Improving Care and Support of America's Seniors and Adults with Disabilities – Trends in Long-Term Services and Supports

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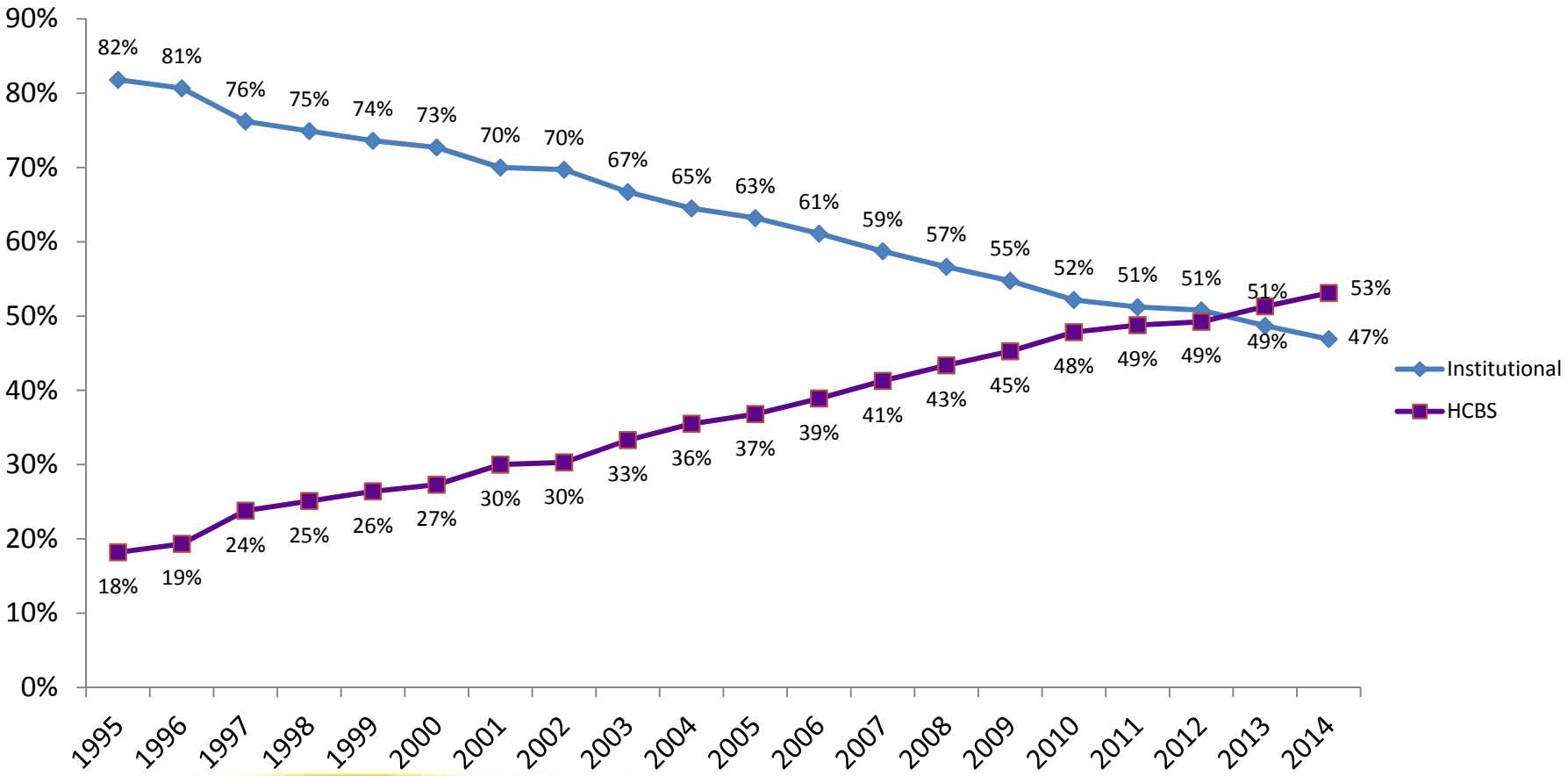
Medicaid Long-Term Services and Supports

- Medicaid is the largest payer of long-term services and supports (LTSS)
- Includes home and community-based services (HCBS), such as personal care, under various authorities (Section 1915(c) waiver services, 1915(i), 1915(k) Community First Choice), as well as institutional services such as nursing homes, intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and mental health facilities.
- In Federal Fiscal Year (FY) 2014, federal and state governments spent about $152 billion on Medicaid LTSS, a four percent increase from $146 billion in FY 2013.

Institutional and Home and Community-Based Services (HCBS) as a Percentage of Long-Term Services and Supports (LTSS), FFY 1995-2014



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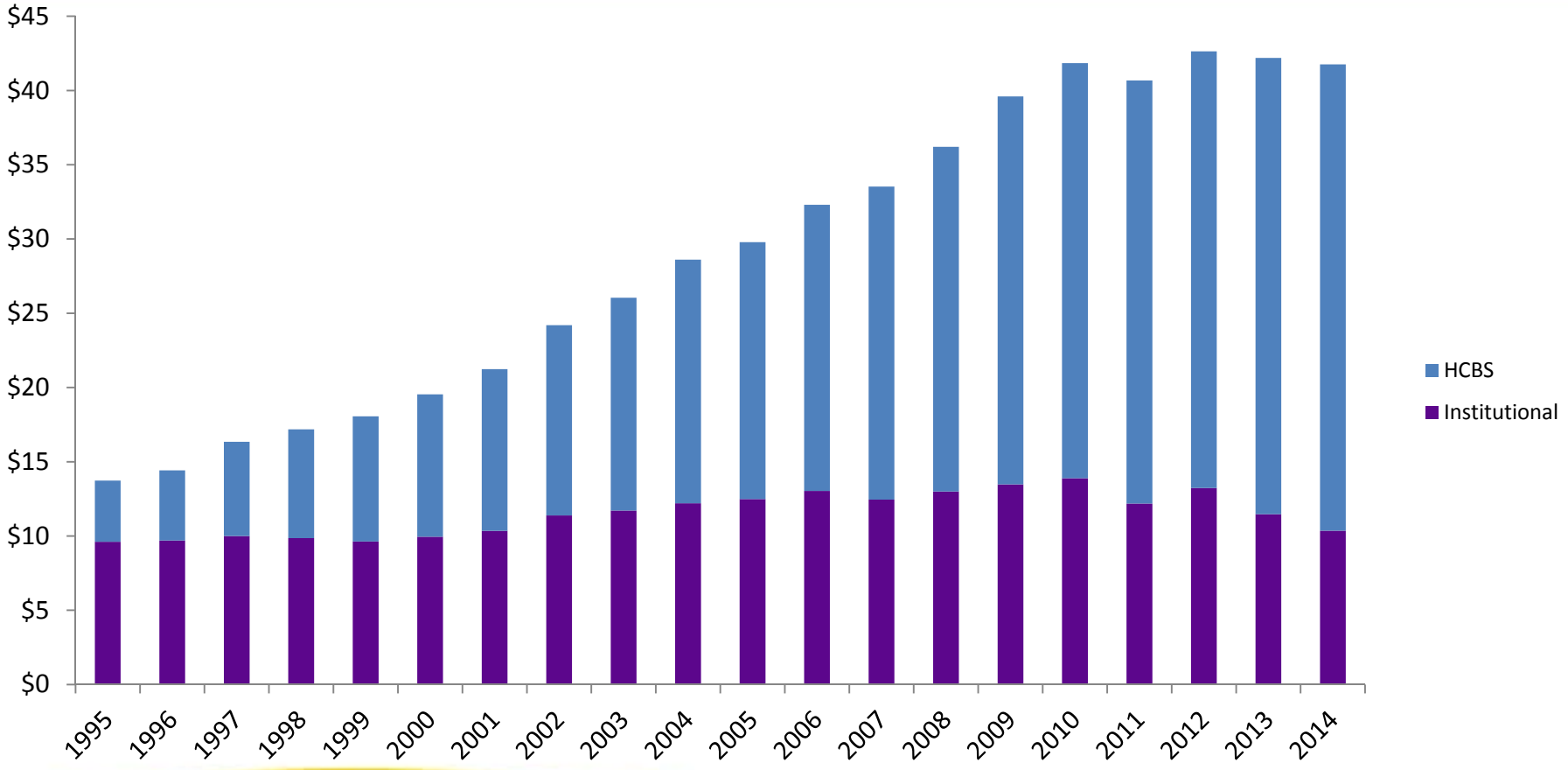
Three Decades of Policy and Legislative Changes Have Supported the Expansion of HCBS

- Many statutory amendments and court decisions changed public policy related to Medicaid LTSS and Medicaid eligibility, including:
  - 1981 - The establishment of Section 1915(c) Waivers
  - 1982 - Option established for states to cover children with disabilities living at home who quality for institutional services
  - 1987 - Nursing Home Reform Act
  - 1990 - The Americans with Disabilities Act
  - 1999 - The *Olmstead versus L.C.* decision
  - 2005 - The Deficit Reduction Act which established Section 1915(i), Section 1915(j), and the Money Follows the Person Demonstration
  - 2010 – The Affordable Care Act, which created the Balancing Incentive Program and Community First Choice

LTSS Spending Targeted to People with Developmental Disabilities, in billions, FY 1995-2014



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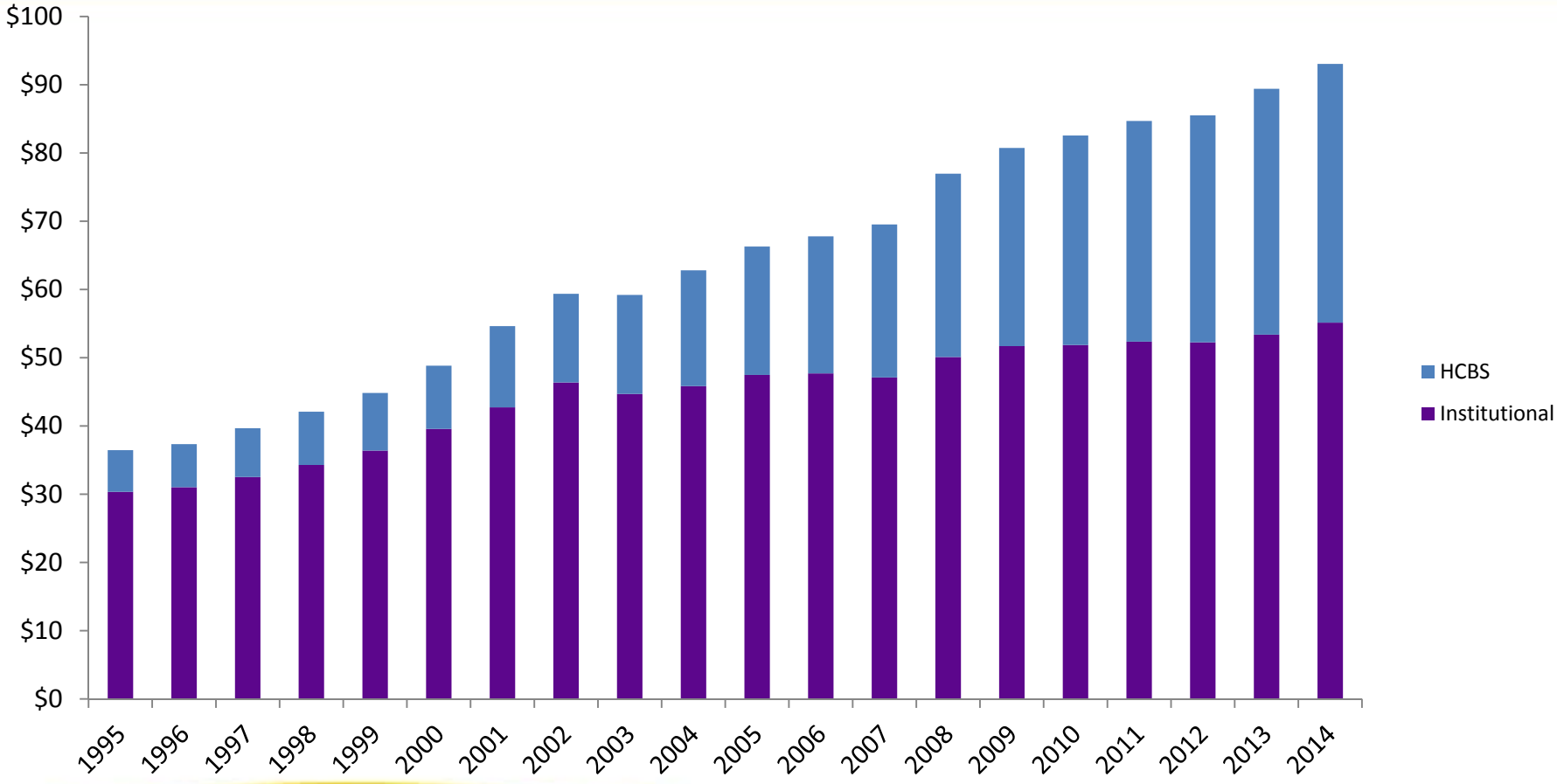
LTSS Spending Targeted to Older People and People with Physical Disabilities, in billions, FFY 1995-2014



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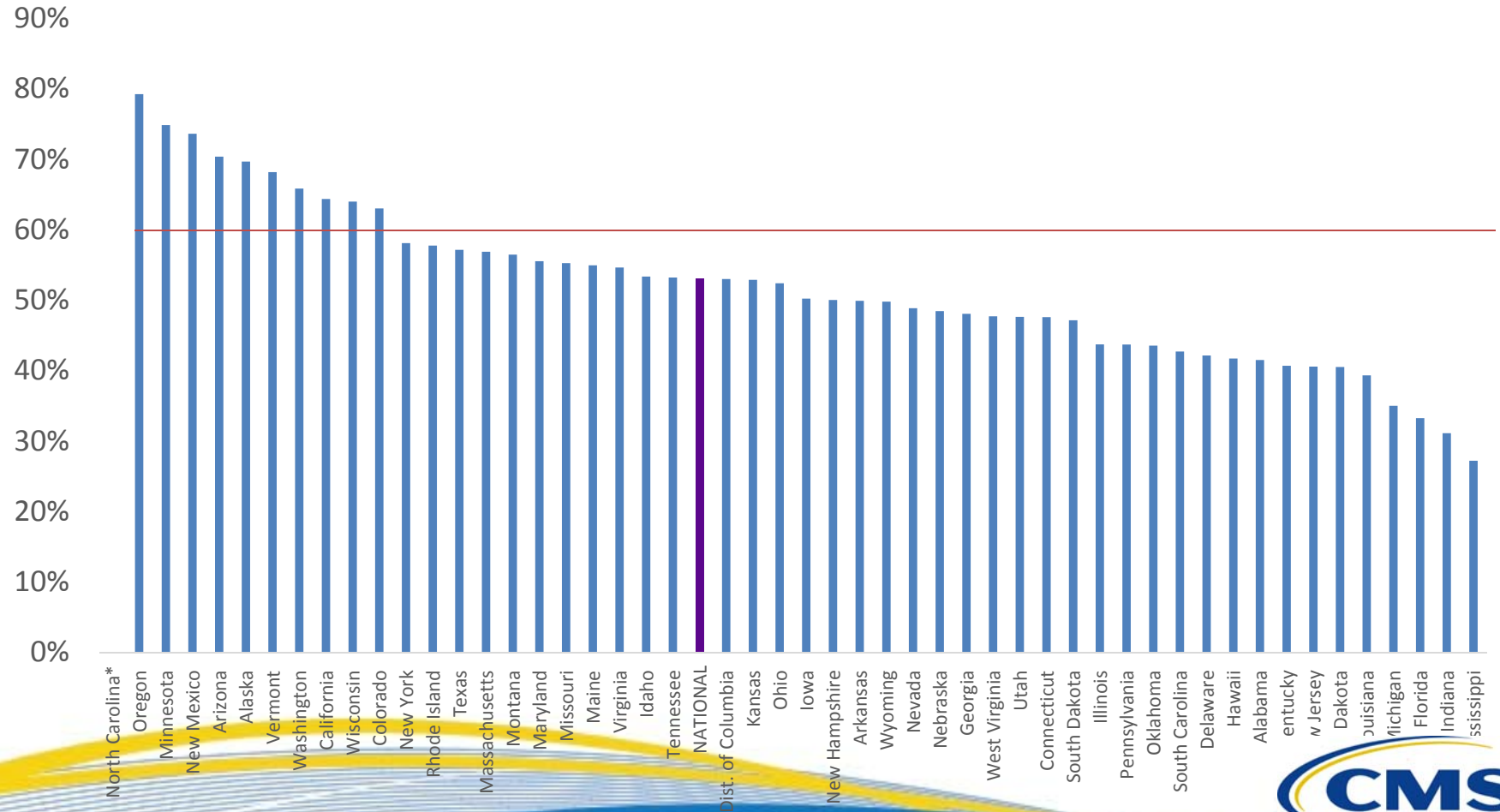
About Half the States Spend More than 50 Percent of Medicaid LTSS on HCBS

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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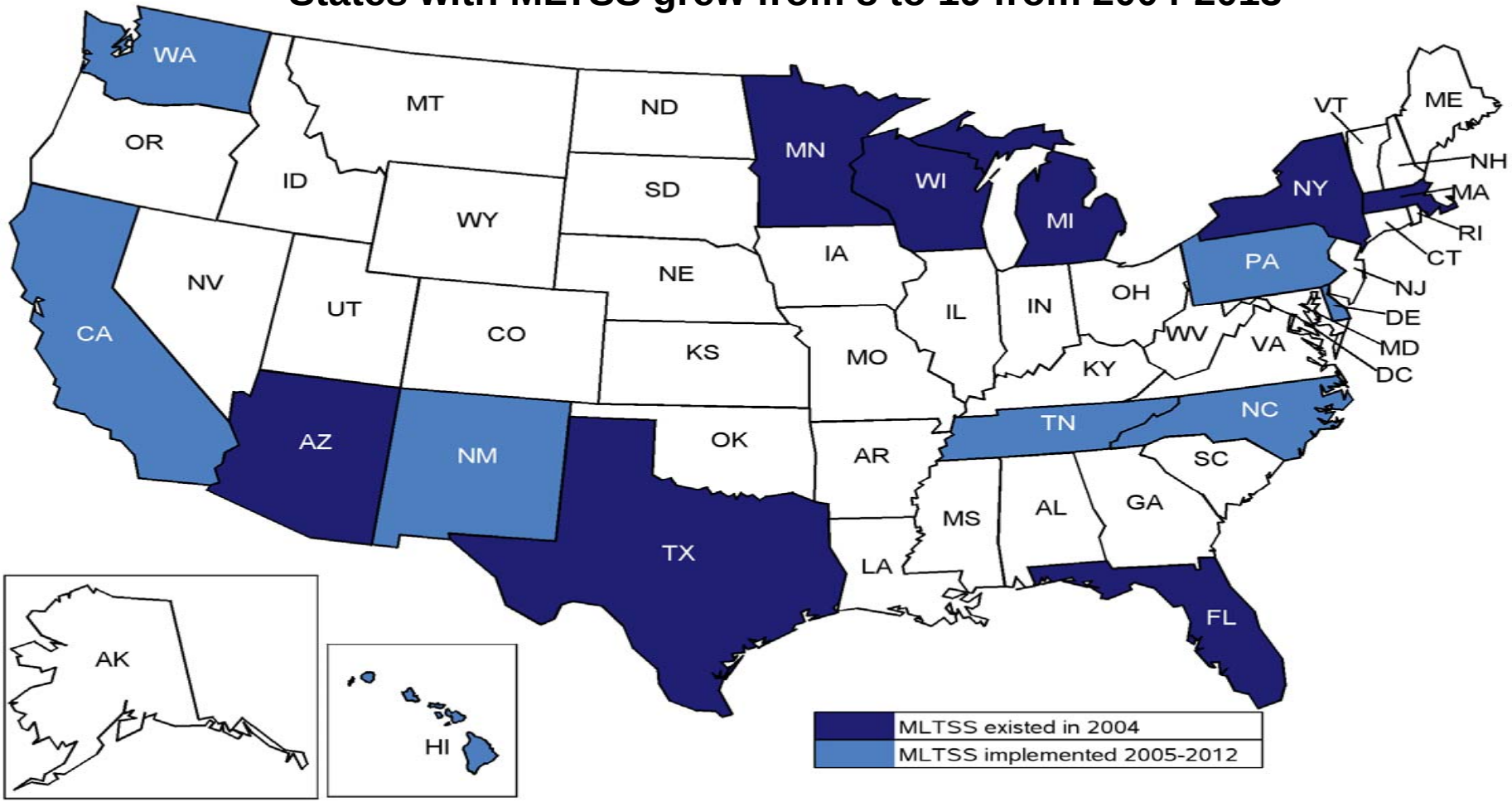
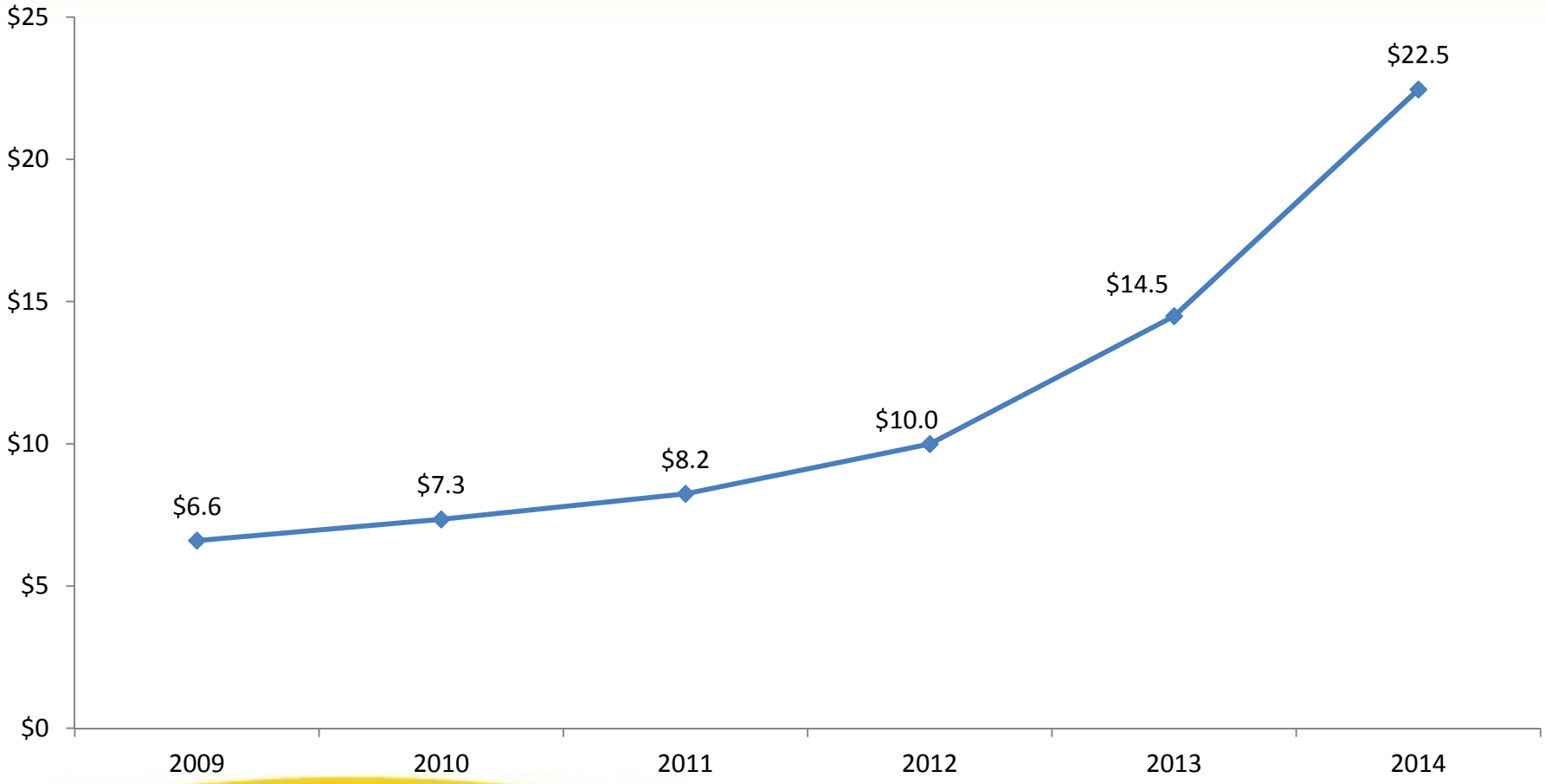
Managed LTSS in 2013

States with MLTSS grew from 8 to 19 from 2004-2013



Source: Truven – Health Analytics - *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*

Medicaid Managed LTSS Expenditures, in billions, FY 2009-2014



Source - *Medicaid Expenditures for Long Term Services and Supports in 2014:*
Prepared for CMS by Truven Health Analytics, April 22, 2016

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Managed Care Regulation - Background

- Final rule is the first update to Medicaid and CHIP managed care regulations in over a decade. The health care delivery landscape has changed and grown substantially since 2002.
- Predominant form of Medicaid is managed care – risk-based arrangements for delivery of Medicaid services
- States have expanded managed care in Medicaid to enroll new populations, including seniors and persons with disabilities who need long-term services and supports, and individuals in the new adult eligibility group
- In 1998, 12.6 million (41%) of Medicaid beneficiaries received Medicaid through capitation managed care plans
- In 2013, 45.9 million (73.5%) of Medicaid beneficiaries received Medicaid through managed care (MCOs, PIHPs, PAHPs, PCCMs)

MLTSS Essential Elements

- Adequate planning and transition strategies
- Stakeholder engagement
- Enhanced provision of Home and Community Based Services
- Alignment of payment structures with MLTSS programmatic goals (“most integrated community setting” for LTSS)
- Support for beneficiaries
- Person-centered processes
- Comprehensive and integrated service package
- Qualified providers
- Participant protections
- Quality

MLTSS

- *Element One: Adequate Planning*
  - States need to conduct readiness reviews for managed care plans delivering LTSS (as well as non-LTSS managed care programs)
  - Information standards for potential enrollees and enrollees
    - Transition of care policies
    - Provider directory information noting physical accessibility of provider offices and equipment

NOTE - These provisions apply to any rating period for contracts starting on or after July 1, 2017, except that transition of care policies are in effect as of the rating period for contracts starting on or after July 1, 2018

MLTSS

- *Element Two: Stakeholder Engagement*
  - States need to create and maintain a managed care stakeholder group to solicit feedback from beneficiaries, providers, and other stakeholders
  - Purpose is to ensure input in the design, implementation, and oversight of the MLTSS program
  - The composition of the stakeholder group and frequency of meetings must be sufficient to ensure meaningful stakeholder engagement

These provisions apply to any rating period for contracts starting on or after July 1, 2017

MLTSS

- *Element Five: Support for Beneficiaries*
  - Beneficiary Support System includes specific supports for individuals receiving MLTSS:
    - Access point for complaints or concerns on enrollment, access to services, or related matters
    - Educate beneficiaries on grievance and appeals process and resources available outside of the managed care plan
    - Review and oversight of LTSS program data to assist the State with identification and remediation of system issues

  Applies to rating period for contracts starting on or after July 1, 2018
  - Creates a new for cause disenrollment reason when a residential, institutional, or employment supports provider terminates their provider agreement and it results in a disruption to the enrollee's residence or employment

  Applies to rating period for contracts starting on or after July 1, 2017

MLTSS

- *Element Six: Person-Centered Process*
  - State needs to have a mechanism to identify individuals needing LTSS which would also be included in the comprehensive quality strategy
  - Assessments and treatment plans for individuals in need of LTSS and those with special health care needs must be comprehensive and conducted by service coordinators with appropriate qualifications
  - Treatment or service plans for individuals in need of LTSS need to conform with person-centered planning standards in the HCBS final rule released in 2014

Provision applies to any rating period for contracts starting on or after July 1, 2017

Improving Quality: Quality of Care

- Extends managed care quality strategy, QAPI (Quality Assessment and Performance Improvement Plans), and external quality review (EQR) to PAHPs and to PCCM entities whose contracts include financial incentives
- QAPI must include mechanisms to assess quality and appropriateness of care for enrollees of LTSS
- Adds two new elements to states' managed care quality strategies related to health disparities and long term services and supports
- Adds new mandatory EQR activity to validate network adequacy
- Improves transparency of quality information

Network Adequacy Standards – State Responsibilities

- States will develop and implement time and distance standards for:
  - Primary care – adult and pediatric;
  - Specialty care – adult and pediatric;
  - Behavioral health (mental health and substance use disorder) – adult and pediatric;
  - OB/GYN; hospital; pharmacy; and
  - Pediatric dental
- States will develop and implement network adequacy standards for MLTSS programs, including for providers that travel to the enrollee to render services
- States will set standards for the geographic scope of the managed care program – standards may vary due to geography

Implementation of HCBS Final Rule

- Published January 16, 2014
- Defines person-centered planning requirements for Home and Community-Based Services
- Defines, describes, and aligns HCBS setting requirements across three Medicaid authorities
  - ✓ 1915 (c) waivers
  - ✓ 1915 (i) state plan
  - ✓ 1915 (k) Community First Choice
- These requirements apply whether delivered under a fee for service or managed care arrangement

Medicaid IAP

- Four year commitment by CMS to build state capacity and support ongoing innovation in Medicaid through targeted technical assistance*
- A CMMI-funded program that is led by and lives in CMCS
- Supports states' and HHS delivery system reform efforts
  - The end goal for IAP is to increase the number of states moving towards delivery system reform across program priorities
- Not a grant program; targeted technical assistance

*IAP is a technical assistance model. IAP refers to "technical assistance" as "support," "program support" or "technical support"

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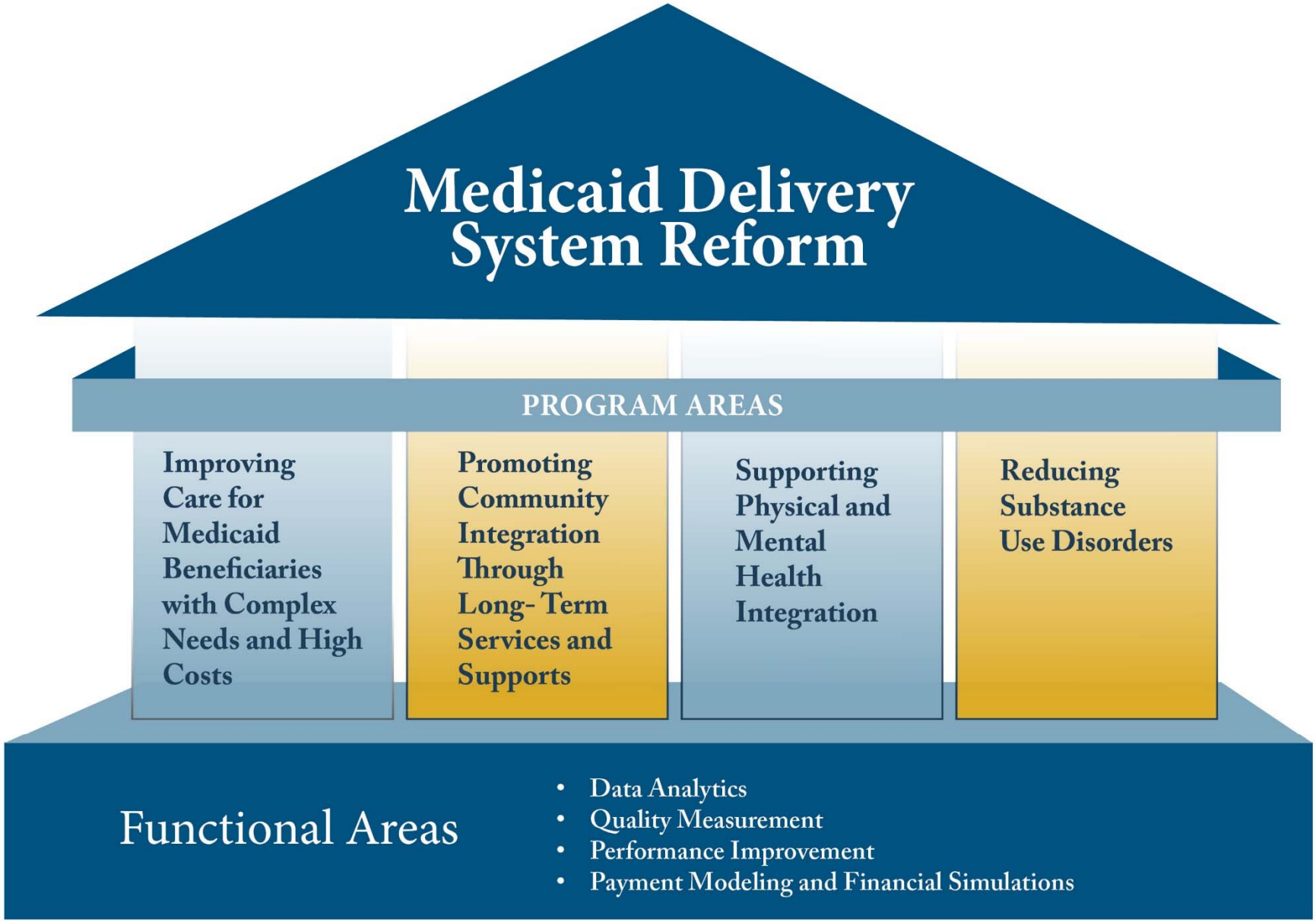
Medicaid Delivery System Reform
PROGRAM AREAS
Improving Care for Medicaid Beneficiaries with Complex Needs and High Costs
Promoting Community Integration Through Long- Term Services and Supports
Supporting Physical and Mental Health Integration
Reducing Substance Use Disorders
Functional Areas
• Data Analytics
• Quality Measurement
• Performance Improvement
• Payment Modeling and Financial Simulations

Considerations & Challenges

- State Fiscal Pressures
- Phase-out of Money Follows the Person and Balancing Incentive Programs
- Increased Focus on Quality
- Innovation and Delivery System Reform
- Increased Focus on Integrated Care
- Increased Focus on Quality
- Workforce
- Housing

HCBS RFI

What additional reforms would accelerate progress in access to HCBS and achieve an appropriate balance of HCBS and institutional services?

What actions would best ensure the quality of HCBS and beneficiary health and safety?

What program integrity safeguards ensure beneficiary safety and reduce fraud, waste and abuse in HCBS?

What are specific steps to strengthen the HCBS home care workforce, such as:

-Establishing standards for rates?

-Establishing minimum qualifications for HCBS workers?

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Resources

- **Main CMS HCBS Website:** http://www.medicaid.gov/HCBS
  - Final Rule & Sub-regulatory Guidance
  - A mailbox to ask additional questions
  - STP Toolkit Resources
- **Request for Information (RFI): Federal Government Interventions To Ensure the Provision of Timely and Quality Home and Community Based Services:** https://www.federalregister.gov/documents/2016/11/09/2016-27040/medicaid-program-request-for-information-rfi-federal-government-interventions-to-ensure-the

Questions

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LTSS Rebalancing Case Study - Background

- The Governor is considering Medicaid managed long-term services and supports (MLTSS) as a mechanism to meet a state goal: to advance rebalancing and shift HCBS spending from 30 to 40 percent of total LTSS spending over five years
- The Governor convenes a Task Force to vet this policy decision, consisting of you and several key stakeholders including:
  - Nursing facilities
  - Beneficiary advocates
  - Current HCBS waiver providers
  - Acute care Medicaid MCOs

LTSS Rebalancing Case Study - Activity

- Participate on Governor's Task Force charged with: developing one recommendation on whether—and why—Plutopia should or should not implement Medicaid MLTSS to encourage LTSS rebalancing
- Discuss and develop talking points per each question:
  1. What are your main arguments for or against MLTSS?
     - » Which arguments are most and least politically feasible?
  2. What are major concerns of the key stakeholder groups (described above any other others) and how do you address them?
  3. How can you ensure your platform is person-centered and focuses on beneficiaries first?
  4. What is your group's recommendation?