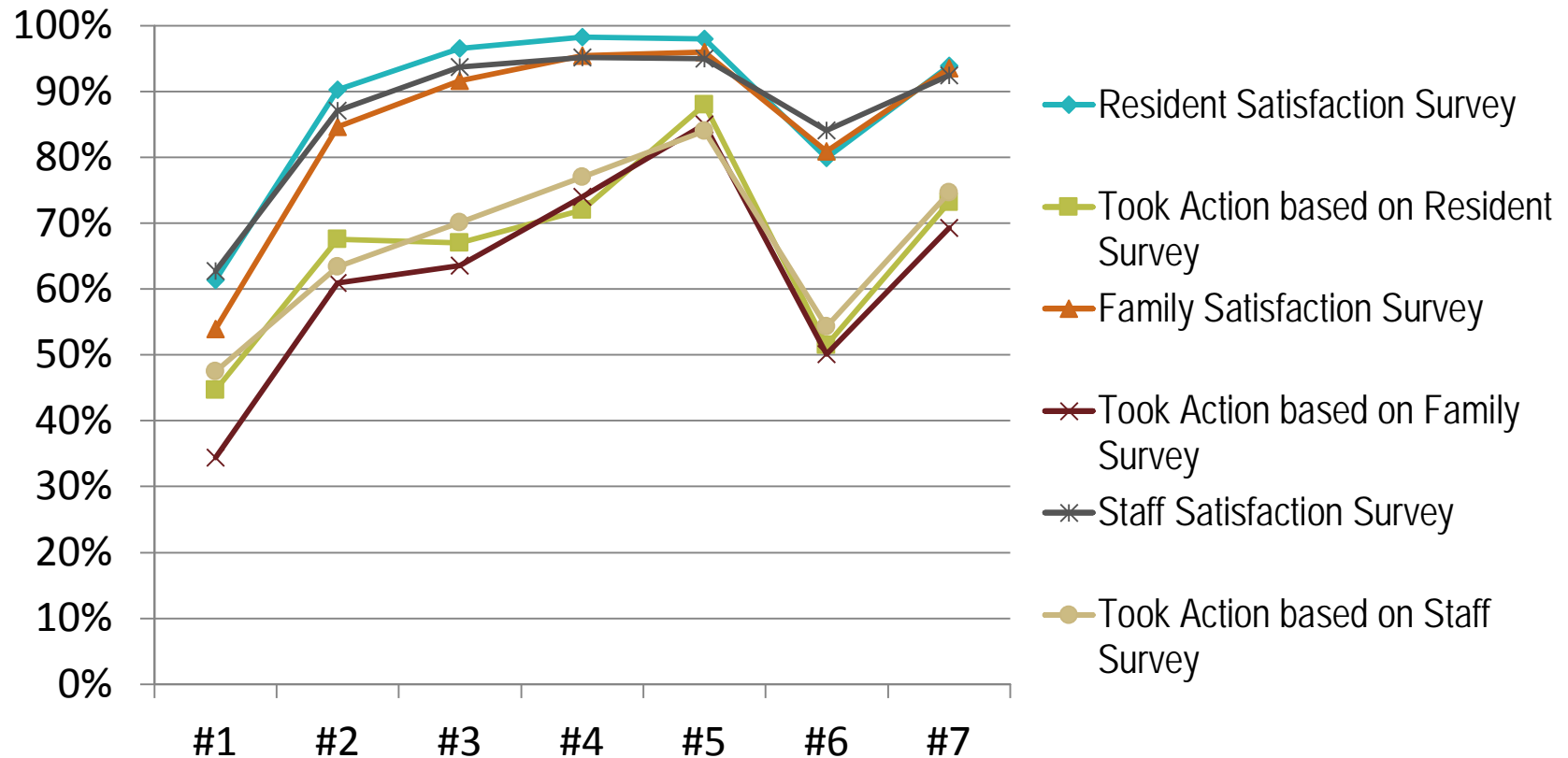
NF Performance

Total QuILTSS Scores (standards raised in #6)



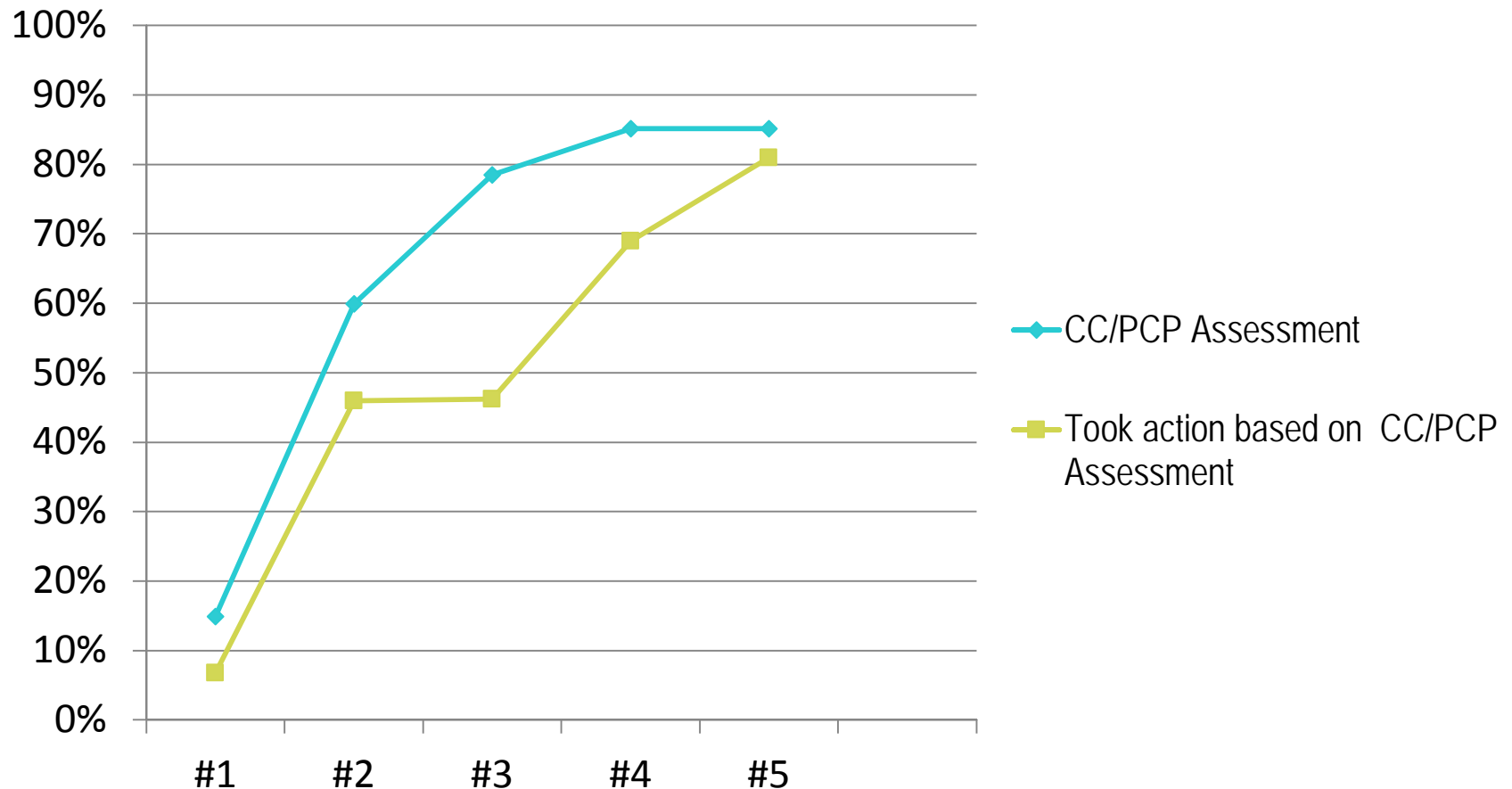
NF Performance

NFs receiving QuILTSS points (standards raised in #6)



NF Performance

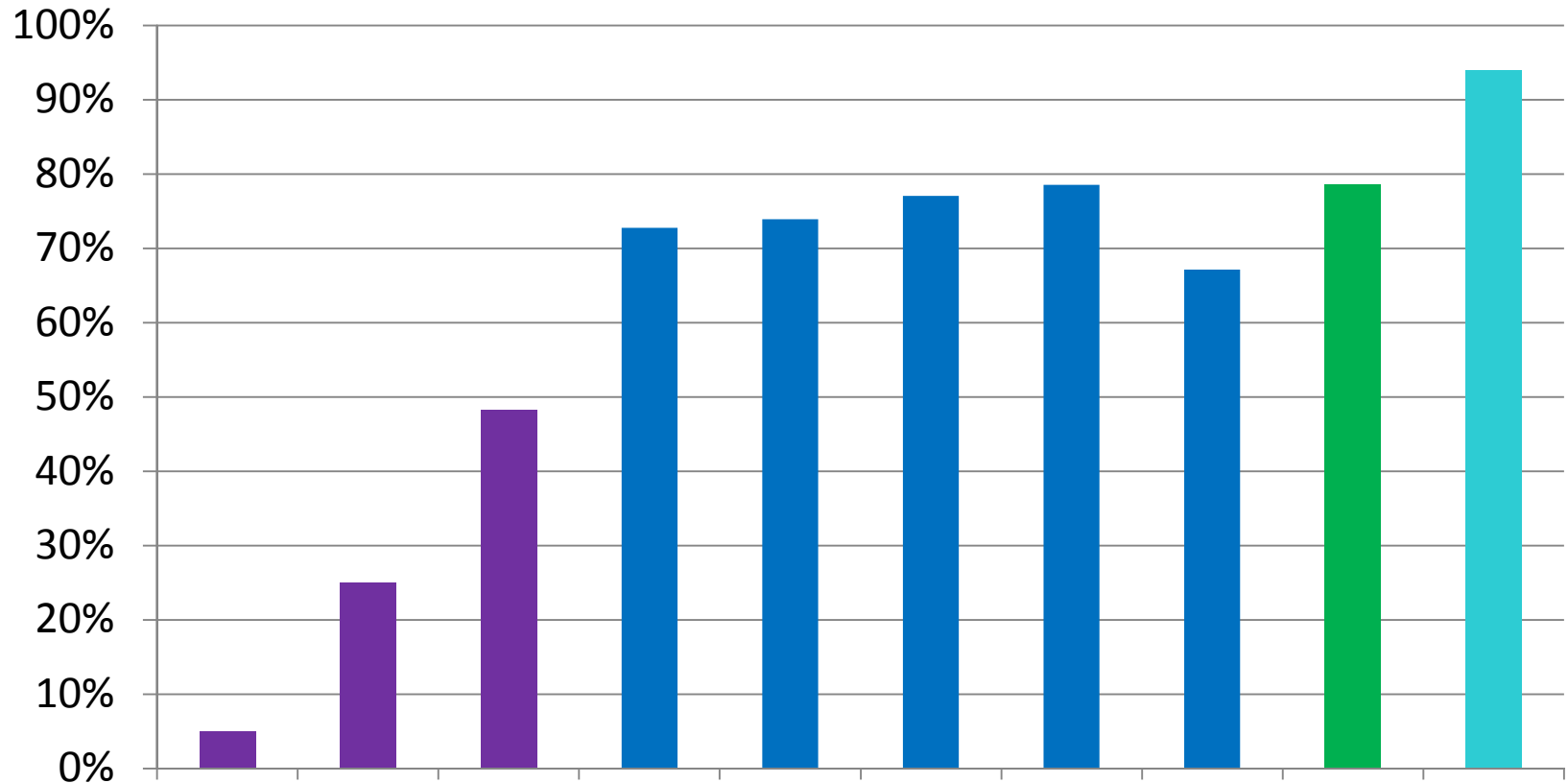
NFs receiving QuILTSS points



Not measured after #5; specific Culture Change/Quality of life measures began with #6.

NF Performance on Submission #7

NFs receiving QuILTSS Points-Culture Change/Quality of Life



Hand in Hand Training 50-74%

Hand in Hand Training 75-99%

Hand in Hand Training 100%

Choice of Meal Time

Choice of Menu

Choice of Sleep and Wake Time

Choice of Shower/Bathing Option

Choice of Furnishings/Appearance

Action based on Resident Council

Implementation of Meaningful Activities Plan

Lessons Learned

- Stakeholder involvement in design and ongoing (formal/informal)
- Transparency is key (nobody likes surprises)
- This is an iterative and developmental process (you cannot get there all at once)
- You will need to develop the capacity of the system to measure and improve quality
- Program must support member-focused quality (person-centered systems)
- Be at least two steps ahead of the system (you need a lot of lead time for the planning)
- Communication, communication, communication (and then communicate some more—frequent, clear, consistent, questions)
- Clear expectations and clear feedback to providers

Comparison of QuILTSS for NF vs. HCBS

NF

- 296 facilities
- Homogeneous providers
- History of data collection
- History of QI processes
- Consistent organizational structure
- 24/7 interaction with members
- Well-organized industry groups
- New money to support quality component of rate via assessment fee

HCBS

- 500+ providers (CHOICES; not including ID Waivers)
- Heterogeneous providers
- Diversity of
 - Data collection history
 - QI process history
 - Organizational structure
- Many have intermittent interaction with members
- Industry groups more diverse
- No new money; for CHOICES, may leverage rate differential for Personal Care Visits and Attendant Care

HCBS QuILTSS

- Begin with *NF Quality Framework*, but modify as needed for HCBS
- Stakeholder discussions began in Spring of 2014
- Input helped develop a “strawman” for HCBS QuILTSS
- Challenges and opportunities
 - Translation between settings (NF to HCBS)
 - Difficulty with conceptualization of HCBS-specific measures
 - Challenges with data collection
 - Person-centered planning capacity and processes
 - HCBS Settings rule--employment and community integration
 - Opportunity for input from a more diverse stakeholder group

Laying a foundation for HCBS QuILTSS

- **Expanded advocacy groups**
 - AARP
 - Arc of TN
 - Council on DD
 - Disability Coalition
 - P&A Agency
 - Statewide CIL
- **Expanded providers and associations**
 - TAHC (HH/HCBS)
 - TNCO (I/DD)
- **Enhanced person person-centered planning requirements**
 - HCBS Rule compliance
 - Individualized goals, interests and preferences
 - Choice of settings
 - Personal funds management
 - Employment
- **Planning for and supporting employment goals**
- **Person-centered planning and service delivery**
- **Baseline employment data** (system-wide)
- **Tablets in members' home collect gaps in care and point-of-service satisfaction data** (EVV component)
- **National Core Indicators – AD** (quality of service, quality of life)

Stakeholder
Engagement

MCO Contract
Amendments

Targeted Technical
Assistance

Data Collection

LTSS Workforce Development

Currently developing a comprehensive **competency based** workforce development program and credentialing registry.¹

Better for Workforce

- Opportunity to both learn and earn acquiring **shorter term credentials** with clear labor market value
- Credentials are portable **across service settings**
- Earn college credit toward certificate and/or degree program—**education path** for direct support professionals
- Build competencies to access more advanced jobs and higher wages—**career path** for direct support professionals
- Learning **and relationship** management system matches worker with coach/mentors/career planning support

Better for Members & Providers

- Promotes delivery of high quality person-centered services
- Supports continuity of staff for members and providers
- Online registry for matching by individuals, families, providers based on needs/interests of person needing support
- Alignment improves member experience
- Agencies employing better trained and qualified staff will be **appropriately compensated** for the increased competency of staff and higher quality of care experienced by individuals they serve

¹ for deployment through secondary, vo-tech, trade schools, community colleges, and 4-year institutions, offering portable, stackable credentials and college credit toward certificate and/or degree program

Guidance and recommendations

- Consider the current structure of your MLTSS system
- Create a vision for the future of your MLTSS system
- Make strategic decisions early that will propel your system from current to future state
- Strategic decisions will differ from state to state based on the structure of your programs and your objectives
- Involve stakeholders early and often
- Consider an independent party to facilitate discussions
- Allow yourself plenty of time for planning
- Prepare for a developmental and iterative process
- Start small and grow as you gain experience
- Accept **and use** feedback as you go

QuILTSS– Questions and Discussion





Overview of Rate-Setting Strategies to Advance Medicaid Managed Long-Term Services and Supports Goals

August 29, 2016

2016 NASUAD HCBS Conference: MLTSS Intensive

Michelle Herman Soper, Director of Integrated Care, Center for Health Care Strategies
Jenna Libersky, Researcher, Mathematica Policy Research

Made possible by the West Health Policy Center

About the Center for Health Care Strategies

CHCS is a non-profit policy center dedicated to improving the health of low-income Americans

Our Priorities and Strategies

Enhancing
access to coverage
and services



Best practice
dissemination

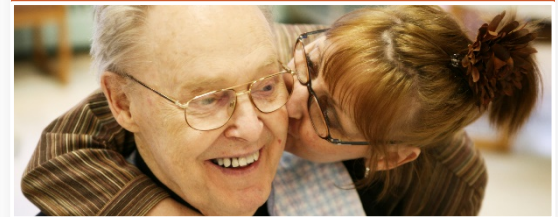


Collaborative
learning



Technical
assistance

Integrating
services for people
with complex needs



Leadership and
capacity building

Agenda

- I. Welcome
- II. The Medicaid Managed Long-Term Services and Supports (MLTSS) Rate-Setting Initiative
- III. MLTSS Rate-Setting Incentives to Promote Community-Based Care
- IV. Considerations for Risk Adjustment in MLTSS Programs



The Medicaid Managed Long-Term Services and Supports (MLTSS) Rate-Setting Initiative

Medicaid MLTSS Rate-Setting Context

- More than 20 states have or will soon establish MLTSS programs
- Different issues in setting MLTSS program rates compared to traditional Medicaid rate setting:
 - ▶ Diverse needs of enrolled populations
 - ▶ Incentives for plans to serve beneficiaries in home- and community-based settings rather than in institutions
 - ▶ Different cost drivers: LTSS costs are more strongly correlated with setting of care, activities of daily living (ADLs), instrumental activities of daily living (IADLs), certain diagnosis codes and other non-traditional variables

MLTSS Cost Drivers

- Setting of care: Residents in nursing facility are generally 2-3x the cost of members residing in the community
- Diagnosis drives LTSS needs
 - ▶ Specific neurological or musculoskeletal diagnoses such as Alzheimer's/dementia, Parkinson's/multiple sclerosis and paralysis
 - ▶ Comorbid behavioral health and medical conditions
- ADLs/IADLs: Number and type of limitations
- Other non-traditional variables:
 - ▶ Behavioral indicators
 - ▶ Communication and cognition
 - ▶ Health services/treatments
 - ▶ Specific health conditions
 - ▶ Availability of natural supports and family caregivers

Medicaid MLTSS Rate-Setting Initiative

- Eight states working on refining rate-setting strategies for MLTSS and/or Medicare-Medicaid integrated care programs
 - ▶ **Arizona, Kansas, Massachusetts, Minnesota, Tennessee, Texas, Virginia, and Wisconsin**
 - ▶ Focus on using functional assessment data for risk-adjustment purposes
 - ▶ Collaboration between the Center for Health Care Strategies (CHCS), Mathematica Policy Research, and Airam Actuarial Consulting
 - ▶ Supported by the West Health Policy Center

For information about the MLTSS Rate Setting Initiative:

<http://www.chcs.org/project/medicaid-managed-long-term-services-supports-rate-setting-initiative/>

Initial Project Findings: State Considerations

- State considerations for developing MLTSS program rates/risk adjustment methodologies
 - ▶ State program elements that impact incentive structures or risk-adjustment methodologies
 - ▶ Data systems and tools needed to collect data
 - ▶ Aspects of functional status and other actuarial issues to improve the predictive accuracy of costs and utilization
 - ▶ Resources needed by states to implement these programs



MLTSS Rate-Setting Incentives to Promote Community-Based Care

MLTSS Rate-Setting Objectives

- Match payment to the cost of the enrolled population
 - ▶ Degree and variation of risk will influence the complexity of the rate structure and rate-setting methodology
- Promote the policy goals of the MLTSS program
 - ▶ Especially rebalancing
- Minimize selection bias
- Meet CMS requirements in 42 CFR 438.3 – 438.8, the actuarial rate-setting checklist, and rate-setting guide
- Assure that rates can be administered and operationalized

Rate Cell Basics

- Rate cells structure rates to be paid for similar populations or services distinguished by:
 - ▶ Population characteristics: for examples, age, gender, geography, or eligibility (Medicare status, institutional versus community-based long term care)
 - ▶ Diagnosis or level of care: serves as a basic form of risk adjustment
- Rates must be actuarially sound
- States *could* directly match payments to rate cells, *however*:
 - ▶ No financial incentive to increase home- and community-based services (HCBS) and reduce nursing facility (NF) placements
 - ▶ Plans may seek to enroll members with particular rate cell classifications based on network capacity, not care needs

Transitional Rates

- Pay separate rate cells based on setting, but limit the availability of the NF rate cell to encourage the use of HCBS over NF
- Massachusetts and Minnesota use this approach
- Pros:
 - ▶ Encourages transition of institutionalized members to the community, but incentives may not be as strong as those in a blended rate
 - ▶ Reduces risk of under/overpayment when NF/HCBS mix is unpredictable
- Cons:
 - ▶ Encourages plans to target particular beneficiaries over others (e.g., NF residents or HCBS)
 - ▶ Requires sophisticated data and tracking, therefore difficult to operationalize and administratively burdensome

Blended Rates

- Pay a single blended rate for those members who meet that state's NF level of care criteria regardless of setting
 - ▶ Blend generally reflects current institutional vs. community mix, but can be adjusted each year to encourage more community care
- Arizona, Kansas, Tennessee, and Virginia use this approach
- Pros:
 - ▶ Can provide a strong financial incentive to serve members in the community rather than in an institution
 - ▶ CMS prefers states use or move toward adoption of a blended rate approach
- Cons:
 - ▶ Mix of members can be difficult to predict
 - ▶ Plans avoid enrolling more costly NF or other institutional residents in favor of members using less costly HCBS

Operational Questions for Blended Rates

- What mix percentage should states use – the actual mix of enrollees in each plan or a target ratio that all plans should achieve?
- How often should states revise the blend – annually or more often?
- How much should states increase the blend from year to year?
 - ▶ Should the increase consider a plan's starting point (current ratio of HCBS:NF use) or local HCBS capacity?
- Should there be a statewide blend, or should it be adjusted by region?
- How should a state incorporate transition bonuses?
 - ▶ Bonuses could include payments to plans for each long-term NF resident they successfully transition to the community



Considerations for Risk Adjustment in MLTSS Rate Setting

Why MLTSS Risk Adjustment?

- More accurately predicts risk of the enrolled population
- Provides more equitable payments between health plans with strong financial incentives to provide care in the most cost effective setting
- Minimizes selection bias and limits gaming
- Recognizes diversity of enrolled population
- Supports managed care plans and/or providers that prefer to specialize in specific population groups

Source: M. Dominiak. Rate-Setting Strategies to Advance Medicaid Managed Long-Term Services and Supports Goals: State Insights. CHCS webinar presentation, August 16, 2016.

Why Standard Risk Adjustment Models Don't Work for MLTSS Rate Setting

- Traditional risk adjustment methods used in Medicaid rate setting rely on demographic and diagnosis information to predict costs
 - ▶ Less predictive of risk for MLTSS programs
- Risk adjustment methods using functional assessment data more accurately predict risk of enrolled population using LTSS
 - ▶ MLTSS risk models using functional assessment data are highly predictive (high R-squared)
 - ▶ Data intensive

Source: M. Dominiak. Rate-Setting Strategies to Advance Medicaid Managed Long-Term Services and Supports Goals: State Insights. CHCS webinar presentation, August 16, 2016.

MLTSS Risk Adjustment Data Sources

- Functional assessment data: demographics, setting of care, diagnosis, ADLs/IADLs, other non-traditional variables
 - ▶ Level of care tool
 - ▶ Comprehensive assessment tool
 - ▶ Minimum Data Set (MDS)/Resource Use Groups (RUGS)
 - ▶ Survey information
- Eligibility data: level of care, category of aid, setting of care, demographics
- Encounter/claims data: setting of care, diagnosis, health service use
- Other state-maintained data: restrictive measures, social determinants

Source: M. Dominiak. Rate-Setting Strategies to Advance Medicaid Managed Long-Term Services and Supports Goals: State Insights. CHCS webinar presentation, August 16, 2016.

Comparing MLTSS Risk Adjustment Models: Wisconsin and New York

	Wisconsin	New York
Functional assessment tool	Single, state developed HCBS waiver eligibility tool	Single, uniform assessment system (UAS)
Data sources, other than functional assessments	<ul style="list-style-type: none"> • Encounters from Family Care • Eligibility data • State database on restrictive measures (DD population only) 	<ul style="list-style-type: none"> • Encounters from Managed Long-Term Care (MLTC) and PACE • Eligibility data
N enrollees	38,000 (80% using HCBS)	97,000 (95% using HCBS)
N MLTSS plans	7	38
N risk predictors in the model	<ul style="list-style-type: none"> • Frail elders: 38 variables • Physical disabilities: 61 variables • Developmental disabilities: 67 variables 	24 variables

M. Dominiak and A. Bohl. "Building Managed Long-Term Services and Supports Risk-Adjustment Models: State Experiences Using Functional Data." Center for Health Care Strategies, August 2016. Available at: <http://www.chcs.org/resource/building-managed-long-term-services-supports-risk-adjustment-models-state-experiences-using-functional-data/>.

MLTSS Risk Adjustment Challenges

- No national model exists
 - ▶ Sophisticated data modeling is required to develop model and refine over time
- Data availability
 - ▶ Diversity of functional assessment tools
 - ▶ Data systems/tools to link functional data to encounters/claims
- Data reliability
 - ▶ Inconsistencies in data collection across assessors and settings
 - ▶ Potential influence of financial incentives on data accuracy
 - ▶ Ability to review/audit data
- State resources to support risk adjustment on ongoing basis

MLTSS Risk Adjustment Opportunities

- Strong interest from states and managed care plans to explore MLTSS risk adjustment models using functional data for rate setting
 - ▶ New York and Wisconsin are using MLTSS risk adjustment models in rate setting
 - ▶ Eight state workgroup to explore the use of MLTSS risk adjustment in rate setting
- High predictive value in New York and Wisconsin models
- Expansion of MLTSS, including enrollment of more diverse populations
- State shift towards use of uniform assessment tool
- National focus on value-based purchasing strategies

Source: M. Dominiak. Rate-Setting Strategies to Advance Medicaid Managed Long-Term Services and Supports Goals: State Insights. CHCS webinar presentation, August 16, 2016.

Developing a MLTSS Risk Model: Key Considerations

- Data drives risk model development and variable selection
 - ▶ Requires linkable functional assessment, eligibility and claims/encounter data
 - ▶ Can be supplemented by other data sources
- Variables selected should be aligned with program goals and minimize gaming
- Different populations may require the inclusion of different variables and possibly different models
- A small number of variables, such as ADLs, IADLs and certain diagnosis codes generally account for a majority of the predictive value
- Model development and ongoing maintenance is resource intensive
 - ▶ Models need to be continuously monitored and refined as the program and data changes

Source: M. Dominiak. Rate-Setting Strategies to Advance Medicaid Managed Long-Term Services and Supports Goals: State Insights. CHCS webinar presentation, August 16, 2016.

Medicaid MLTSS Rate-Setting Resource Center

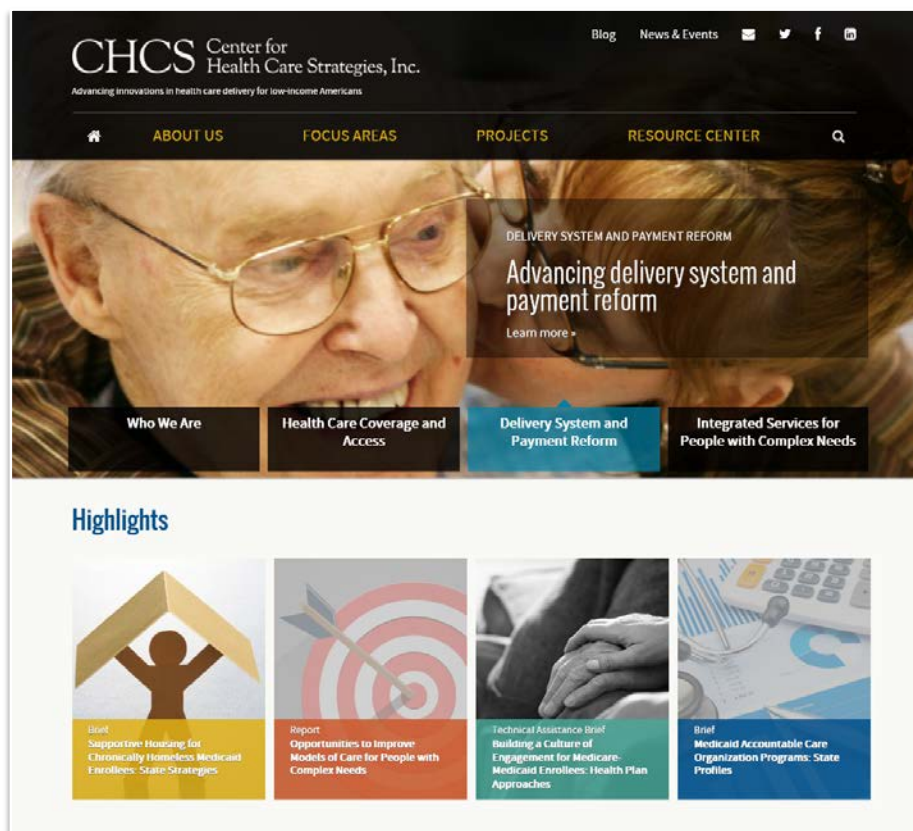
- Foundational Concepts
- State Policy and Operational Considerations
 - ▶ Developing Capitation Rates for Medicaid MLTSS Programs: State Considerations
 - ▶ Tennessee's Approach to Ensuring Accurate Functional Status Data in its Medicaid MLTSS Program
 - ▶ Engaging Managed Care Plans in Medicaid MLTSS Rate Setting Activities
 - ▶ Medicaid MLTSS Risk Mitigation Strategies
- Risk Adjustment for Functional Status
 - ▶ Look Before You Leap: Risk Adjustment for Managed Care Plans Covering LTSS
 - ▶ Population Diversity in MLTSS Programs: Implications for Risk Adjustment and Rate Setting
 - ▶ Building Medicaid MLTSS Risk-Adjustment Models: State Experiences Using Functional Data
- Federal and Professional Guidance
- Access at: <http://www.chcs.org/resource/rate-setting-managed-long-term-services-supports-programs-resource-center/>

Visit CHCS.org to...

Medicaid MLTSS Rate Setting Initiative website:

<http://www.chcs.org/project/medicaid-managed-long-term-services-supports-rate-setting-initiative/>

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services
- **Subscribe** to CHCS e-mail, blog and social media updates to learn about new programs and resources
- **Learn** about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries





Implications of new MLTSS Regulations

MLTSS Intensive - HCBS Conference

August 29, 2016

Camille Dobson
Deputy Executive Director

www.nasuad.org

The Basics

- NPRM published on June 1, 2015 (CMS-2390-P)
- Final Rule published on May 6, 2016 (CMS-2390-F)
<https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>
- First update in 14 years
- Guided by 5 principles
 - Supporting State efforts to advance delivery system reform
 - Strengthen beneficiary protections
 - Strengthen program integrity by improving accountability and transparency
 - Align key Medicaid and CHIP managed care requirements with other health coverage programs
 - Modernize regulatory requirements and improve quality of care

The Basics

- Effective dates vary by section (table on Medicaid.gov - <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/implementation-dates.pdf>)
- States/health plans must comply based on EITHER rating period or contract term
- Intended so that states with lengthy contract terms do not avoid compliance until reprocurement.
- Rates are set at least annually (per new CMS requirement) so rating period that occurs during one of the 'implementation years' will trigger compliance even for those states with multi-year contracts.

Regulatory Approach

- MLTSS-specific provisions are based on May 2013 published guidance for States implementing Medicaid-only MLTSS and are weaved throughout rule primarily in sections dealing with care coordination, stakeholder engagement, and beneficiary supports
- The regulations address these elements:

1. Adequate planning and transition strategies	6. Support for beneficiaries
2. Stakeholder engagement	7. Person-centered processes
3. Enhanced provision of HCBS	8. Qualified providers
4. Alignment of payment structures with MLTSS programmatic goals	9. Participant protections
5. Comprehensive and integrated service package	10. Quality

Regulatory Approach

- There are also LTSS references - not directly related to the 10 elements - weaved throughout the regulation which specifically enumerate that those broad managed care requirements should apply to MLTSS programs.
- Intent is to 'normalize' MLTSS
- CMS defines LTSS in the reg so that it is easily determined when MLTSS provisions apply

Policy and Operational Implications

- Have ordered the provisions from most impactful to least (based on feedback from members and plans)
- DOES NOT MEAN unimportant!
- Simply reflects complexity of compliance for states and/or plans.

Key New MLTSS Requirements

- **Provider Availability and Accessibility**

- State must establish a credentialing and recredentialing policy that addresses LTSS providers
- State must set network adequacy standards for both in-home and out-of-home providers
- MCOs must ensure physical access, reasonable accommodations, and accessible equipment for enrollees with physical and mental disabilities and MCO provider directories must include this info



eff. 7/1/17



eff. 7/1/17



eff. 7/1/17

Key New MLTSS Requirements

- Application of HCBS regulations to all MLTSS programs, regardless of authority
 - Settings (with appropriate transition period)
 - Conflict of interest
- Allow consumer to change their MCO if NF/residential/employment provider leaves network



eff. NOW



eff. 7/1/17

Key New MLTSS Requirements

- Provide support for enrollees
 - Comprehensive choice counseling
 - Ombudsman for MCO problem resolution
- Quality Monitoring and Reporting
 - MCOs must assess the quality and appropriateness of care including assessment of care between care settings and a comparison of services received with those in person-centered service plan.
 - MCOs must measure enrollee quality of life of beneficiaries and any rebalancing and community integration outcomes



eff. 7/1/18



eff. 7/1/17

Key New MLTSS Requirements

- Person-Centered Processes

- Service plan must be developed by individuals who are trained in person-centered planning and who meet State's LTSS service coordination requirements
- Service plan must conform with person-centered planning standards in the HCBS final rule
- As part of transition of care policy, State must permit consumer to continue services they had prior to MCO enrollment with current providers (if not in MCO network)



eff. 7/1/17



eff. 7/1/18

Key New MLTSS Requirements

- MCOs must collaborate on critical incident detection and remediation with State
- MLTSS-specific stakeholder input on design, implementation and oversight
- Aid paid pending appeal
 - Enrollee must request continuation of benefits before the expiration of the original authorization BUT benefits must continue for the duration of the appeal or State Fair Hearing



eff. 7/1/18



eff. 7/1/17



eff. 7/1/17



For more information, please visit: www.nasuad.org

Or call us at: **202-898-2583**

The Wisconsin Experience & Community[®]

National Home & Community Based Services Conference
Washington D. C.
August 29, 2016

Wisconsin's Experience

- **1981 – 1999:**

- ✓ State –funded Community Options Program
- ✓ Community Integration Program Waiver
- ✓ Community Options Program Waiver;
- ✓ Brain Injury Waiver;
- ✓ growing waitlists; silos of service; institutional use growth; cost increases

- **26,000** persons served through Legacy Waivers

- **1993:** Piloting of Partnership Program
- **1998:** Stakeholder process, hundreds of consumers, family members, providers and advocates creating Family Care (includes Adults with ID/DD, PD, & Elders)
- **2000:** Piloting of Family Care – 5 Counties

- **Four Family Care Goals:**

- ✓ **CHOICE:**

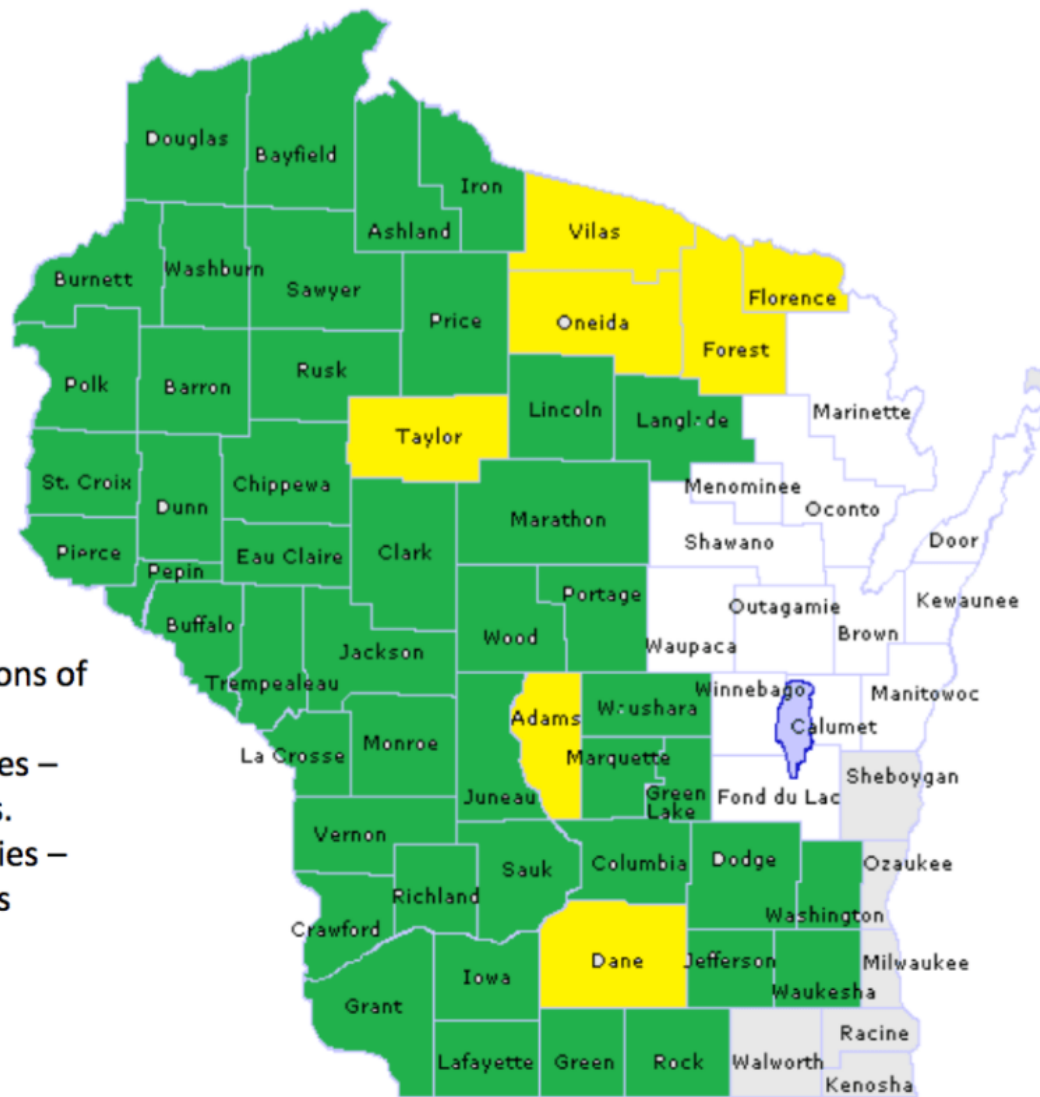
- ✓ **ACCESS:**

- ✓ **QUALITY:**

- ✓ **COST-EFFECTIVENESS:**

- Total Medicaid Costs = **\$452 PMPM** less for FC enrollees outside Milwaukee
- Total LTC Costs = **\$565 PMPM** less for FC enrollees in Milwaukee
- Total LTC Costs - **\$722 PMPM** less for FC enrollees outside Milwaukee

- **2006:** Gov. Doyle announces expansion of Family Care
- **2016:** 65 of 72 Counties served by 7 Managed Care Organizations (FC enrollment as of 6-1-2016 = 42,840)
- **2016:** DHS release proposed expansion to remaining 7 Counties by 1st Quarter of 2018



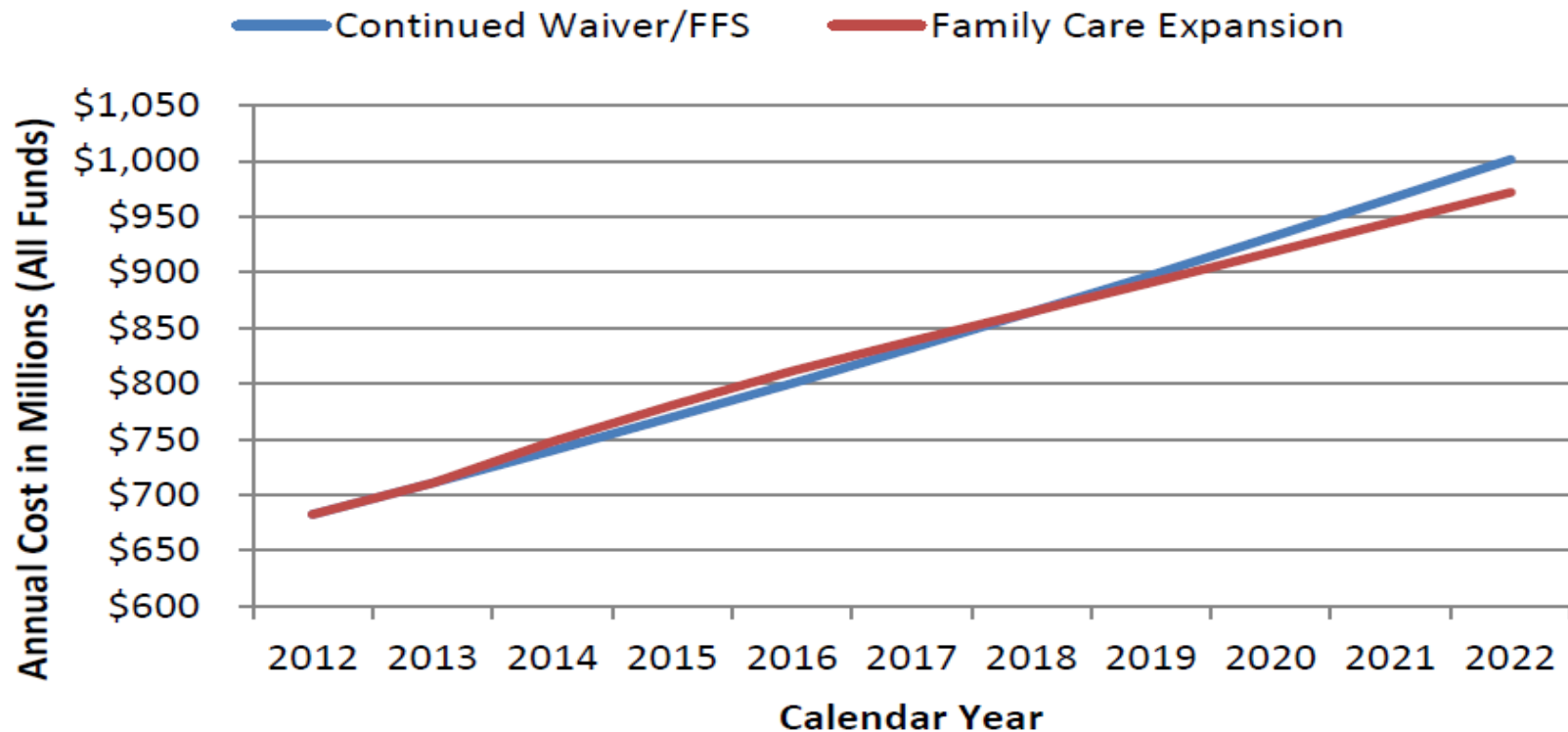
- Combined Service Regions of CCCW, ContinuUs, and Western Wisconsin Cares – **Green** Shaded Counties.
- Non-Family Care Counties – **Yellow** Shaded Counties

MCO Experience

- Forty-four quality compliance standards were applicable to every managed care organization, and carried a maximum possible score of 88 points.
 - ✓ Individually, five of the eight organizations scored 80 points or above.
 - ✓ The results for all eight organizations ranged from 64 to 86 points

- All programs (Family Care, Family Care Partnership, and PACE) achieved aggregate results over 90 percent in the following areas of Care Management Review:
 - ✓ “Comprehensiveness of Assessment”
 - ✓ “Reassessment Done When Indicated”
 - ✓ “Risk Addressed When Identified”
 - ✓ “Timeliness of Service Authorization Decisions”
 - ✓ “Identified Needs are Addressed”
 - ✓ “Member/Guardian/Family/Informal Supports Included.”

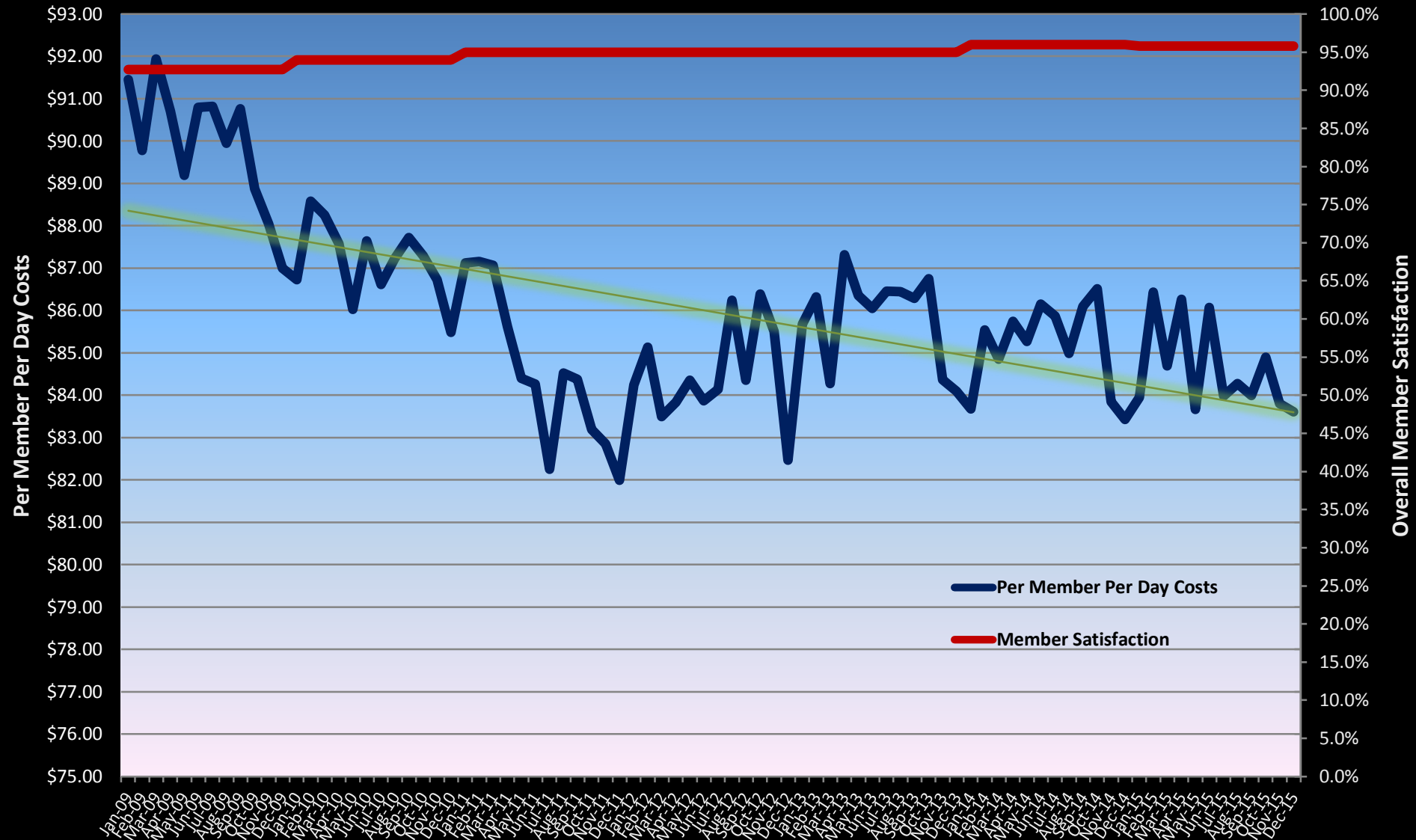
**Chart 1:
Projected Elderly, Blind or Disabled
Medicaid Costs
Waiver/FFS Counties:
Continued Waiver/FFS vs. Family Care
Expansion**



Per Member Per Day Costs & Member Satisfaction

Community Care Connections of Wisconsin

2009-2015



* 2012 PMPD Costs include a one-time 1% provider incentive payment.

* CCCW expanded to 11 additional counties in January 2014. PMPD costs

Per Member Per Day Costs & Member Satisfaction

Western Wisconsin Cares

2013 - 1st Quarter of 2016



MEMBER EXPERIENCE

Family Care

■ Excellent ■ Very Good ■ Good ■ Fair ■ Poor

Overall, how would you rate the supports and services you receive?

56.10%

31.13%

9.00%

2.90%

0.87%

Overall, how would you rate the help you get from your {care team}?

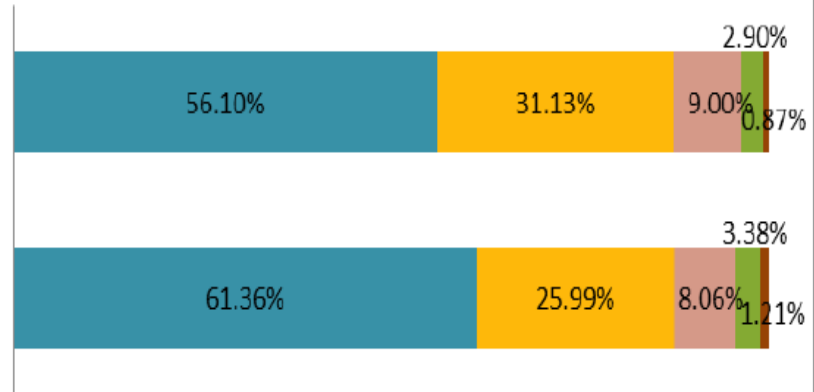
61.36%

25.99%

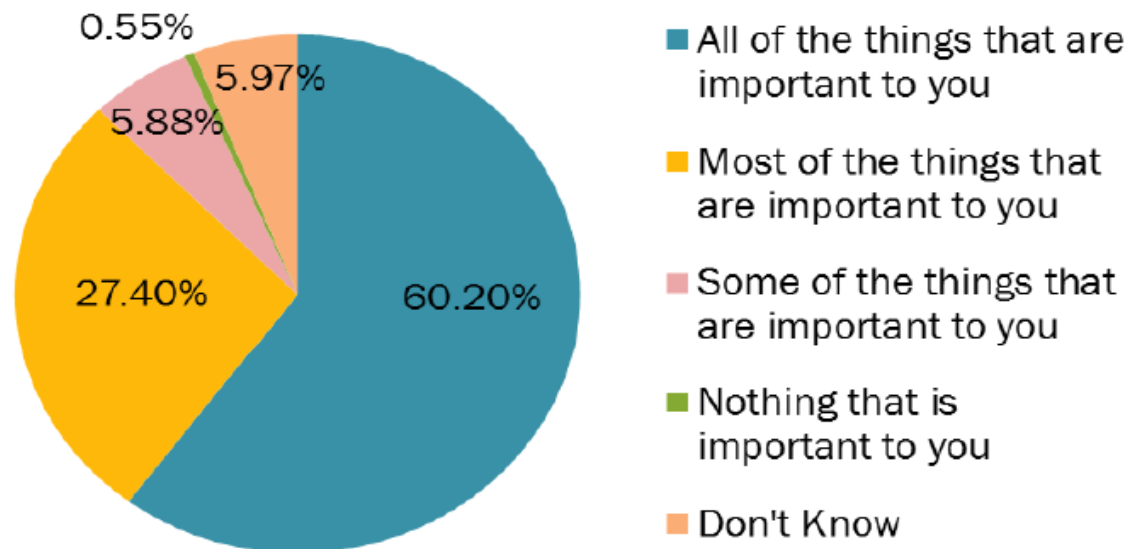
8.06%

3.38%

1.21%



Family Care members Does your {care plan} include?





Commonunity® is Community Care Connections of Wisconsin's trademarked delivery of a member-focused and community-centric approach to managed long term care, which, through its core values, supports the State of Wisconsin Family Care Program. Commonunity recognizes the power of combining community connections, self-determination, community living options, integrated employment, and mobility in supporting people to live meaningful lives as full citizens in their communities.





- **Community Connecting:**
 - Commonunity® is built from the belief that everyone deserves the right to contribute to community and actively participate in full citizenship.
- **Self-Determined:**
 - Commonunity® is built from the belief that everyone deserves the right to control his/her life and actively participate in full citizenship.
- **Community Living:**
 - Commonunity® is built from the belief that everyone deserves the right to embrace the ideals of home and actively participate in full citizenship.



- **Integrated Employment:**

- Commonunity® is built from the belief that everyone deserves the right to pursue employment opportunities and actively participate in full citizenship.

- **Mobility:**

- Commonunity® is built from the belief that everyone deserves the right to access his/her community and actively participate as a full citizen.

You are wonderful!

A great helpful team! Very good and thoughtful to me!

Always very helpful!

Communication and care are excellent.

***Great job -
wonderful staff.***

***I am appreciative of everything.
I am pleased with my care.***

“They are the best team anyone could have.”

***Always ready to
help!***

***You all do a Great Job!
Team Work at its best.***

***Great staff! Really
appreciate all their help.***

***Great staff
always willing to
answer questions
or help you find
the right
direction to
follow.***

Very friendly, accessible, helpful!



- <http://mycccw.org/>
- Kris Kubnick – Executive Director of Operations
- Kris.kubnick@communitycarecw.org



- <http://www.wwcares.org/>
- Maryellen Paudler – Director of Operations
- mpaudler@wwcares.org

Contact Information

- [dhs.Wisconsin.gov/familycare/enrollment](https://dhs.wisconsin.gov/familycare/enrollment)
- Family Care Independent Study – CY 2003 - 2004 APS Healthcare, Inc.
- Metastar. (2016) External Quality Review Annual Technical Report FY 2014-2015
- Promising Practices in LTC Systems Reform – WI Family Care, March 2013
- Wisconsin Department of Health Services. (2013) Joint Committee on Finance Long Term Care Expansion Report. Madison, Wisconsin Department of Health Services
- Wisconsin Department of Health Services. (2016) 2014 Family Care Member Survey Results. Madison, Wisconsin Department of Health Services

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Conference
2016
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Symposium

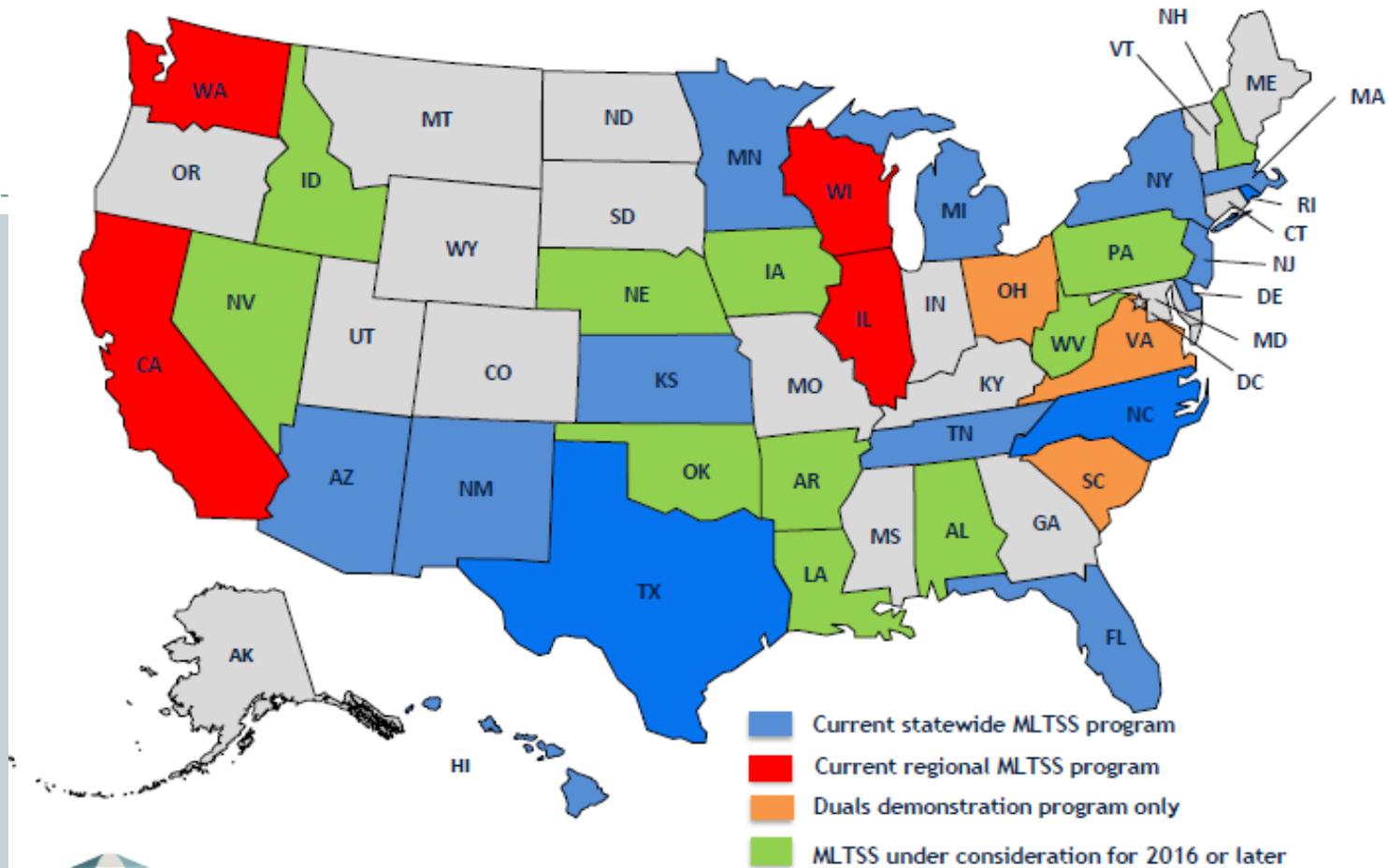
MLTSS for People with I/DD: What Makes a Difference?



**Barbara Brent, Director of State Policy
National Association of State Directors of Developmental Disabilities
Services NASDDDS**

This is inclusive of all populations and does include those carved out (I/DD mostly carved out)

MLTSS Programs - 2015



Managed LTSS Care Including I/DD-More Out than In-But the List Changes Often

3

In MLTSS

- Arizona (1115)
- Michigan (b/c)
- Wisconsin (b/c)
- North Carolina (b/c)
- Kansas (1115)
- Tennessee (1115 started rolling out for I/DD in July 2016)
- Texas – beginning roll out
- New Hampshire (1115), I/DD rolling out soon
- New Jersey (1115)
- Illinois- submitted (1115)
- Iowa- fast track roll-out

In Planning or Pre Implementation Stage

- Illinois- submitted (1115)
- Florida – legislative exploration
- Louisiana* (1115) delayed
- New York* (b/c)
 - * pre-implementation DISCOS implementing (dual eligible, including I/DD)

Planning, Design & Implementation: Services for people with IDD, seniors, and those with physical disabilities are not all the same- Through the Lens of I/DD Community

4

- **Primary Focus**

- Seniors – Comfort, quality, and keeping/building connections in remaining years of life
- I/DD - “Getting a Life”

- **Length of Service**

- Seniors- Averages 3 years – but hopefully more
- I/DD - up to 60 years or more

- **Community Supports**

- Seniors- Many people have friends, family, relationships from spiritual community, clubs, etc. to rely on, focus is on helping people stay connected to these supports
- I/DD - need to build and maintain relationships and supports throughout life



Takes honest conversations on why managed care is needed and helpful in the lives of people with I/DD: types of services, costs, support coordination, etc.

Planning, Design & Implementation: IDD, & Seniors, and those with Physical Disabilities are not the same- I/DD state systems view

5

- **Primary Services and Supports**

- Seniors - medical care, home health and personal assistance
- Support to keep family relationships and socialization
- I/DD –learning and growing over a lifetime, finding and keeping a job, supporting families, in home supports, accessing the community

- **Family Care Giving**

- Seniors – In the later years of life
- I/DD - Begins at birth and continues through a lifetime-with varying intensity, but the caregiving role is always there.



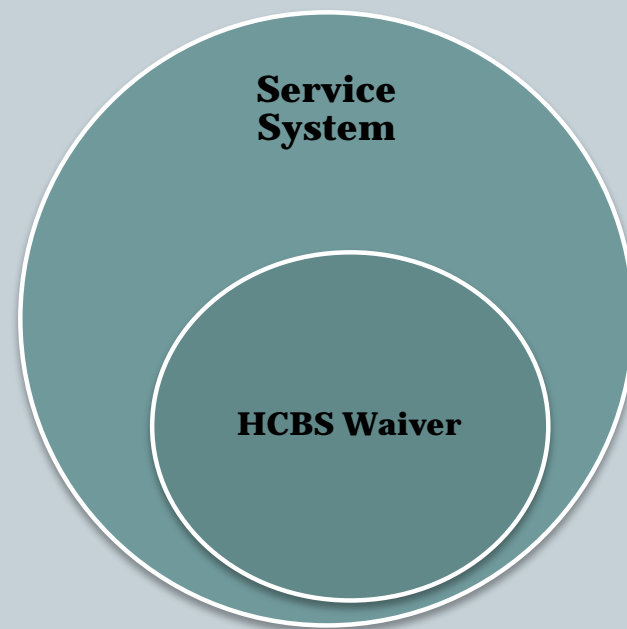
Over 56% on average of people known to system nationally live with their families and always have, well into adulthood. Some states higher, 80% or more. Support families to support family member with I/DD

Managed Care LTSS in I/DD– Why the Resistance?

6

Families Built DD Systems over 50 years ago

- 1950s & 60s - State programs and State Statues
- 1970s Right to Education
- 1980s Deinstitutionalization litigation
- 1990s Medicaid HCBS



Families and People with I/DD can be Skeptical About Replacing Current System

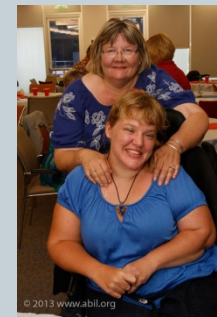
7

- State I/DD Director - In many states high and direct touch. Concerns that families, self advocates and providers can't pick up phone and talk
- Families and people with I/DD considered essential stakeholders
- Families and people with disabilities aren't highly supportive of generic "call centers"-how will there be a touchstone when MLTSS rolls out?
- Service coordinator to assess needs, create a person-centered plan and monitor service delivery-coming to our home and not based on a single assessment
- Services –medical is not the primary focus, especially for majority of adults (don't want to be medicalized)
- Provider network almost all non-profits, started by families and faith based organizations; families and self advocates sit on boards
- Oversight through licensing, certification and monitoring of direct provider organizations-many states have provider report cards or other open review records. Will there be transparency?
- Hearing that this will save money sounds like *cuts to services for people living with families – it always has in the past*

What is Important to Families & People with IDD when moving to MLTSS

8

- Vision and Values – there is a purpose beyond coordinating care and reducing costs
 - Support to families
 - School to work transition
 - Competitive employment
 - Self-direction – control over services & budget
 - Small, innovative providers
- Reducing waiting lists
- Supports for families that are flexible, meet their needs and are consumer/family directed and what will assist their sons, daughters, brothers, sisters have a good and happy life with friends, family, a valued role in the community
- Collaboration with self advocacy and family groups & associations....having a say in design, implementation and review of system



Considerations & Cautionary Notes:

Readiness is Key



9

A Cautionary
Note

Conducting a Careful Readiness Assessment- Takes Time

- Stakeholder engagement should start as soon as possible
- Identify program goals-what do we want to achieve and why (even before determining Medicaid authority or moving to managed care)
- Assumptions about savings should be tested and design taken from there
 - Not solely about enough physicians, psychiatric hospitals, home health agencies and personal assistance services (while important) ...it's about employment services, respite, and supports families & new models of relationship-based living services.

Considerations & Cautionary Notes:

Readiness is Key-state I/DD Perspectives

10

A Cautionary
Note

Readiness Assessment- Takes Time, Enough Time

- Provider Networks- Already network of service providers known by families, people with I/DD and state agency. How to best ensure continuity
- Small providers often considered most creative and most at risk - no large cash flow or I.T system
- I/DD stakeholders accustomed to meaningful seat at the table, strong voice and close connections with state I/DD agency as changes are contemplated & implemented
- Stakeholders know state I/DD agency and are accustomed to close contact- generic call centers are not generally welcomed. What/who will be the touchstone in MLTSS?
- More data needed in MLTSS for quality improvement, trends, network development in HCBS services-need infrastructure for state to help MCO and providers be successful

Tools to Encourage Integrated Settings for People with I/DD -Contracts, Manuals, Rate Setting

11

- Keep institutions in capitation rate, ICF/DD and nursing homes- biggest cost savings. Make expectations about self determination, community integration, and work clear in MCO contracts
 - School to work transition
 - Service approvals based on desired outcomes, not just an assessment
 - Employment
 - Supporting families
- Use manuals and policies to communicate expectations- more nimble than contracts alone i.e. case management/support coordination, provider qualifications specific to I/DD

Tools to Encourage Integrated Settings for People with I/DD- Expectations and Measurement

12

Measure the delivery of services and supports for integration and quality value

- In family homes with support
- In own homes
- In shared living
- Age appropriate for children and adults
- Employment outcomes
- Integration regardless of medical or behavioral labels
 - ✦ People with trachs, g-tubes, suctioning, ventilators
 - ✦ People with behavioral reputations; criminal offenders
- Support coordinators well versed in community supports and services that are valued by individuals/ families



What Can Be Accomplished - Aligning Payment Structures with Goals- cont. * State I/DD perspective

13

Effective Capitation in (MLTSS) is unique for people with I/DD. In past, capitation often relied/relies primarily on what was spent in past year(s), plus regulatory changes & basic demographics

To drive innovation, realistically predict costs, attain desired outcomes & achieve rebalancing over time, capitation should not look solely at factors listed above.

- Include elements actuarially sound (and in line with new rules) e.g., desired policy changes, valued outcomes-in home, crisis, employment, aging caregivers, individualized living, transitioning youth
- MLTSS capitation in I/DD relatively new for most states. Robust data and analytics are necessary to develop capitation rates with these factors. If not readily available, more time needed to pull data for first capitation (and then ongoing)

Aligning Payment Structures with Goals and Network Sufficiency

14

- **Rate setting- decide which components will be retained by state vs. what authorities MCOs will have:**
 - Can balance-state sets rate parameters for some services especially when MLTSS for I/DD begins
 - Does state provide rate guidelines for desired outcomes such as HCBS employment & in home support, or does MCO have full ability to design rates as long as enough providers in network?

Defining strong network adequacy and oversight

- Networks beyond traditional “adequacy”. More than sufficient health providers (while important!) or day programs/ group homes. Specific about desired & needed services to achieve program's purpose

Network Sufficiency

15

- Need strong I/DD state oversight of MCO networks
- In I/DD, takes specific analysis of the landscape- # and types of providers in each area of the state to meet families' need for respite and supports, people moving into integrated employment, shared living, community connections, transforming legacy services into strong community practices. Should be reviewed, approved and monitored by the state staff with I/DD expertise
- Involve others at the regional and local levels in identifying network strengths and gaps
- Review of the network at least every quarter by state- is it increasing, decreasing, matching the individual plans of each part of state?

Keeping Strong Support Coordination

16

People with I/DD and families (and advocates, providers, and state I/DD staff) can fear losing support coordination and receiving “traditional” care managers. Care management is better known in managed care and should contain elements known for decades in the I/D community

MCOs need specific training, contract expectations, mentoring, policies, clinical practice guidelines to enhance skills to meet expectations

A support coordinator is a person who:

- Does not work for a provider (conflict free)
- Develops a relationship with person and family over time-knows me, not only my plan
- Develops individual plan with me and I am primary person participant
- Conducts on-going oversight (checks in) to make sure my services are delivered, are achieving outcomes-and to see how I am doing overall
- Is available for ad hoc problem solving when I need it

Support Coordination

17



AZ introduction to case management:

- **The case manager must**
 - Foster a person-centered approach
 - Maximize member/family self-determination promote the values of dignity, independence, individuality, privacy and choice.
 - Support the member to have a meaningful role in planning and directing their own care to maximum extent possible.
 - Facilitate access to non-ALTCS services available throughout the community
 - Advocate for the member and/or family/significant others as the need occurs
 - Assist members to identify their goals and provide information about local resources that help transition to greater self-sufficiency in the areas of housing, education and work
- **Case management begins with a respect for the member's preferences, interests, needs, culture, language and belief system**

While AHCCCS uses case manager in manual, DDD uses support coordinator and adds policies, job descriptions, and metrics based on I/DD services.

Qualified Providers

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- Basics are certification, licensing, background checks, credentialing
- MCOs and providers need training in disability specific areas, history and value- base, I/DD vs. behavioral health, self direction
- Assure training of non-certified direct support professionals, establish core curriculum
- Keep small providers of HCBS agencies known in community
- Provider training in billing, encounters, coding & other insurance based knowledge
- Involve people with disabilities and families as trainers
- Determine if people with I/DD and families are on boards of providers and policy committees of for profit MCOs and agencies (consider adding to MCO contracts)

Acute, Behavioral Health & LTSS Coordination

19

Potential benefits- more coordinated discharge planning to prevent illness, wellness in homes *when* framed around values of community living

Opportunities to better coordinate with behavioral/mental health care; polypharmacy, trauma informed care, linking mental health supports for overall support plan

Won't stop the “hot potato” between systems, but can reduce it



Anchoring What Works

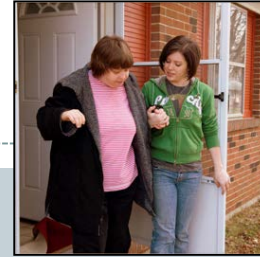
20

Private MCOs have less experience in I/DD. Most Medicaid agencies don't have existing rules, statutes, policies completed by state I/DD agencies with I/DD stakeholders in current contracts. Encourage Medicaid agency to consider referencing, binding by MCO contract

- Human Rights Committees with self advocacy and family representatives at local & state levels and right to contact any time
- Program Review Committee for behavior support including self advocates and families
- Positive behavior support policies, rules, committees with oversight specific to I/DD
- Right to be free from excessive medications and review of any medications used to modify behavior -committees and person's entire team
- Right to date – and more

Quality

21



- Incident management
 - Evaluate Support Coordination
 - Utilization- who is receiving supports and where- who isn't why- underserved, specific areas of state? Has MCO implemented and tracked network plan to address?
 - Participant Feedback
 - Trend grievances, complaints, appeals, claims, provider monitoring, incidents, quality of care concerns, outcomes, PIPS, compliance data
-
- *The oversight of the MCOs' quality by the State is as important as the MCO's system*
 - *Includes stakeholders in data review, provide recommendations on ongoing basis*

State Roles and Responsibilities Differ but not Lessen

22

- States must ensure adequate state staff, with I/DD experience and skillset, to develop and implement program and monitor performance against the established benchmarks
- Role of the state may shift, but not lessen in MLTSS. MCOs may undertake certain functions previously performed by state staff, state must vigilant in oversight/ plan management to ensure the program is implemented as designed and progress is made toward established goals
- States must continuously bring stakeholders together for program evaluation and improvement

Stakeholder Engagement –

What state agencies have learned so far

23



- Communicate often, even if updates are minimal- some information is better than not hearing from state. Have family members and self advocates review memos state sends out to stakeholders for clarity
- Ensure stakeholders have a chance to share what they want to keep and why, not just what they want changed
- Stakeholders have a voice in identifying quality outcomes before the managed care proposal is written
- Consider contracting with family and/or self advocacy groups to assist in consumer satisfaction, what is/ what is not working
- Engage the I/DD stakeholder community early and keeping engagement ongoing
- What stakeholder involvement will be mandated for MCO's?

Measuring Progress

24

Managed care is a financing mechanism but can do more! Defining quality outcomes for people with disabilities, seeking opportunities for integration, and supporting more people and their families in the *community*= Progress.



Maureen and Conner

Thank You!

25

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