NASUAD
National Association of States United for Aging and Disabilities

Managed Long-Term Services and Supports

Pre-Conference Intensive
2017 HCBS Conference

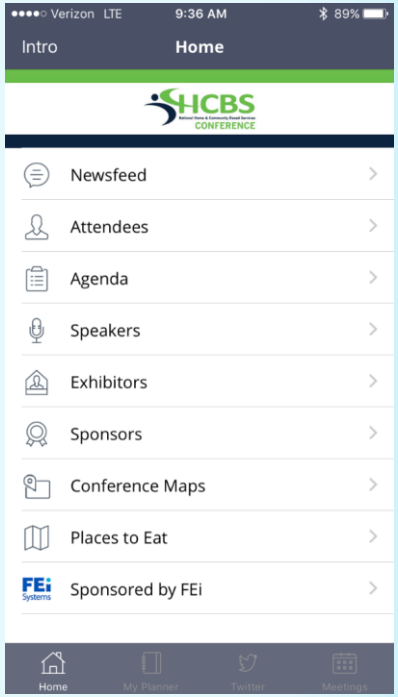
Camille Dobson
Deputy Executive Director

Welcome to the HCBS Conference

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

Download the HCBS Conference App

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



Connect to the Complimentary HCBS Wifi

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 Medicaid managed care plans who are capitated and are at-risk for all covered benefits.

- Plans can be a national for-profit company, a non-profit company, and even hospitals and other providers who operate an insurance product.

- In many cases, plans are covering medical services as well, which provides a comprehensive delivery system for beneficiaries

Why Do States Choose an MLTSS Delivery System?

- In FFY 2015, LTSS expenditures represented about 30% of all Medicaid expenditures (~$158B) [1]
  - These services still constitute the largest group of Medicaid services remaining in traditional fee-for-service systems in over half the states (even with growth in MLTSS programs)
  - Fragmented approach to the 'whole person'
  - Of note: since FFY 2012, managed care expenditures have grown 182% (to 18% 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 2017

[2] MACPAC, June 2014 Report, Chapter 2

Why Do States Choose an MLTSS Delivery System?

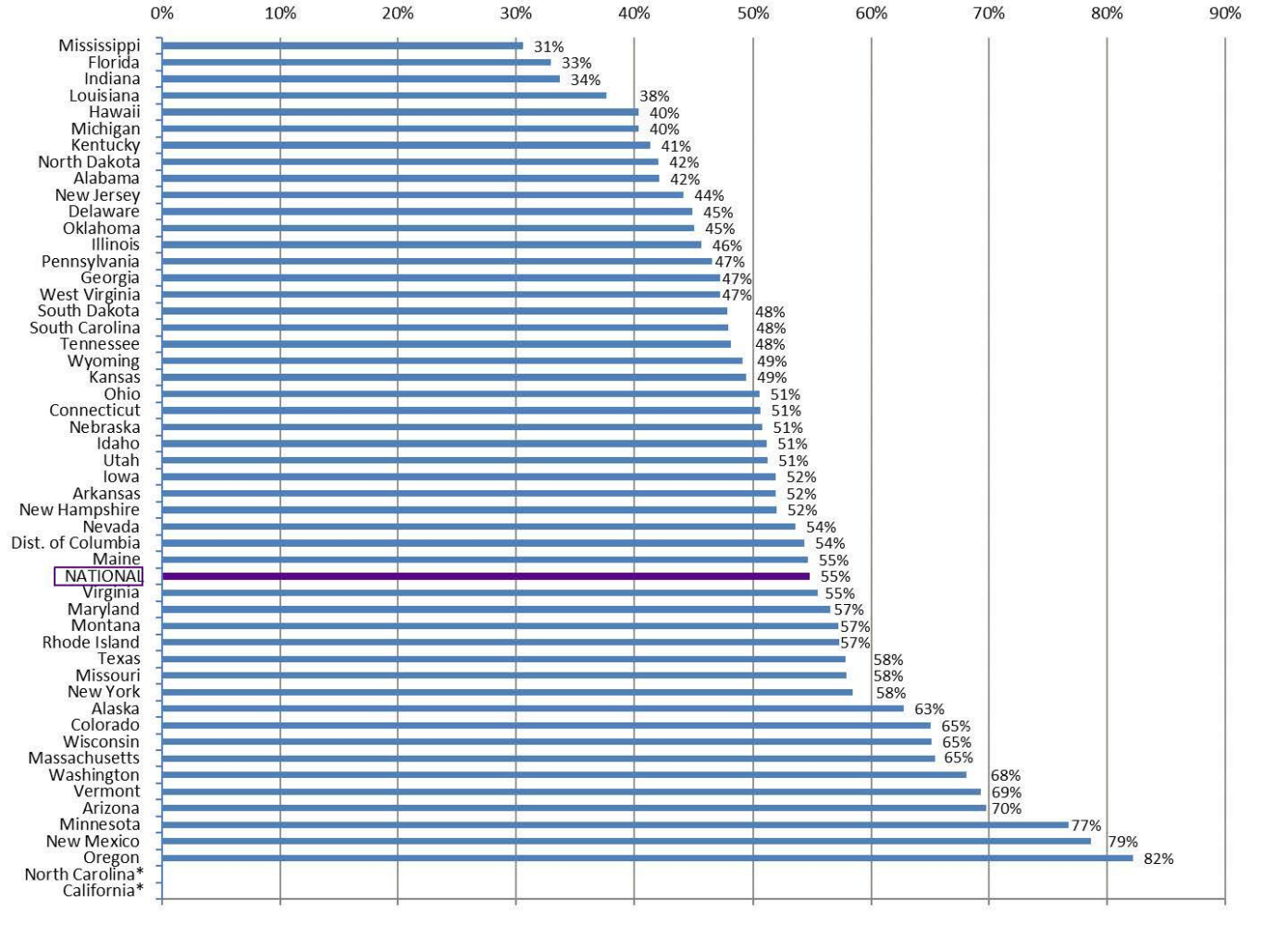
- Accountability and quality improvement rests with a single entity
  - Integrating acute and long-term care makes the consumer (rather than their ‘services’) the focus
  - Improved quality can follow in all aspects of consumer’s life
  - Financial risk for health plan provides opportunity to incentivize performance for health outcomes and quality of life
- Administrative simplification
  - Eliminates need to contract with and monitor hundreds/thousands of individual LTSS providers
  - Can build on managed care infrastructure to provide support to members

Why Do States Choose an MLTSS Delivery System?

- Budget Predictability
  - Capitation payments greatly minimize unanticipated spending
  - Can more accurately project costs (especially with LTSS as enrollment doesn't have as much variation based on economic circumstances)
- Shift focus of care to community settings
  - Most consumers express preference for community-based services
  - Health plans may be able to effectuate transfers from institutions to community more easily

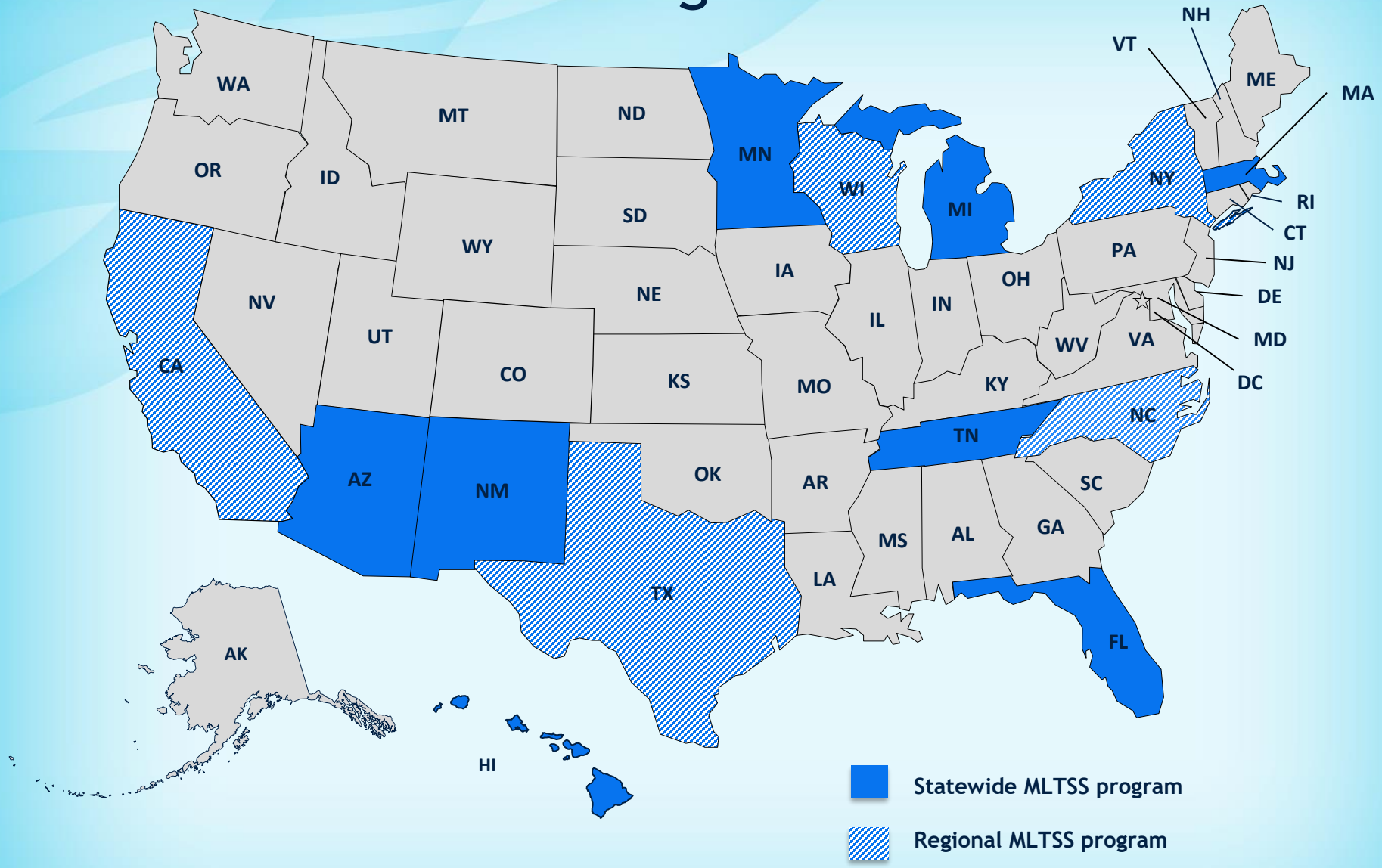
And this…….

HCBS Expenditures as % of all LTSS Expenditures, FFY 2015



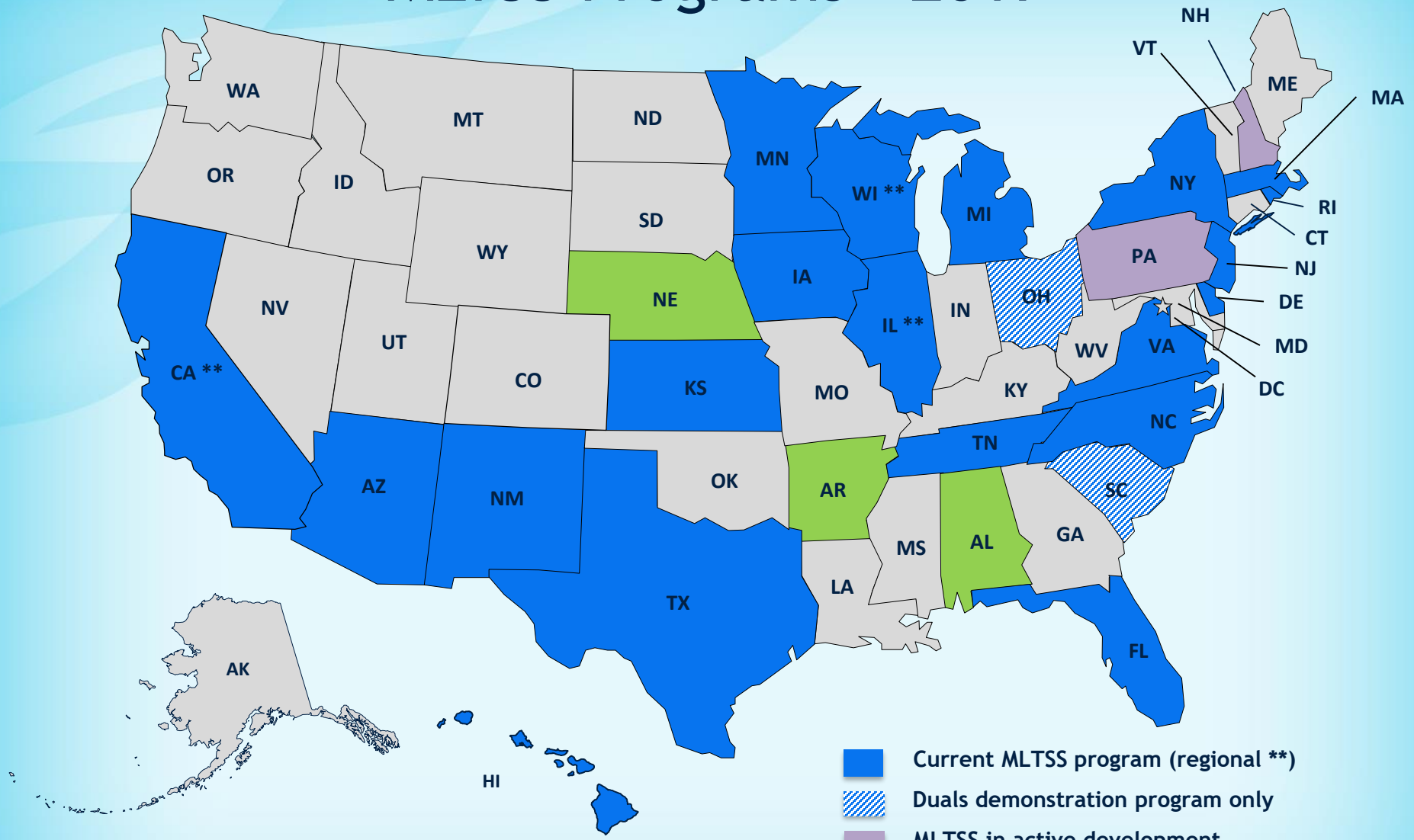
Source: Truven Health Analytics, June 2017

MLTSS Programs - 2010



Source: Truven Health Analytics, 2012

MLTSS Programs - 2017



Source: NASUAD survey; CMS data

Keys to Success for any MLTSS Program

- State must take responsibility for the success of the program
- It is a multi-faceted approach including:
  - MCO contract
  - MCO expectation-setting/training
  - Consumer and provider education
  - Beneficiary support system
  - State oversight and monitoring
- All of this can be imperiled WITHOUT thoughtful planning and design in collaboration with stakeholders and implementation timeframes that accommodate systemic change

Keys to Success for any MLTSS Program

1. Transparency and Stakeholder Engagement – early and often
2. Strong Care Coordination Requirements
3. Appropriate Network Adequacy Standards
4. Provider Contracting and Training (before start-up)
5. Consumer Protections
6. Timely Assessments and Service Delivery
7. Minimized Payment Anxiety
8. Collaboration with Health Plan Partners
9. Strong State Oversight and Accountability Mechanisms

Trends for 2018 and beyond

- MLTSS continues to be the biggest trend/opportunity for states to address accountability, cost efficiency and better outcomes for consumers
- NEW programs (PA, NC, AR, AL) or expansion of existing programs
- Inclusion of LTSS services for individuals with intellectual/developmental disabilities in MLTSS programs
- Focus on quality – concern about putting plans in charge of service plans has amplified calls for outcome measurement

Trends for 2018 and beyond

- States without managed care capacity OR hostility toward managed care looking at managed FFS alternatives (ie. ACOs with shared savings), or provider-led arrangements (although if taking risk, it's really an MLTSS program)
- States starting to expand P4P/VBP efforts from NFs and other large providers to HCBS providers
  - Nascent effort due to lack of standardized measures and need for significant stakeholder engagement
- More and more focus by MCOs on member's social determinants of health and caregiver supports

Context for today's intensive

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

- We picked 4 today (among many still out there)
  - MLTSS program management is complex
  - Caregiver supports becoming ever more important
  - Social determinants of health = supports for members
  - Measuring MLTSS quality continues to be a challenge

Context for today's intensive

- Goal for intensive: Share learnings on ongoing challenges in MLTSS for states, health plans, providers and consumers

- Outcome of intensive: Leave with greater understanding of each area and how innovations underway in states and plans could improve and/or inform MLTSS programs in your state.

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

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

Community HealthChoices

MLTSS Intensive: Lessons from the Field-Program Design and Implementation
August 28, 2017

Jennifer Burnett
Deputy Secretary
Office of Long-Term Living
Department of Human Services

pennsylvania
DEPARTMENT OF HUMAN SERVICES

PROGRAM DESIGN FEATURES

- LTSS and Medicare-Medicaid duals
- 3 Statewide MCOs
- Physical Health and LTSS
- Behavioral Health Carve out
- ID Carve out
- 1915(b)(c) waiver—mandatory MC
- Coordination with Medicare
- Innovation

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PROGRAM DESIGN DECISIONS

- Mandatory Managed Care Program
- PA Managed Care Experience
- Medical Model v. Social Model
- Feedback from Stakeholder engagement
- DHS organizational structure and readiness
- Project management and governance
- Phased Implementation
- Rate Configurations

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STAKEHOLDER ENGAGEMENT: INITIAL

- Discussion Document
- 6 Listening Sessions
- Concept Paper
- Public comment on Draft Agreement and RFP
- Advisory Committees

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STAKEHOLDER ENGAGEMENT: PARTICIPANT

MLTSS SUBMAAC

- Monthly meetings

AWARENESS FLYER

- Mailed five months prior to implementation. Southwest: August 2017

AGING WELL EVENTS

- Participants will receive invitations for events in their area. Southwest: September & October 2017

SERVICE COORDINATORS & NURSING FACILITY STAFF

- Will reach out to their participants/residents to inform them about CHC. Southwest: September 2017

NURSING FACILITIES

- Discussions about CHC will occur with their residents. Southwest: September 2017

PRE-TRANSITION NOTICE AND ENROLLMENT PACKET

- Mailed four months prior to implementation. Southwest: September 2017

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STAKEHOLDER ENGAGEMENT: ONGOING

- MLTSS SubMAAC
- Third Thursday Webinars
- Provider Communications
- Provider Summits
- Partnership with Pennsylvania Health Funders Network
- Monthly meetings with provider association
- Video and website
- Media inquiries

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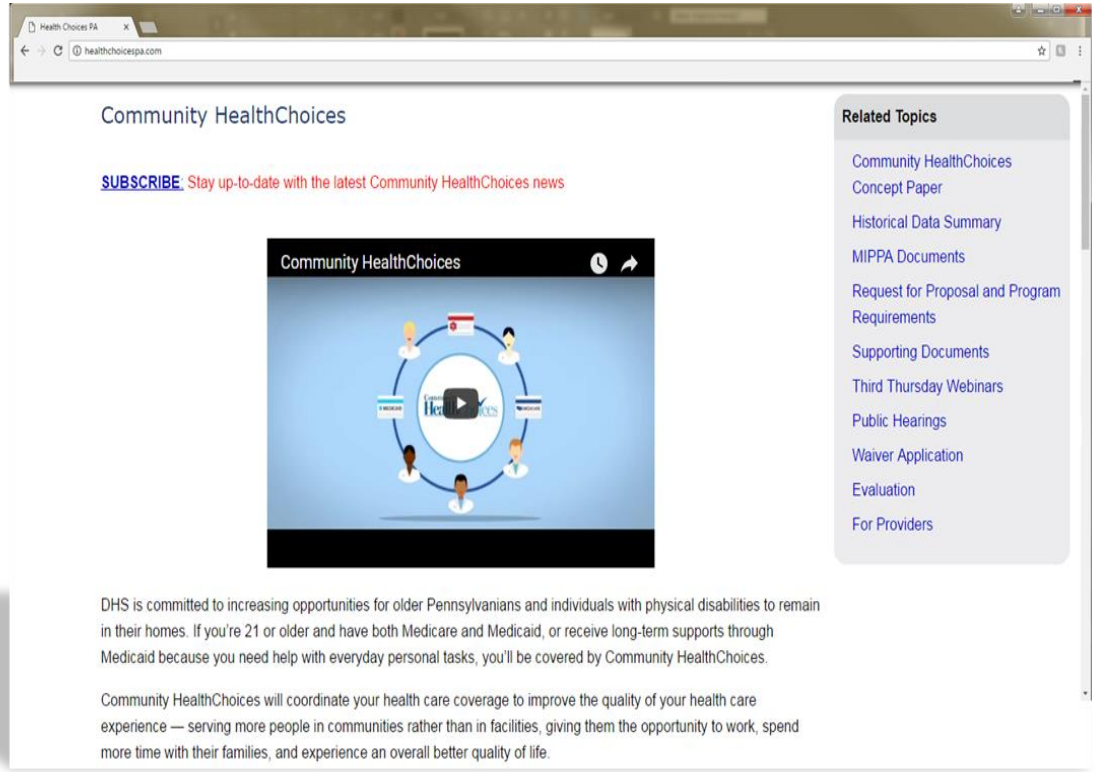
PROVIDERS

- Bi-weekly email blasts on specific topics
  - ✓ Examples: Billing, Service Coordination, Medicare, HealthChoices vs. CHC, Continuity of Care
- Established provider page on website
- Provider events in local areas to meet with MCOs and gain information about CHC

CHC WEBSITE



www.HealthChoices.PA.gov

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WHAT ARE THE GOALS OF CHC?

GOAL 1

Enhance opportunities for community-based living.

GOAL 2

Strengthen coordination of LTSS and other types of health care, including all Medicare and Medicaid services for dual eligibles.

GOAL 3

Enhance quality and accountability.

GOAL 4

Advance program innovation.

GOAL 5

Increase efficiency and effectiveness.

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PRIORITIES THROUGH IMPLEMENTATION

ESSENTIAL PRIORITIES

- No interruption in participant services
- No interruption in provider payment

HOW WILL WE ENSURE NO INTERRUPTIONS?

- The Department of Human Services (Department) is engaged with the MCOs in a rigorous readiness review process that looks at provider network adequacy and IT systems.
- The Department of Health must also review and approve the MCOs to ensure they have adequate networks.

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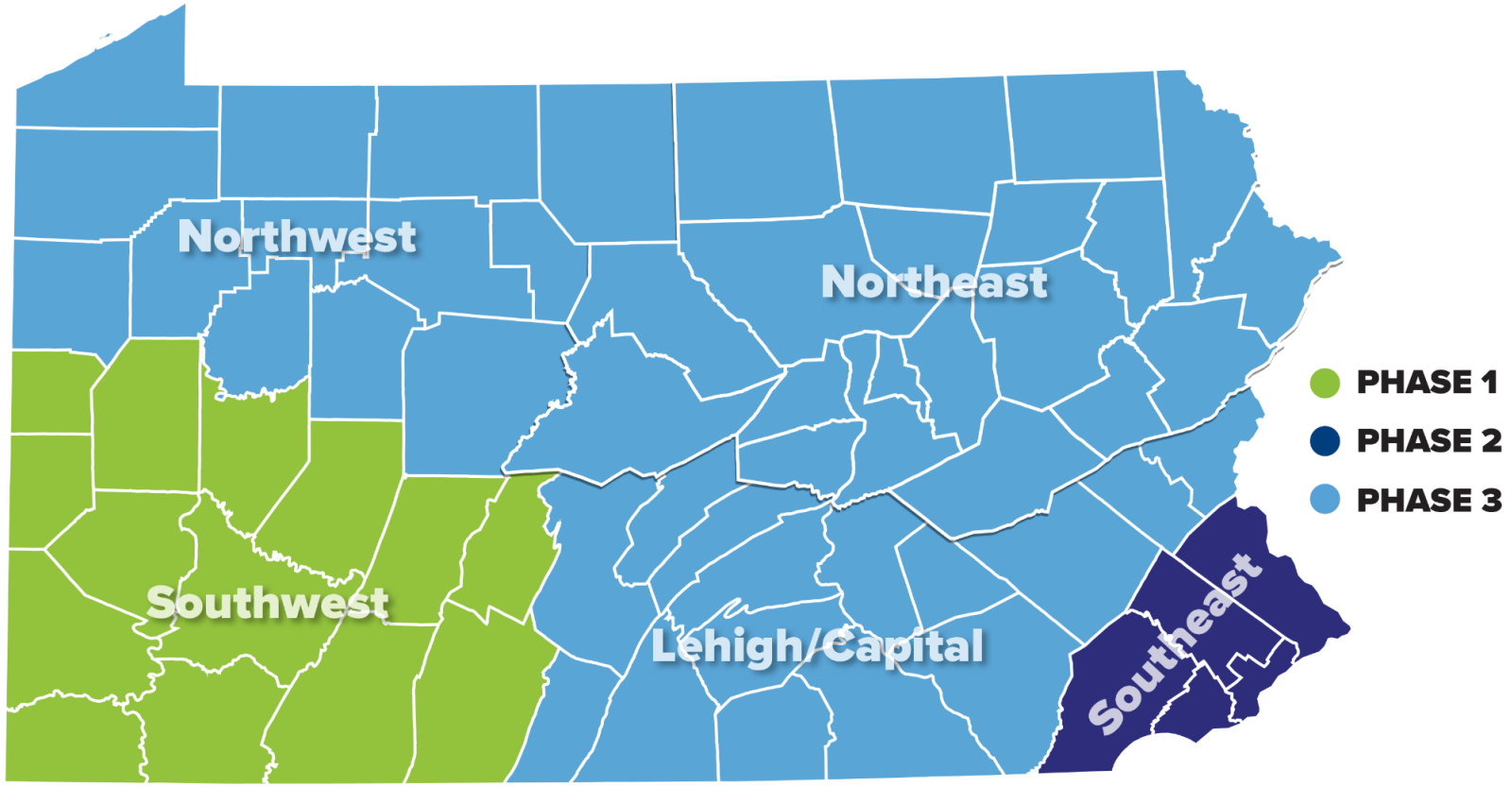

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MANAGED CARE ORGANIZATIONS

- The selected offerors were announced on August 30, 2016.

AmeriHealth Caritas Pennsylvania	CHCProviders@amerihealthcaritas.com
pa health & wellness	information@pahealthwellness.com
UPMC Community HealthChoices	CHCProviders@UPMC.edu

Community HealthChoices

Contact Information:

Jennifer Burnett

jenburnett@pa.gov

www.healthchoicespa.gov

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Commonwealth Coordinated Care

Medicare & Medicaid working together for you

Plus

Commonwealth Coordinated Care Plus

Your Health. Your Care.

VIRGINIA'S COMMONWEALTH COORDINATED CARE PLUS MLTSS PROGRAM

Karen Kimsey, Deputy Director
Department of Medical Assistance Services
Commonwealth of Virginia
Karen.Kimsey@dmas.virginia.gov

Virginians Covered by Medicaid/CHIP

1 in 8 Virginians rely on Medicaid

Medicaid is the primary payer for **behavioral health** services

Medicaid covers **1 in 3** births in Virginia

50% of Medicaid beneficiaries are children

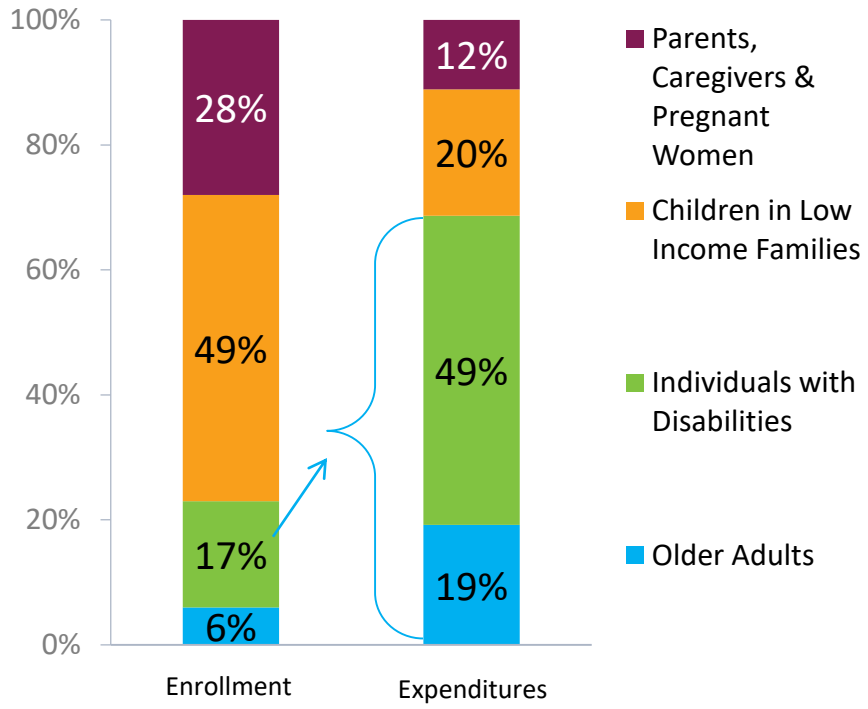
2 in 3 nursing facility residents are supported by Medicaid

62% of long-term services and supports spending is in the community

Medicaid plays a critical role in the lives of over 1 million Virginians

Virginia Medicaid: Enrollment & Expenditures

Enrollment vs. Expenditure SFY 2016



1.3 M Enrolled

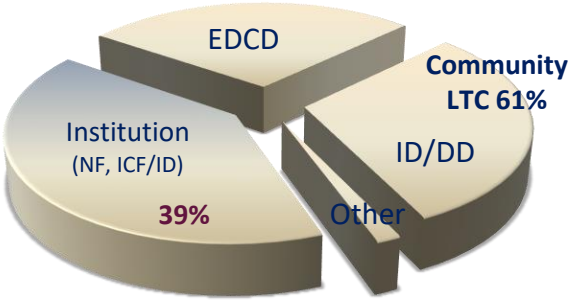
$8.41 B Spent

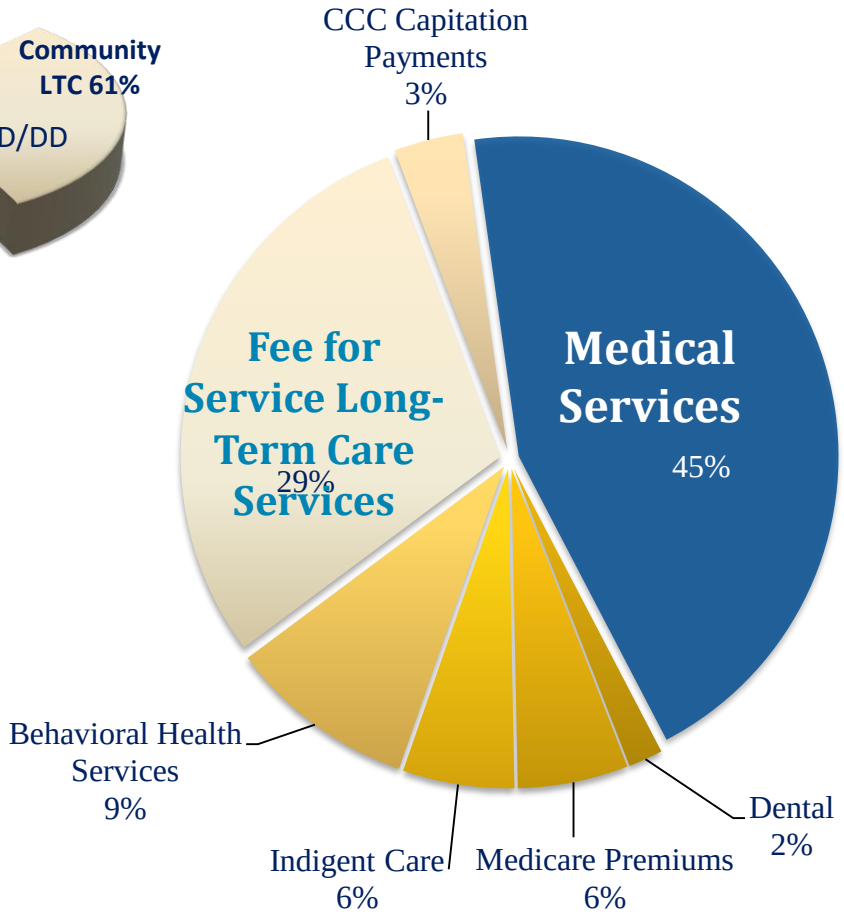
23% of the Medicaid population **Drives** **68%** of total expenditures

Expenditures are disproportionate to population where services for older adults and individuals drive a significant portion of Medicaid costs

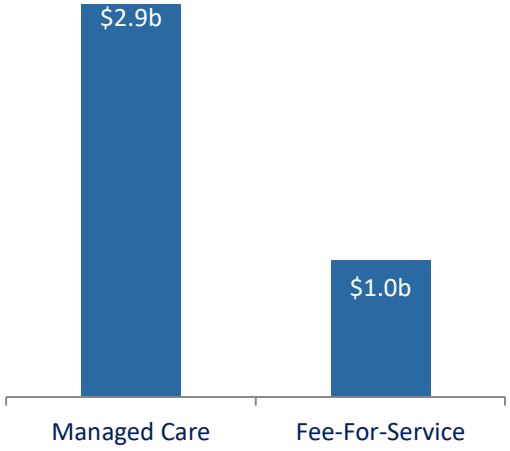
Virginia's Medicaid Expenditure Breakdown – SFY 2016

FFS Long Term Care Expenditures

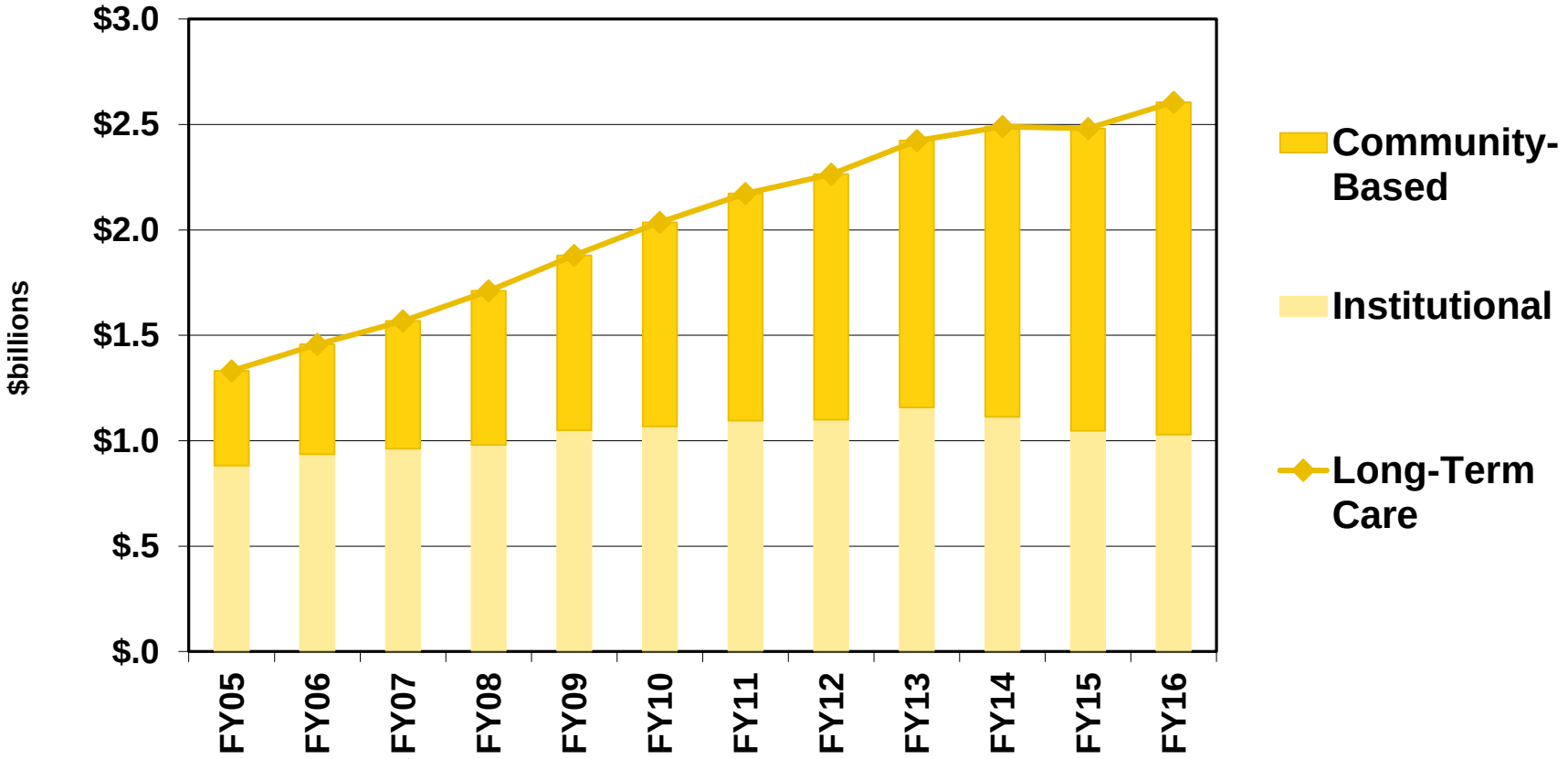




Medical Services by Delivery Type



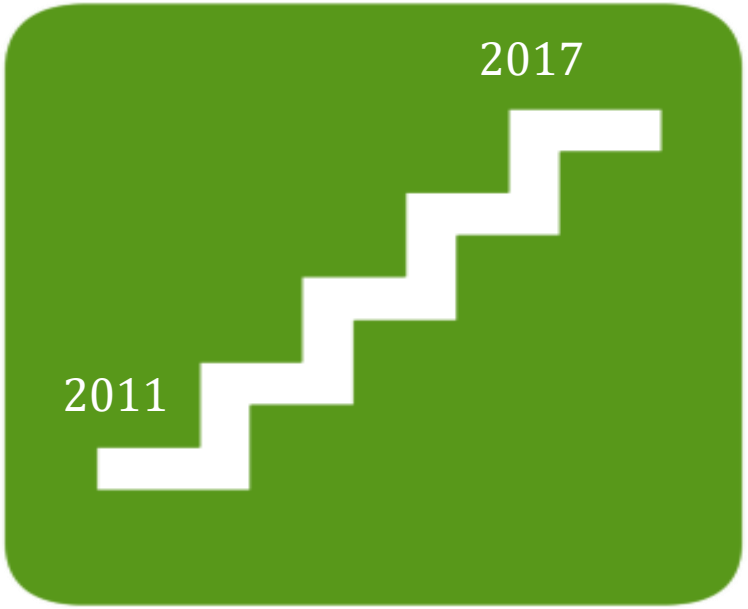
Virginia Medicaid Expenditures – Rebalancing Long-Term Services and Supports



Notes:
Average annual growth total fee for service Long Term Care services: 6%
Average annual growth Institutional services: 1%
Average annual growth Community-Based services: 12%
Proportion of Long Term Care services paid through Community-Based care has increase from 36% in FY05 to 61% in FY16

Virginia Legislative Support

Bipartisan support from the legislature to transition individuals from the fee-for-service delivery model into the Managed Care Model to achieve high quality care and budget predictability.



Commonwealth Coordinated Care (CCC): Virginia's Duals Demonstration

Primary goal is to improve health outcomes of Duals through alignment of Medicare and Medicaid benefits

- Financial Alignment Demonstration began in March of 2014; currently serving 30,000+ dually eligible individuals across 5 regions of the Commonwealth
- Participation is **voluntary**
- Integrated delivery model that includes medical services, behavioral health services and long term services and supports (LTSS) provided by three health plans
- Care coordination and **person centered care** with a interdisciplinary team approach

Care Coordination Works!
Improving Beneficiary Quality of Care

"If I had to put a number on the whole Medicaid/Medicare insurance, as far as making [my] quality of life better, I would have to give it a 10. Because it has evolved so much now that it's enough even in the medical stance and getting you [out of] the house and helping you not to sit in the house wasting away. … When I was no longer able to walk, I had to depend on the Muscular Dystrophy Foundation to help me get a lot of my stuff. Now Medicaid [MMP] helps me get it or Medicare helps me get it. You have somebody to talk to now. They call you, like I say, once a month, make sure everything's all right, make sure the quality of life is still there, if there's [anything] they can do to help."

- CCC enrollee

Where Do We Go From Here: CCC Plus

VISION: To implement a coordinated system of care that builds on lessons learned and focuses on improved quality, access and efficiency

1. Provide individuals with high-quality, person centered care and enhanced opportunities to improve their lives

2. Improve community-based infrastructure and community capacity to enable/ support care in the least restrictive and most integrated setting

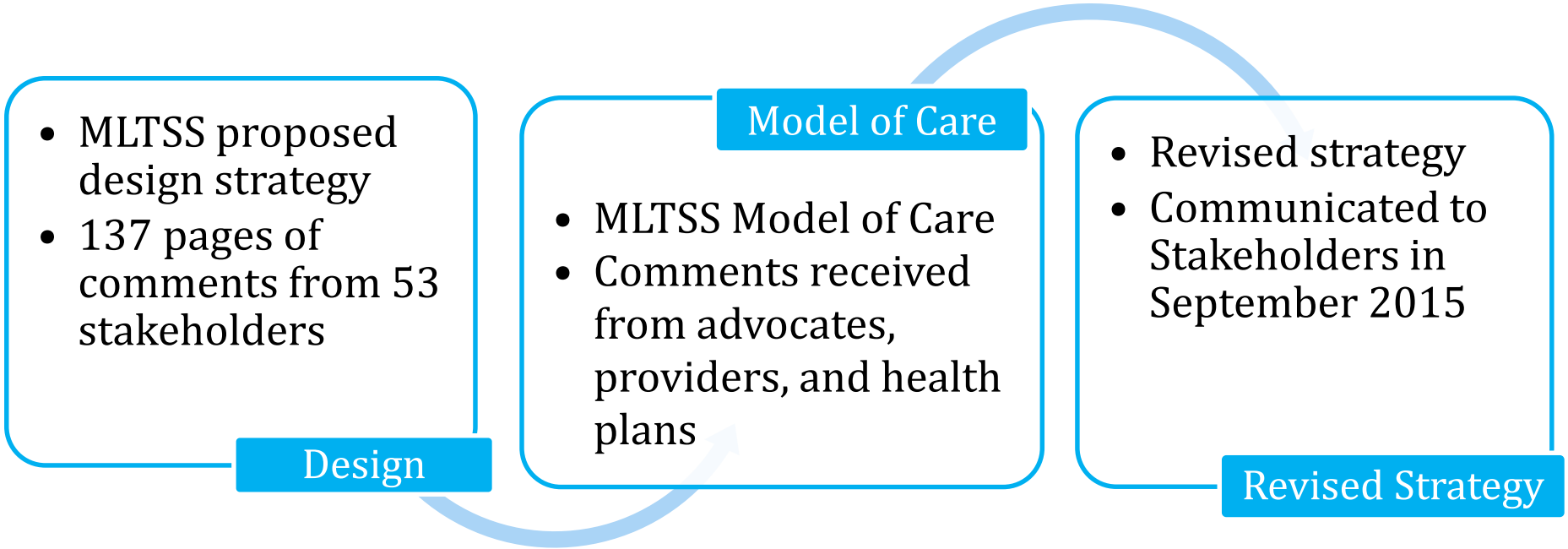
3. Promote innovation and value-based payment strategies

4. Provide care coordination and better accommodate progressive needs of members

5. Better manage and reduce expenditures; reduce service gaps and the need for avoidable services, such as hospitalizations and emergency room use

Stakeholder Input

Stakeholder input significantly informed the DMAS CCC Plus program design and implementation strategy



Key Differences

CCC Plus	CCC
Statewide in 6 regions	5 of the 6 regions
Required Enrollment: ~217,000	Optional Enrollment: ~30,000
Duals/non-duals, children/adults, NF and 5 HCBS Waivers	Full Dual adults; including NF and EDCD HCBS Waiver
6 Health plans across 6 regions	3 Health plans across 5 regions
Coordination of Medicare benefits through companion DSNP	Coordination of Medicare benefits through same Medicare Medicaid Plan
Continuity of care period is 90 days	Continuity of care period is 180 days

Major Program Design Changes

Data

- Collect Robust Encounters and Clinical Data
- Enhanced Care Management Activities
- Enhanced monitoring, oversight and reporting

Quality

- Care Coordination for all Members with Ratios
- Quality Studies and Measures
- Quality Withholds

Common Core Formulary

- DMAS PDL is the CCC Plus Common Core Formulary
- Enhances Continuity of Care
- Decreases Admin Burden for Prescribers

CCC Plus Program Roadmap

- RFP; find high-quality plans (draft, publish, evaluate, negotiate, award, readiness begins)
- Program Authority - 1915 b/c Waivers, Regulations, MCO Contracts
- Systems enhancements; testing with plans and providers
- Readiness with plans, providers, internal staff, and stakeholders (minimum of 6-9 months)
- Ongoing stakeholder & member engagement, outreach and education (webinars, townhalls, etc.)
- Program launch in regional phases
- Ongoing program monitoring and evaluation
- Anticipate implementation issues; respond quickly and effectively; keep stakeholders informed

6 Health Plans Contracted Statewide

- Aetna Better Health of Virginia
- Anthem HealthKeepers Plus
- Magellan Complete Care of Virginia
- Optima Health
- United Healthcare
- Virginia Premier Health Plan

A list of CCC Plus regions by locality is available at: http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx

CCC Plus Regional Program Launch

Aug 1, 2017 – Jan 1, 2018

Assignment happens on the 18th of the month

Tidewater Assign 6/18/17	Central Assign 7/18/17	Charlottesville Assign 8/18/17	Roanoke, & Southwest Assign 9/18/17	Northern & Winchester Assign 10/18/17

June	July	Aug	Sept	Oct	Nov	Dec

Tidewater Effective 8/1/17	Central Effective 9/1/17	Charlottesville Effective 10/1/17	Roanoke & Southwest Effective 11/1/17	Northern & Winchester Effective 12/1/17

CCC Plus effective date

CCC and ABD assignment 11/18/17; effective 1/1/18

Thank You!

For More Information . . .

Additional CCC Plus information is available at:

http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

DELAWARE MLTSS
PAST PRESENT & FUTURE

Kathleen D. Dougherty
Chief, Managed Care Medicaid Operations
Delaware Medicaid & Medical Assistance

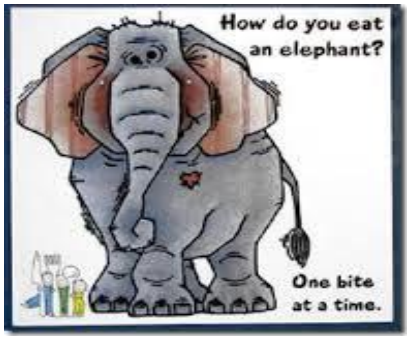
PAST: 2012 -2015

- Contacted CMS June 2011 Implemented MLTSS in Delaware April 2012
- MLTSS included:
  - Adult and Child Nursing Facility Residents
  - 1915c Elderly & Physically Disabled and AIDS Waiver Participants
  - Money Follows the Person (MFP) Demonstration Participants
  - Full Benefit Dual Eligibles (Medicaid/Medicare)
- 2014 to 2015 Evaluate Program:
  - Talk to stake holders for input into the Medicaid program
  - Established New Contract and go out for Managed Care Bid

Present: 2015-2017

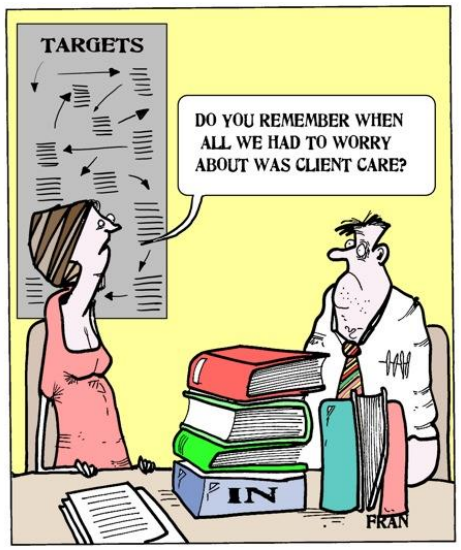
- Evaluate the program ~ What's working – What's not
- Managed Care Provider Contracts
- Same Goal: Promote the achievement of the Triple Aim+1
  - Need innovative approaches to improve the quality and delivery of services
  - Focus on Member Satisfaction and Active Participation

Future:2018- 2020



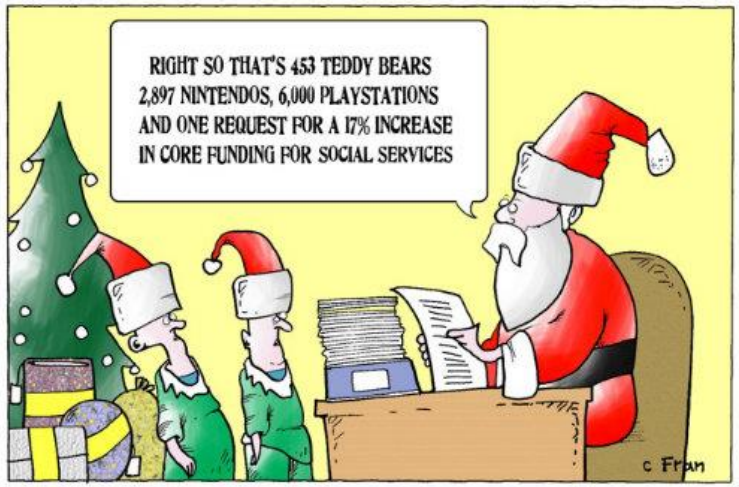
- NCI-AD Survey is the Key to understanding the Member Perspective
  - Drive innovation in person-centered planning approaches
  - Adopt more robust measurement of meaningful outcomes
- Adopt innovation in payment approaches:
  - Pay-for-Quality (P4Q)
  - Total Cost of Care (TCC) models
- Incorporate Social and Economic Determinants of Health
- RFQ is the start of change for the Diamond State Health Plan and upcoming 1115 Waiver Renewal

LESSONS:



- Evaluation of your Program is Key
- Change really is O.K.
- You have to be a Good Partner to get a Good Partner

Kathleen D. Dougherty
Chief, Managed Care Medicaid Operations
Division Medicaid & Medical Assistance
Delaware Health & Social Services
Kathleen.Dougherty@state.de.us



Focusing on Caregiver Supports in MLTSS

Home and Community-Based Services Conference

Monday, August 28, 2017

Wendy Fox-Grage

AARP Real Possibilities
Public Policy Institute

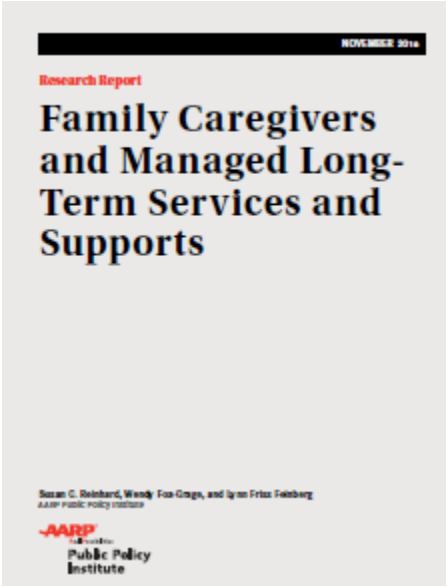
Our Report

Family Caregivers & Managed Long-Term Services and Supports

1st major research report in this emerging field

Acknowledgement of AARP Roundtable and Learning Collaborative

www.aarp.org/familycaregiversandMLTSS



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Rationale for Focusing on Family Caregivers and Managed Long-Term Services and Supports

- Family caregivers are major providers of care
- Some family caregivers are in need of support themselves
- Managed long-term services and supports is rapidly expanding
- Managed care plans can lead the way toward person- and family-centered care

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Emerging Issue

Family caregiving supports is not commonplace in managed long-term services and supports

Focus has been on the individual member, not the family unit

Stakeholders have focused on “preventing harm” and consumer protections

Several promising practices and lots of opportunities

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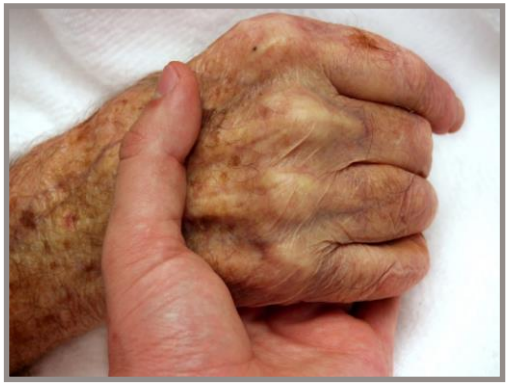
Family Caregiving



- An estimated 40 million family caregivers provide about 37 billion hours of care
- Most (60%) also have paid jobs
- Nearly half (46%) perform medical/nursing tasks

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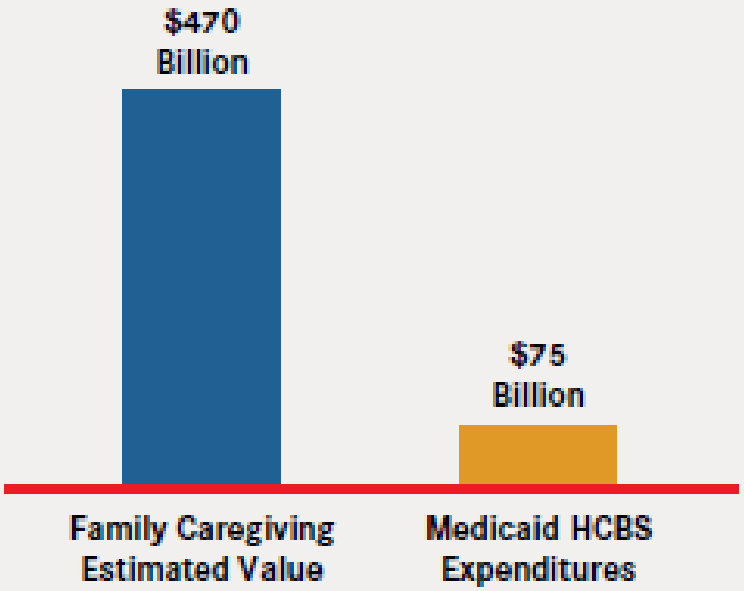
Estimated Value of Family Caregiving & Medicaid Home and Community-Based Expenditures, 2013



Sources: Susan C. Reinhard, et al., *Valuing the Invaluable 2015 Update: Undeniable Progress, but Big Gaps Remain* (Washington, DC: AARP Public Policy Institute, July 16, 2015); Steve Eiken, et al., *Medicaid Expenditures for Long-Term Services and Supports in FY 2013*, (Cambridge, MA: Truven Health Analytics, June 30, 2015).

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Caregiving in the U.S.

- Only 1 in 3 (32%) family caregivers said a doctor, nurse or social worker ever asked them about what was needed to care for their relative/close friend

- Half as many (16%) said a health provider had asked what they need to care for themselves.

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Caregivers Can Be At-Risk Themselves

Family caregivers can experience enormous stress from their responsibilities

- Physical demands
- Financial burdens
- Workplace issues from juggling caregiving & work
- Loss of employment income & benefits/retirement insecurity
- Emotional strain/mental health problems
- Social isolation

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Caregivers Can Be At-Risk Themselves (con't)

- The stress on family caregivers can lead to negative consequences:
  - Impede the caregiver's ability to continue providing care
  - Lead to higher costs for health care and LTSS for the care recipient
  - Affect quality of care and quality of life for *both* the care recipient and family members.

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Moving Toward Person- and Family-Centered Practices

- Support for family caregivers is a key component of a high-performing LTSS system
  - AARP State LTSS Scorecard, www.longtermscorecard.org

- Practitioners must consider not only how the family caregiver can help the care recipient, but also what support the family needs
  - *Person- and family-centered perspective*

- Viewing family not just as "resources" but as "clients"

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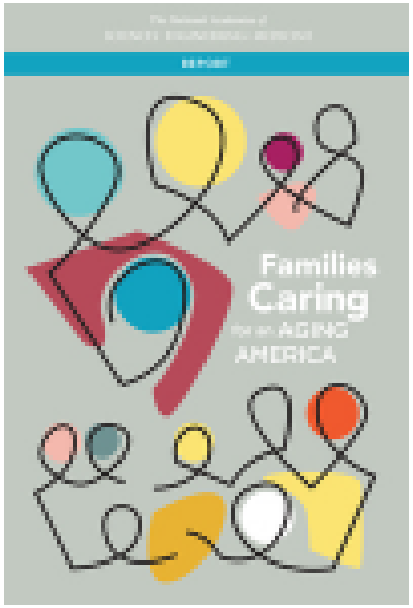
- Managed care plans are suited to operationalize recommendations from the National Academies' report on "Families Caring for an Aging America"

- Capitated payments can incentivize MLTSS plans to engage and support family caregivers, especially with evidence-based programs



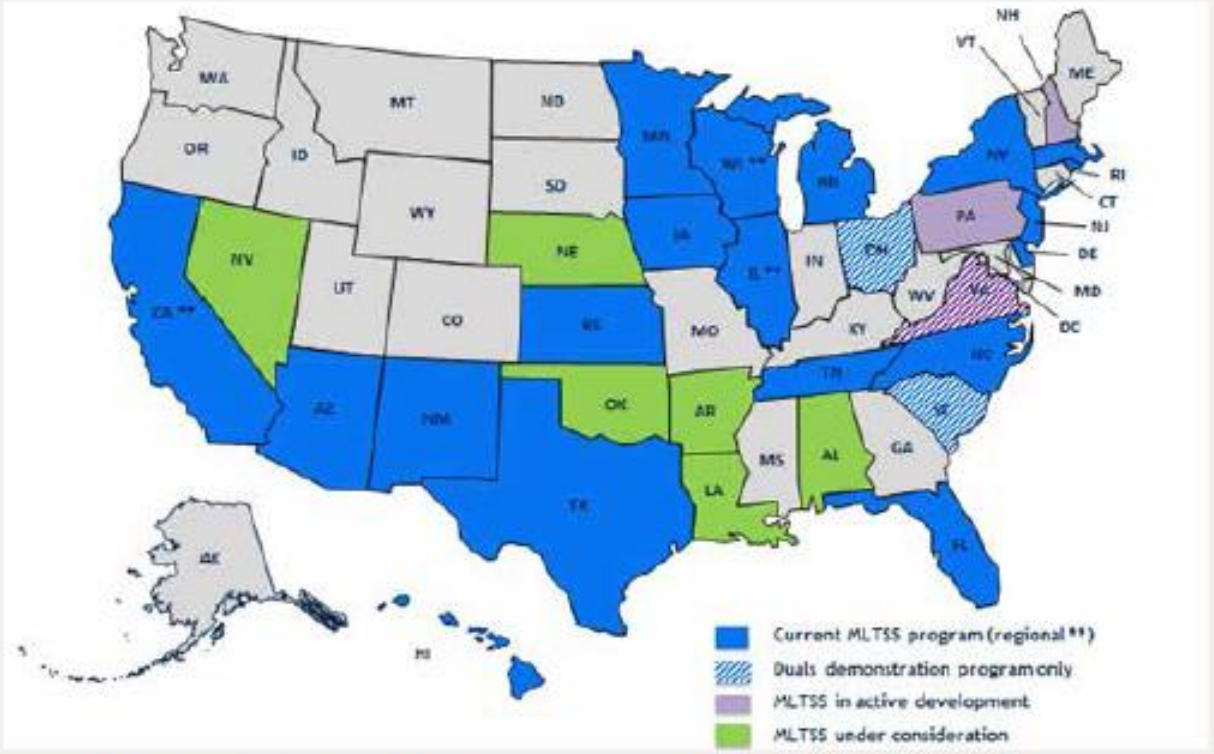
AARP
Real Possibilities
Public Policy Institute

How can managed care plans help family caregivers?

- The medical record and service plan can identify family caregivers.
- Family caregivers can participate in care planning.
- Family caregivers and care coordinators can have each others' contact information.
- Care coordinator can refer them to learning caregiving skills such as administering meds and wound care.
- Care coordinator can refer them to respite care and other needed services.

AARP Real Possibilities
Public Policy Institute

States with Medicaid Managed LTSS Programs, August 2016



Source: Camille Dobson, NASUAD, emailed to authors with permission on 8/26/16.

AARP Real Possibilities

Public Policy Institute

Truven Study for AARP: 19 Managed LTSS Contracts

Acknowledge-ment of Family Caregivers	Care Coordinator Contact Info Given to Family Caregivers	Training of Family Caregivers is a Covered Benefit
15 state contracts	9 state contracts	3 state contracts

AARP Real Possibilities
Public Policy Institute

Promising Practices

TennCare

South Carolina Healthy Connections Prime

UnitedHealthcare

Cal MediConnect Dementia Project

Public Policy Institute

TennCare Contract Language & Needs Assessment Protocol

Family Caregiver: Broadly defined as "routinely involved in providing unpaid support and assistance to the member"

Typically assessed face-to-face:

- Once a year,
- Upon a significant change, or
- When recommended by the care coordinator.

Assessment for one or more family caregivers.

Caregiver's role determined, health and well-being assessed, and training and other needs identified.

AARP Real Possibilities
Public Policy Institute

Cal MediConnect Dementia Project

- Promising practice for family caregivers of people with dementia in California's dual Medicare-Medicaid demonstration in 7 counties

- Cal MediConnect is a project run by the Alzheimer's Greater Los Angeles, other Alzheimer's groups, and the CA Department of Aging and receives funding from U.S. Administration for Community Living

AARP
Real Possibilities
Public Policy Institute

Cal MediConnect Dementia Project

The Dementia Care Management Toolkit, an evidence-based toolkit, was developed for care managers and family caregivers

- A tool for identifying family caregivers
- A caregiver stress and strain instrument
- A caregiver needs assessment
- Plain language fact sheets

The toolkit can be downloaded at www.alzgla.org
Plans can make referrals to Alzheimer's of Greater Los Angeles for supportive services
University of California, San Francisco is the independent evaluator

AARP Real Possibilities
Public Policy Institute

Findings & Recommendations

Plans have a strong financial incentive to support family caregivers since they can make it possible for the member to live at home.

Helping to prevent caregiver burnout can delay or prevent more costly nursing home placement.

Managed LTSS can lead the way by addressing the needs of family caregivers and improving the experience of care.

Plans should involve family caregivers, especially when the care plan depends on them.

Family caregivers' feedback and involvement can help ensure better quality.

AARP Real Possibilities
Public Policy Institute

Next Steps

AARP Public Policy Institute has commissioned Health Management Associates to conduct an inventory of promising practices of Medicaid managed care plans.

To be published in late 2017.

AARP Real Possibilities
Public Policy Institute

Delivering the Next **Generation** of Health Care

Caring for the Caregiver

AmeriHealth Caritas

CARE IS THE HEART OF OUR WORK℠

National Association of States United for Aging and Disabilities (NASUAD)
Baltimore, Maryland

Sharon Alexander
President, Long-Term Services and Supports (LTSS) Solutions
August 28, 2017

Agenda

Who is AmeriHealth Caritas?

Why is family caregiving important to us?

Family caregiving and managed long-term services and supports (MLTSS) promising practices and new approaches:

- South Carolina Medicare-Medicaid plan (MMP).
- Pennsylvania MLTSS.

WHO WE ARE

Committed.
Connecting more than 5.7 million members with critical, high-quality health care services.

Experienced.
Delivering proven, integrated health care services in 17 states and the District of Columbia.

Multifaceted.
Providing Medicaid, Medicare, behavioral health services, pharmacy benefit management, LTSS, third-party management, and administrative services.

Rooted.
We began as a mission-driven neighborhood health plan in West Philadelphia and are proud of our passion to serve those most in need.

Nimble.
Customizing solutions based on our members' and partners' needs.

Award winning.
National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction Award recipient.

Evolving.
An industry thought leader giving its customers the edge with innovative, evidence-based products and services.

Leading Managed Care Organization

Owned by two leading Blue companies: Independence Health Group (majority) and Blue Cross Blue Shield of Michigan (BCBSM).

Our mission

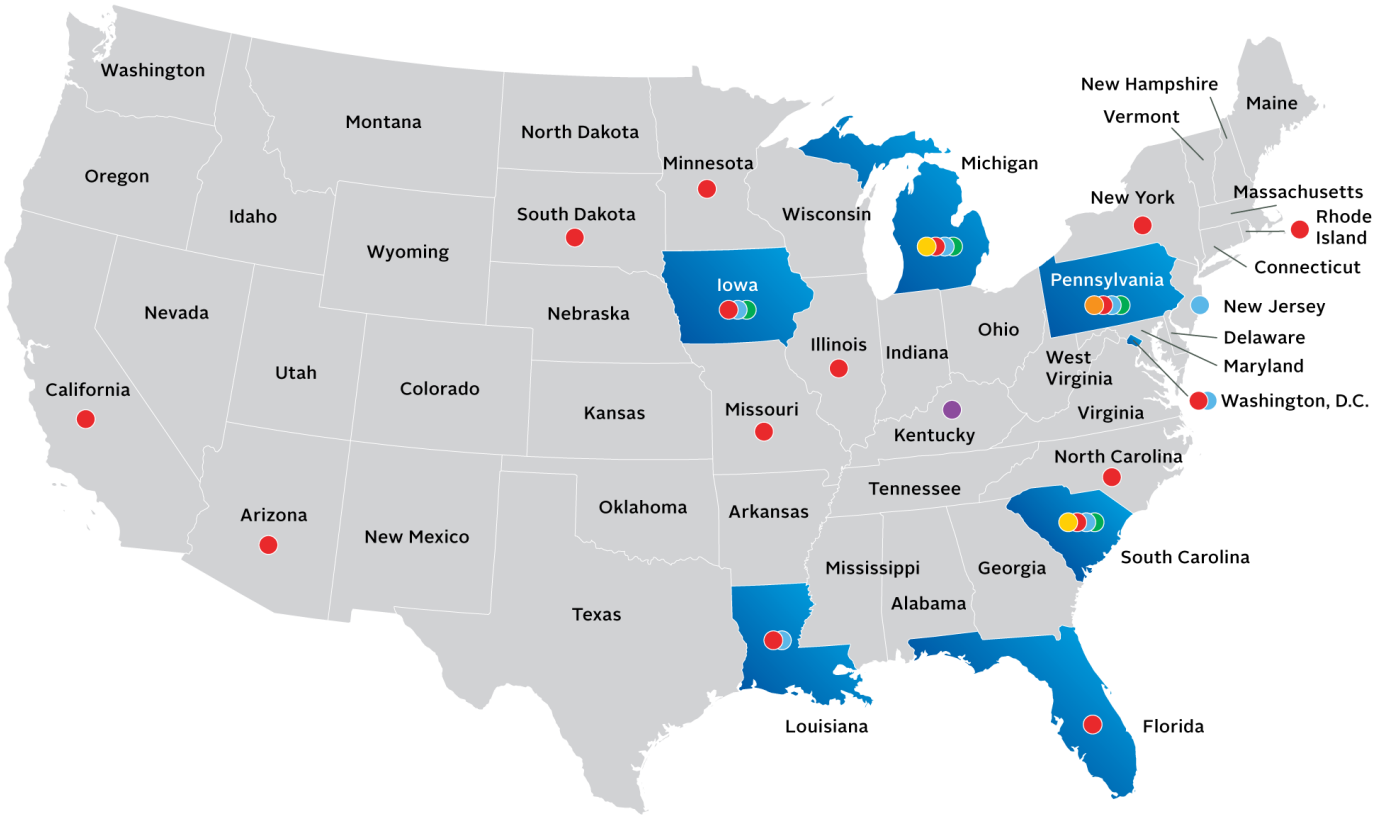
We help people get care, stay well, and build healthy communities.

Our vision

Leading America in health care solutions for the underserved.

States	Members	2016 Revenue*	Associates
17	5.7M	$10.6B	6.0K
and the District of Columbia		* Includes joint venture revenue	

Our National Footprint



DEV-1522-01

Blue states Existing AmeriHealth Caritas Medicaid health plan markets

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

Why Is Family Caregiving Important to Us?

Frontline heroes:

- A third of caregivers each provide more than 21 hours of care per week.
- Family caregivers are generally unpaid, but the economic value of their care is estimated at $470 billion a year — roughly the annual American spending on Medicaid.

Caregiver stress:

- Important and significant predictor of a person's placement in a nursing home, and ability to rebalance the system.
- Physical and emotional toll of extended caregiving.

Caregiver education:

- The health care system, under pressure to reduce costs, increasingly relies on caregivers to manage illness at home, yet fewer than half of family caregivers receive the training they need to perform complex tasks.

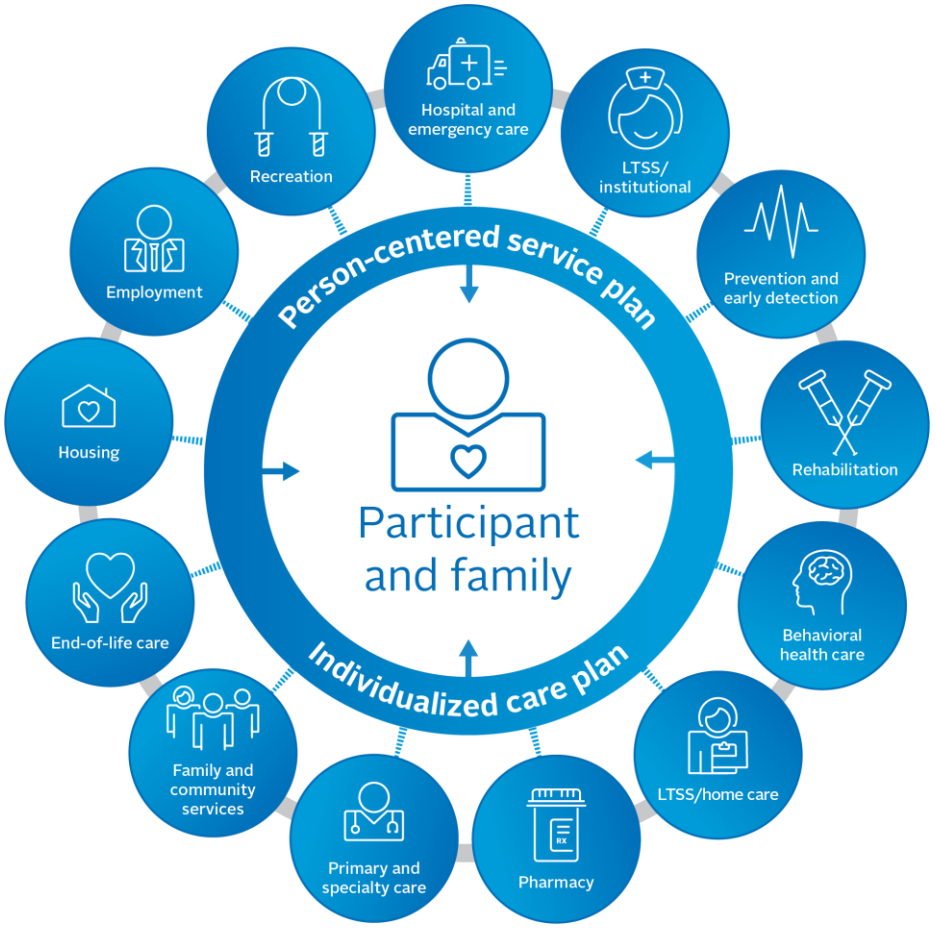
Caregiver "workforce":

- Demand for caregiving is growing due to longer life expectancies and more complex medical care.
- Supply is shrinking, a result of declining marriage rate, smaller family sizes, and greater geographic separation.
- Is family caregiving the next public health crisis?

Person-Centered Approach to Participant Care

Integrated health care management programs address participants' comprehensive needs

- The "unit of care" is the care recipient and the family caregiver.
- The caregiver is part of the care team and service plan.
- Services are consumer-directed and family-focused.



South Carolina: Healthy Connections Prime

Caregiver assessment:

- Caregiver identification up front.
- Assessment of caregiver status and abilities using state's comprehensive assessment tool, including capacity, qualifications, and risks.

Connection supports and services:

- High-touch care team with field-based community navigators.
- Caregiver information and education.
- Coordination with covered services, including adult day health care, transportation, meals, and respite care.
- Leverage flexible benefit, if indicated.

South Carolina: Healthy Connections Prime

Care coordinator training:

- Through the University of South Carolina Office for the Study of Aging (OSA).
- Modules include effective care planning, determinants of abuse and neglect and safety concerns, dealing with difficult people, the impact of multidisciplinary teams, and improving transition care practices.
- Supplemented by internal training on respite benefit, family involvement in the interdisciplinary care team (ICT), and care planning.

Quality measurement in family caregiver supports:

- Track enrollees receiving home- and community-based services (HCBS) who experience changes in respite hour authorizations.
- Caregiver Quality Improvement Project (QIP):
  - Goal is to increase respite utilization 10 percent per year to improve the quality of life of enrollees by helping reduce stress and burnout among family caregivers.
  - Strategies include caregiver assessment, engagement through in-home visits, and caregiver education of respite care benefit.

Pennsylvania: Caring for the Caregiver

Engage, support, and educate:

- Robust caregiver support is essential to the ongoing success of home and integrated community living arrangements, delaying or preventing more costly nursing home placement.
- Based on a caregiver assessment that identifies the primary caregiver, captures the values and preferences of the individual and caregiver, determines the caregiver understanding of the role and abilities needed to carry out tasks, and identifies unresolved problems and potential risks to meeting caregiver needs.
- Ensure that each person's plan of care addresses caregiver needs, caregiver support, emergency backup plans, and ongoing monitoring.

Recognizing that caregivers play a critical role in sustained community living, we have incorporated the Caring for the Caregiver program in our MLTSS plan design:

Caregiver assessment and supports plan

Caregiver community

Caregiver University

Caregiver connections

Caregiver respite and relief

More than

30 YEARS

of making

care the **heart**

of our **work.**

AmeriHealth Caritas

Care is the heart of our work

ACPR-1714457

Family Caregivers: Challenges and Opportunities

Julie Weinberg, UnitedHealthcare Community & State

UnitedHealthcare®
COMMUNITY & STATE

Caregivers

UnitedHealthcare COMMUNITY & STATE

The number of family caregivers available for caregiving is declining from **7:1** in 2010 to **4:1** by 2030[12]

$470 BILLION
In care provided by informal caregivers in 2013[3]

In 2009, families spent an average of **$6,300** on out-of-pocket family support expenses[25]

Caregivers may be **3x more likely** to lose work productivity[18] due to both hours of work missed because of caregiving and decreased work due to distraction and/or fatigue.

Impact

UnitedHealthcare COMMUNITY & STATE

Caregivers are essential for supporting people ***living at home*** and ***in the community***.

We cannot rebalance the LTSS without sufficient caregivers.

Considerations

UnitedHealthcare COMMUNITY & STATE

States	Health Plan
• Leverage the available Medicaid authorities to target caregiving supports	• Support navigation through the health care system
• Encourage caregiver assessments as part of the LTSS program	• Evaluate natural supports and address gaps
• Reduce administrative burden	• Provide targeted resources for CSHCN
• Evaluate strategies that offer support – what is most impactful	• Explore, test and evaluate novel support programs
	• Expand proven strategies to improve outcomes

Panel

Tuesday, August 29th 10:30 – 11:45 AM

Caring for Those who Care; Addressing the Family Caregiver's Needs

- Debbie Wiederhold, United Partners-Pflugerville. National Advisory Board Member, Family Caregiver
- Martha Roherty, NASUAD
- Catherine Anderson, UnitedHealthcare Community & State

Thank You

Julie B Weinberg | Director, Medicaid Policy
UnitedHealthcare Community and State
julie.weinberg@uhc.com

Accountable Health Communities (AHC) Model

Georgetown Business in Innovation EMHA Course

July 12, 2017

Alexander Billioux, MD, DPhil - Director

Division of Population Health Incentives and Infrastructure

Preventive & Population Health Group

What Does the Accountable Health Communities Model Test?

The Accountable Health Communities Model is a 5-year model that tests whether systematically identifying and addressing the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries impacts health care quality, utilization and costs.

Health-Related Social Needs

Core Needs	*Supplemental Needs
Housing Instability	Family & Social Supports
Utility Needs	Education
Food Insecurity	Employment & Income
Interpersonal Violence	Health Behaviors
Transportation	

* This list is not inclusive

Targeted Outcomes

- Increased beneficiary awareness of community resources
- Increased beneficiary access to community resources
- Optimized community capacity to address health-related social needs
- Reduced inpatient and outpatient health care utilization and total cost of health care

Model Participants

- Bridge organization
- State Medicaid agency (SMA)
- Community service providers that have the capacity to address the core health-related social needs
- Clinical delivery sites, including at least one of each of the following types:
  - Hospital
  - Provider of primary care services
  - Provider of behavioral health services

Map of Bridge Organizations

Regions:

Northeast: 10
Midwest: 6
Southeast: 6
Southwest: 6
West: 4

Accountable Health Communities

Thank You!

Alexander Billioux, MD, DPhil
alexander.Billioux@cms.hhs.gov

For important updates and more information on the Accountable Health Communities Model visit:
https://innovation.cms.gov/initiatives/ahcm

Addressing Social Determinants of Health

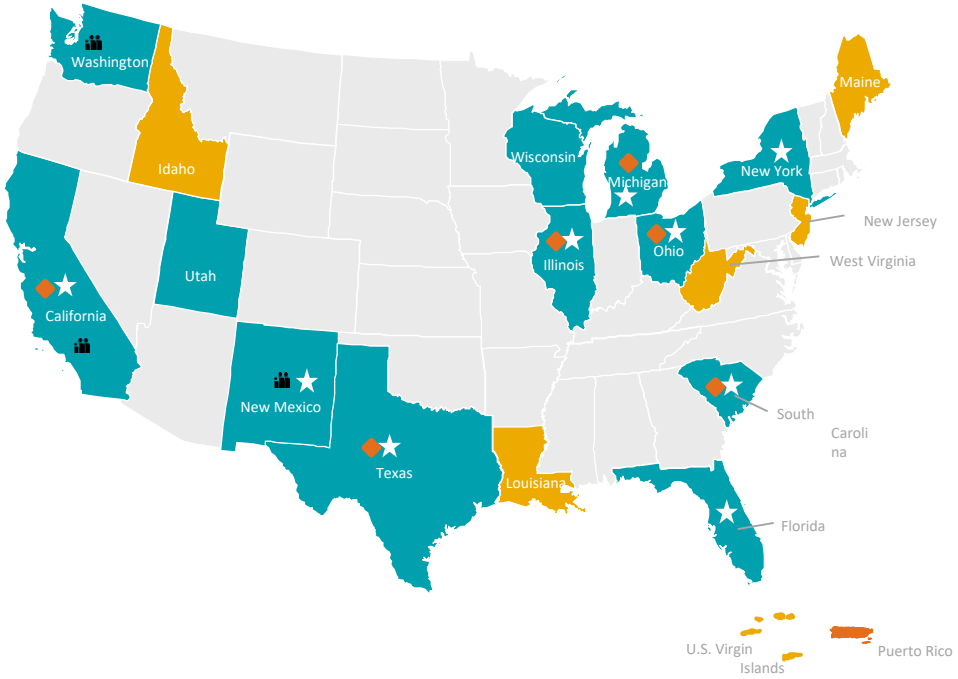
Michelle Bentzien-Purrington, Vice President MLTSS and Duals Integration
August 28, 2017

MOLINA® HEALTHCARE

The Molina Healthcare Story

Taking care of kids, adults, seniors and families for over 35 years

Molina Healthcare was founded by emergency room physician Dr. C. David Molina in 1980. After having treated patients with everyday ailments in the ER because they had no primary care physician, Dr. Molina opened a clinic especially for them. Today Molina Healthcare continues his mission, serving millions of people through Medicaid, Medicare and the Marketplace, as well as other government-sponsored programs for low-income families and individuals.



9 OF 12 Molina plans are NCQA accredited

National Community of Quality Assurance (NCQA)

11 of 12 Molina Health Plans have earned NCQA's Multicultural Health Care Distinction

- 4.6M[1] served through managed care
- 235K[1] MLTSS program enrollment in 9 states
- Largest Medicare/Medicaid demo enrollment (6 states) >53K
- National Leader in D-SNP, FIDE SNP approval pending
- >100K dually eligible members

Molina Health Plans
Medicaid, Medicare, Marketplace and other government sponsored programs

Molina Medicaid Solutions
Medicaid Management Information Systems

Molina Medical Clinics
Primary care clinics
- California 19
- New Mexico 1
- Washington 1

Includes MLTSS
California, Florida, Illinois, Michigan, New Mexico, New York, Ohio, South Carolina, Texas

Medicare Medicaid Plan (demos)
California, Florida, Illinois, Michigan, Ohio, South Carolina

[1] as of June 30, 2017

MOLINA HEALTHCARE

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Heiman, Harry J. & Artiga, Samantha (2015). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. http://www.kff.org

THE HENRY J. KAISER FAMILY FOUNDATION

MOLINA HEALTHCARE

Addressing Social Determinants of Health – It Takes a Village

Top Social Determinants of 2016 for Molina Members
Housing
✓ Effective training and resources
✓ Collaborations with affordable, accessible housing communities
Food Security
✓ Transition meals program
✓ Nutritional counseling and programs through CBO partners
Support Systems and Community Engagement
✓ Caregiver support training program
✓ Caregiver assessment and toolkit
✓ Community Champion awards and grants
✓ Molina Quality Living Program
Quality of Care
✓ Change in condition training and support

"My next goal is to start, try to start, walking without my walker and my biggest goal is to get on the back of a motorcycle."

-Molina Medicare-Medicaid Plan demonstration member

MOLINA HEALTHCARE

Impacts of Addressing Social Determinants

- >8:10 people satisfied with care coordination
- >8:10 people satisfied with heath plan
- Molina Quality Living Program
  - ✓ 67,287 lives enriched through attendance at community integration activities (in just one state pilot program)
  - ✓ 2% lower total claims cost for members residing in a MQL facility
  - ✓ 22% lower admissions to acute for members residing in a MQL facility
- Nursing Facility to Community Transitions
  - ✓ 9.6%
  - ✓ $1.1M savings in overall healthcare costs
- Nursing home diversion rate >96%
- 15% reduction in inpatient admissions and 10% reduction in readmissions following caregiver change in condition training

NASUAD
National Association of States United for Aging and Disabilities

The MLTSS Institute

MLTSS Pre-Conference Intensive
August 28, 2017

Purpose

- NASUAD identified growing interest from states and plans in:
  - Assistance on MLTSS program design, stakeholder engagement, intelligence on CMS policy priorities, training for State staff and providers as needed
  - Information on national trends and emerging issues
  - Opportunities for state to state exchange of promising practices and lessons learned
  - Discussing policy issues stemming from new managed care rule and other challenging areas in small group settings
- Securing outside help for MLTSS is challenging for many states
- Funding, procurement rules and capacity to write RFPs for assistance limited

Activities

Direct State Technical Assistance

NASUAD (and consultants as needed and appropriate), will provide intensive, state-specific MLTSS technical assistance. These may include:

- Identifying critical program design decisions and providing options
- Providing guidance for MLTSS quality measurement activities
- Assist in writing or editing managed care authority documents (SPAs or waivers), MLTSS RFPs or managed care contracts
- Development and/or review of MCO readiness review tool and recommendations for addressing MLTSS program elements, including participation on readiness reviews if requested
- Presentations to state leadership, legislators and providers on national MLTSS trends and implications for state on implementation and oversight
- Serving as a national subject matter expert in meetings with key advisory boards and taskforces in the community.

Activities

MLTSS Policy Academy

NASUAD will bring together selected national thought leaders on a variety of MLTSS topics to identify promising practices or provide options for policy implementation.

- Discussions will lead to papers, reports, or possibly letters to CMS
- Brainstorming session at MLTSS Symposium in May has provided topics for first conversations

Activities

State and Health Plan Collaboratives

NASUAD will sponsor an annual in-person roundtable or collaborative.

- Growing interest in the MLTSS Symposium sponsored by NASUAD each spring identified a real hunger for face-to-face and focused interactions among states and with health plans.
- Each roundtable or collaborative will focus on 2-3 topics of interest from a variety of perspectives.
- National experts as well as Federal policy officials, will attend where appropriate, to spur lively and fruitful exchange of information and problem-solving.

Advisory Council

- Will provide leadership and direction for the Institute's policy activities

- Will recommend:
  - Topics for small group discussion and potential white paper development;
  - Areas for additional research and data-collection;
  - Possible partnerships and/or collaborations with other like-minded organizations; and
  - new tools and strategies that NASUAD can use to support states' and health plans in their efforts to manage successful MLTSS programs.

- Will publicize the Institute to the maximum extent possible

Advisory Council

State Representatives	Health Plan Representatives
Curtis Cunningham - Wisconsin	Catherine Anderson – United Healthcare Community and State
Kate Layman - Texas	Merrill Friedman - Anthem
Patti Killingsworth - Tennessee	Michael Monson - Centene
Eunice Medina - Florida	Victor Negron – Amerihealth Caritas
Ginny Rountree - Arizona	Carol Steckel - Wellcare

http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/mltss-institute

cdobson@nasuad.org

NASUAD

National Association of States United for Aging and Disabilities

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

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

CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

Demonstrating the Value of MLTSS Programs

Stephanie Gibbs, JD, Senior Program Officer
Center for Health Care Strategies

About the Center for Health Care Strategies

A non-profit policy center dedicated to improving the health of low-income Americans

Need for Study

- **Repeated requests for 'proof' of MLTSS benefits**
  - » Providers and consumer groups argue that FFS is good enough
  - » Common questions about access and quality
- **Little objective research is available**
  - » Available studies focus on population or aspects of care
  - » Rare to see formal evaluations of MLTSS
- **Evidence of 'success' is primarily anecdotal and scattered**
  - » No compilation of states' results
  - » Would fill identified gap to gather state-reported data

Approach

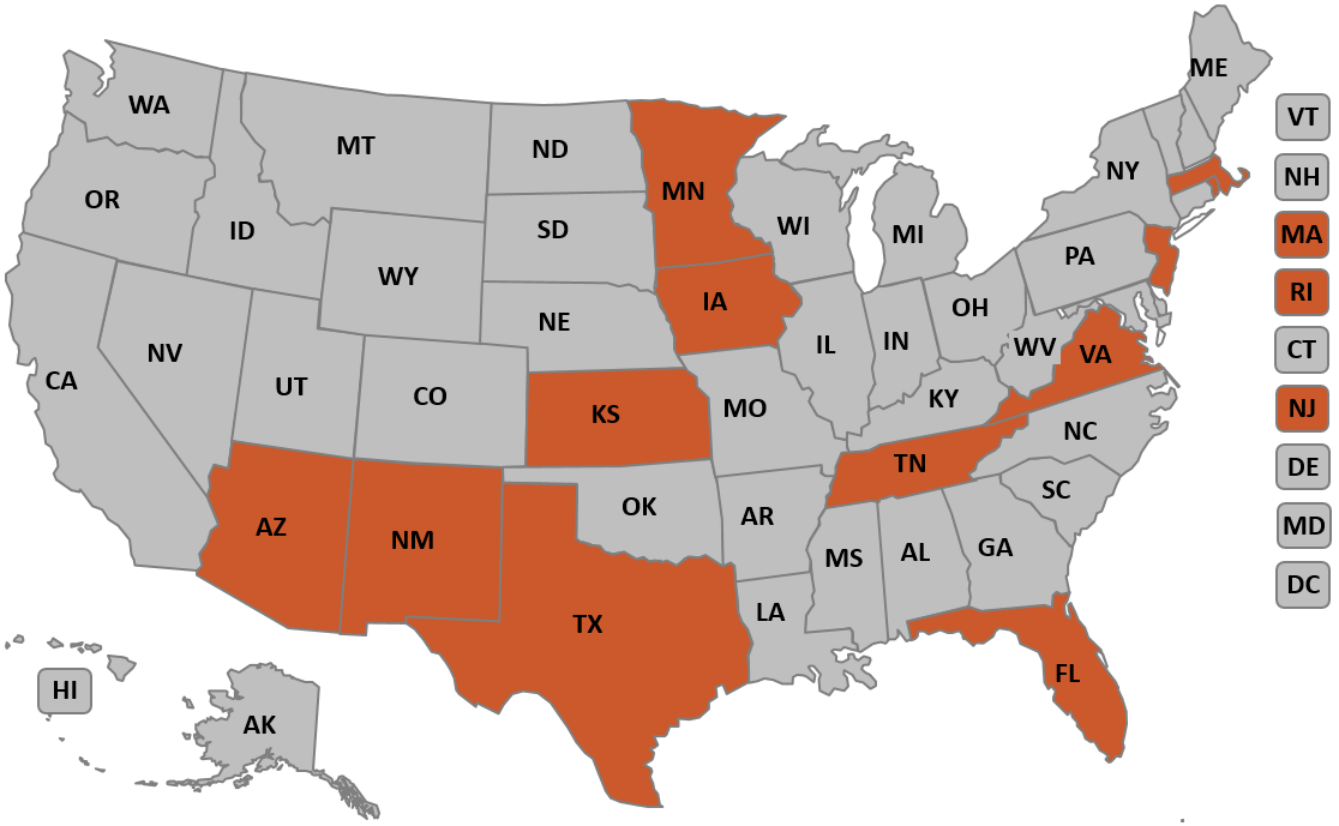
- **Partner with CHCS**
  - » Focuses writing and state TA on MLTSS (primarily dual eligibles)
- **Gather existing research**
  - » Provide high-level overview of MLTSS programs – structure, benefits, populations and authority
  - » Review publications by AARP and Kaiser Family Foundation
- **Survey MLTSS states**
  - » Identify common goals
  - » Obtain state-specific data (some nonpublic)

Methodology

- **Solicit survey responses from NASUAD members**
  - Of 22 states with MLTSS programs, surveys sent to 19
  - No MLTSS contact with Michigan, North Carolina and Hawaii
  - Survey in field for 40 days
- **Analyze information from respondents**
  - Of 19 sent, full responses received from 12
- **Follow-up emails**
- **Highlighted states review prior to publication**

State Survey Respondents

- Arizona
- Florida
- Iowa
- Kansas
- Massachusetts
- Minnesota
- New Jersey
- New Mexico
- Rhode Island
- Tennessee
- Texas
- Virginia



State MLTSS Goals

- Rebalancing LTSS Spending
- Improving Member Experience, Quality of Life, and Health Outcomes
- Reducing Waiver Wait Lists and Increasing Access to Services
- Increasing Budget Predictability and Managing Costs

Rebalancing LTSS Spending

- **State Goals:**
  - Rebalancing Medicaid LTSS spending toward HCBS and providing more options for people to live in and receive services in the community—if that is consistent with their goals and desires
  - All of the states responding to the survey reported rebalancing as a key goal
- **Data Collected:**
  - 8 states (AZ, FL, KS, MA, MN, NJ, NM, TN) reported that MLTSS has promoted rebalancing the LTSS delivery system
- **Progress to Date:**
  - Florida – Goals for nursing facility settings
  - Tennessee and Arizona – Rebalanced spending and increased HCBS

Improving Member Experience, Quality of Life, and Health Outcomes

- **State Goals:**
  - Improving consumer health and satisfaction/quality of life
  - Ensuring effective care coordination to improve consumer experience and quality of life
  - All of the states responding to the survey reported improving consumer health and satisfaction/quality of life was a key goal
- **Data Collected:**
  - 10 states (AZ, FL, IA, MN, NJ, NM, RI, TN, TX, VA) collect information on individual and family satisfaction
  - 9 states (AZ, FL, IA, KS, MN, NJ, TN, TX, VA) collect information on the quality of life of participating individuals
  - 7 states (AZ, FL, KS, NJ, MA, MN, TN) reported that their MLTSS programs improved the physical health of individuals enrolled

Improving Member Experience, Quality of Life, and Health Outcomes

- **Progress to Date:**
  - Minnesota Senior Care Options (MSHO), Florida, and Texas – improved health outcomes
  - Texas – HCBS and improved quality of life
  - Virginia – positive feedback on care coordinators
  - Florida – 77% of respondents to a state survey reported an improved quality of life since joining an MLTSS plan

- **Reported Challenges:**
  - Labor intensive data collection
  - Staffing and resources
  - Attributing physical health improvements

Reducing Waiver Waitlists and Increasing Access to Services

- **State Goals:**
  - Reducing or eliminating waiting lists, which, in turn, would result in increased access to LTSS
  - Increasing access to HCBS options, the preferred service setting for most consumers
  - 6 states (FL, IA, KS, NJ, NM, TN) reporting reducing waiting lists as a goal
- **Progress to Date:**
  - Tennessee – Eliminated waiting lists by expanding community options and providing targeted services to at-risk consumers
  - Florida – Invested $12.6 million to enroll wait-listed individuals with the most critical needs into its MLTSS program

Increasing Budget Predictability and Managing Costs

- **State Goals:**
  - Improving budget predictability—MCOs are paid a monthly capitation rate for all covered services
  - Containing Medicaid costs
  - 7 states (FL, IA, KS, MA, NJ, RI, TN) identified budget predictability as a goal
  - 5 states (FL, IA, NJ, NM, VA) identified Medicaid cost containment as a goal

- **Data Collected:**
  - 7 states (FL, IA, MA, NJ, NM, RI, TN) collect data to demonstrate "bending the cost curve" or reducing the rate of growth in Medicaid expenditures

Increasing Budget Predictability and Managing Costs

- **Progress to Date:**
  - 3 states (FL, MA, TX) reported that implementing MLTSS decreased administrative burden in their Medicaid programs
  - Florida – Enhanced the predictability and management of its MLTSS program and achieved five percent savings targets established by the legislature during statewide implementation in 2013 and 2014
  - Tennessee – Monitored relevant targets prior to CHOICES implementation to establish a baseline and later demonstrate program outcomes
- **Reported Challenges:**
  - Attributing cost effectiveness solely to the efforts of the MLTSS program
  - Effective engagement and oversight of managed care plans

Key Takeaways

- Challenges with demonstrating program value
  - » Lack of standardized quality measures across MLTSS programs to assess person-centeredness and outcomes
  - » Need for better monitoring approaches to managed care performance
  - » Complexities with collecting and analyzing encounter data and other programmatic data
- State considerations
  - » Dedicate sufficient staff resources to MLTSS for smooth transition from a fee-for-service system and to ensure comprehensive structure for ongoing oversight
  - » Collect baseline measures on consumers' health status and other program variables like cost and service utilization, and tie outcome measures to these benchmarks
  - » Factor stakeholder priorities and concerns into program monitoring efforts

State Discussion

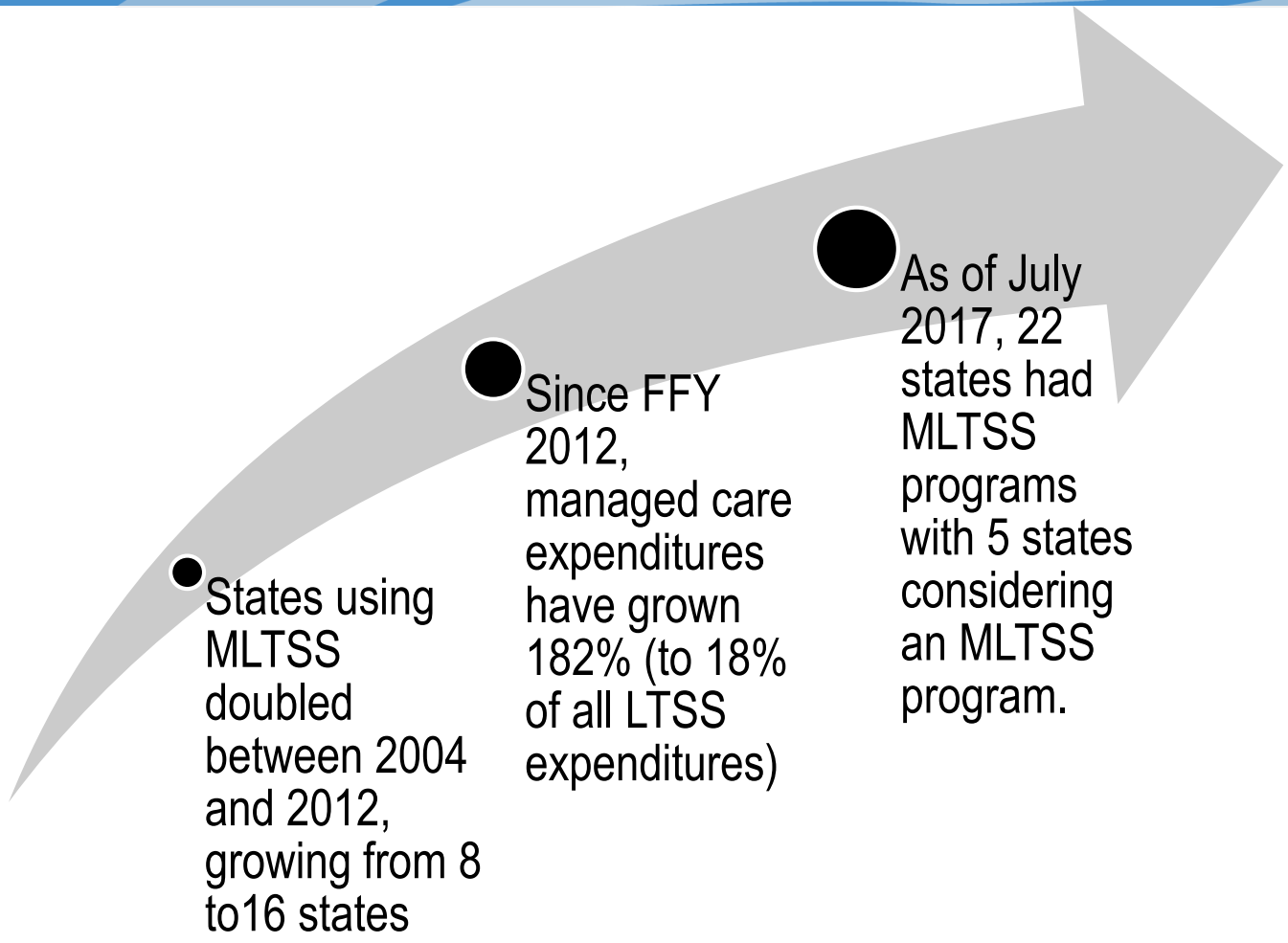
BUSINESS ACUMEN CENTER
Providing Resources to Sustain Disability Organizations

DISABILITY NETWORK BUSINESS ACUMEN CENTER

Erica Anderson, MA
Senior Director of Business Acumen, NASUAD

NASUAD
National Association of States United for Aging and Disabilities

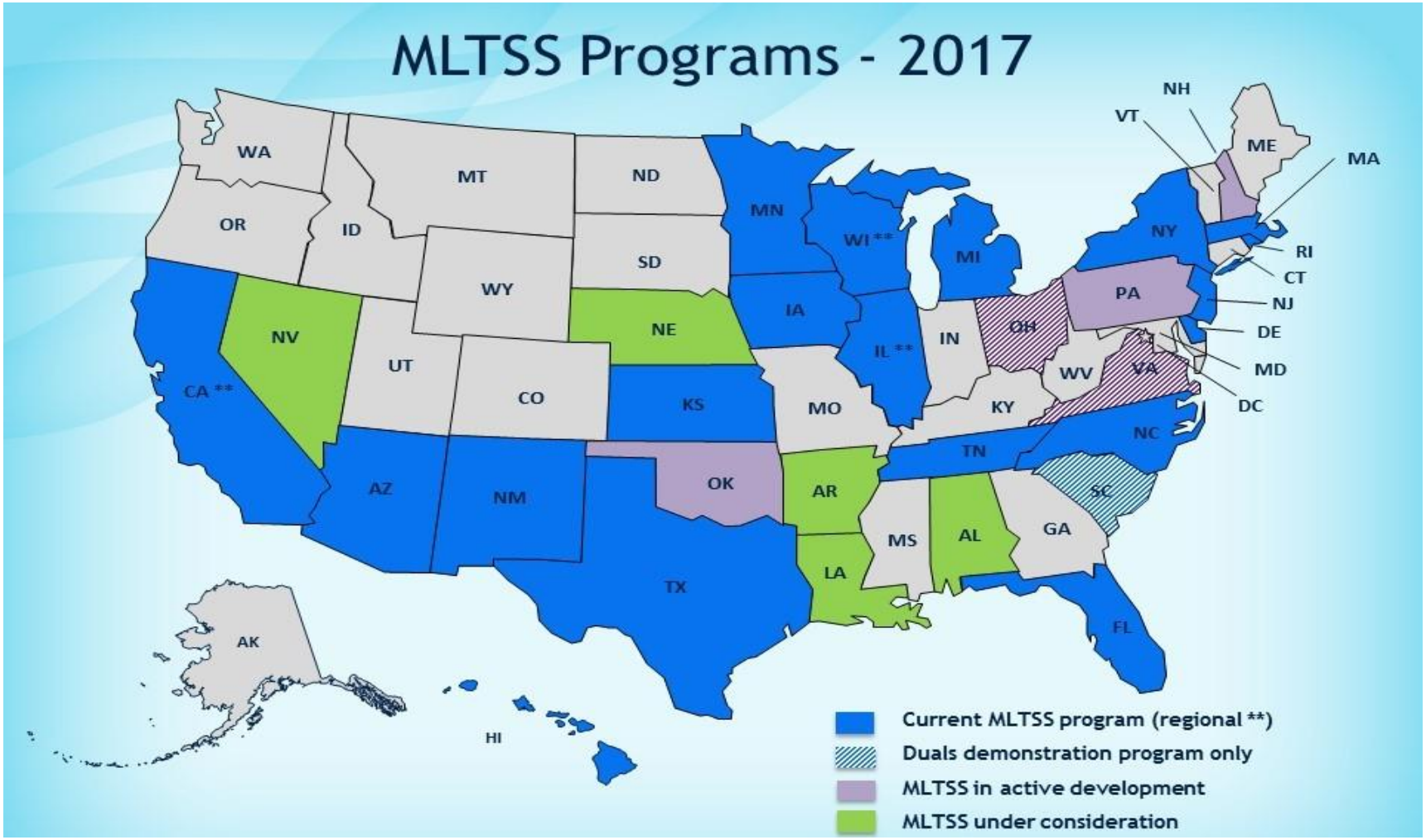
What's the problem?



Sources: CMS Whitepaper – The Growth of Managed Long-Term Services and Supports Programs: A 2012 Update, July 2012; Truven Health Analytics, June 2017; GAO Report – Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports, January 2017; NASUAD 2017

States with MLTSS

BUSINESS ACUMEN CENTER
Providing Resources to Sustain Disability Organizations



So, why is that a problem?

BUSINESS ACUMEN CENTER
Providing Resources to Sustain Disability Organizations

Community Based Organizations

BUSINESS ACUMEN CENTER
Providing Resources to Sustain Disability Organizations

Local organizations that offer community living services and supports to advance the health, well-being, independence, and community participation of older adults and people with disabilities and may include:

- Aging and Disability Resource Centers
- Behavioral health organizations,
- Centers for Independent Living,
- Developmental disability organizations,
- Protection and Advocacy Agencies,
- University Centers for Excellence in Developmental Disabilities Education, Research & Service
- Faith-based organizations,
- Area Agencies on Aging,
- Aging services organizations,
- Native American tribal organizations,
- Nutrition program providers, and
- Other local service providers for persons with disabilities and/or older adults

Managed Care Plans Tell Us…

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- They need CBOs to…
  - Provide services that impact Social Determinants of Health
  - Remain connected to the community
  - Demonstrate their value through data

Community Based Organizations tell us…

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Providing Resources to Sustain Disability Organizations

- They need…
  - To know who to connect with
  - How to market their services
  - To understand and articulate their value proposition
  - How to price their services
  - How to meet contract expectations

The Disability Network

If you've seen one…

you've seen <u>one</u>.

- Disability community organizations vary in:
  - Structure
  - Focus
  - Knowledge of MLTSS and business capacity

Disability Business Acumen Grant

- What is the purpose of our work?
  - Build Capacity: Build the capacity of community-based disability organizations (CBOs) to contract with integrated care and other health sector entities,
  - Foster Collaborative Relationships: Connect payers, providers and states to establish well-functioning integrated care systems,
  - Stakeholder Engagement: Improve the ability of disability networks to act as active stakeholders in the development and implementation of integrated systems within their state.

Business Acumen for Integrated Care

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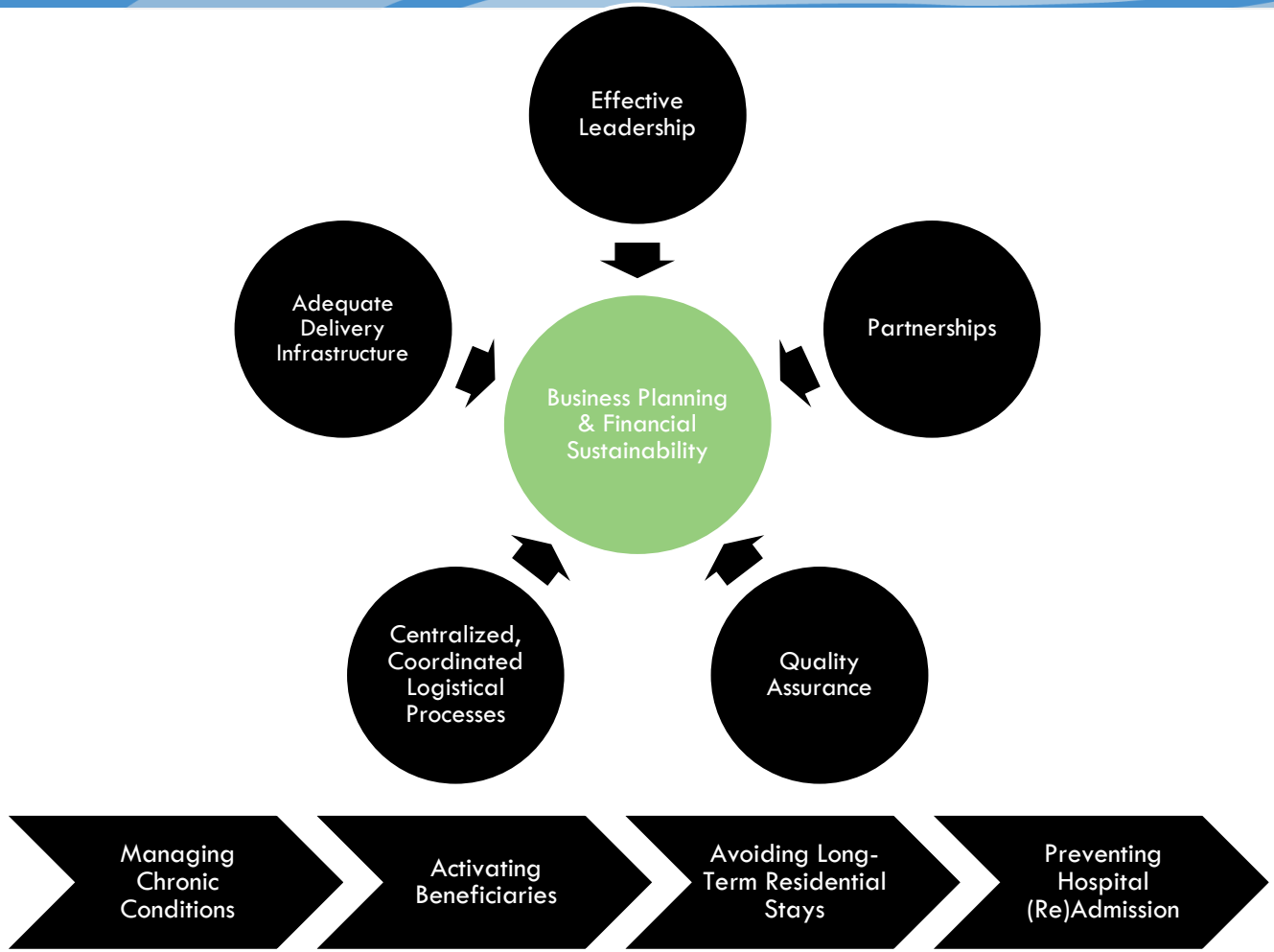

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Business Acumen Grant Partners

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Providing Resources to Sustain Disability Organizations

NASUAD
National Association of States United for Aging and Disabilities

NCIL
National Council on Independent Living

ANCOR
American Network of Community Options and Resources
SHAPING POLICY • SHARING SOLUTIONS • STRENGTHENING COMMUNITY

American Association on Health and Disability

NATIONAL DISABILITY RIGHTS NETWORK
Protection & Advocacy for Individuals with Disabilities

UNIVERSITY OF MINNESOTA

ncoa
National Council on Aging

MERCER
MAKE TOMORROW, TODAY

ASAN
AUTISTIC SELF ADVOCACY NETWORK

NASDDDS
National Association of State Directors of Developmental Disabilities Services

Funded by: ACL Administration for Community Living

Disability Business Acumen Grant: Key Activities

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- How are we accomplishing our work?
  - Developing baseline knowledge of current community-based organizations
  - Providing broad-based training and technical assistance for disability networks to build their capacity
  - Convening and provide targeted technical assistance utilizing a learning collaborative model
  - Engaging integrated care organizations, managed care plans, and other health care entities regarding the needs of consumers and the roles of CBOs

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Disability Business Acumen Grant: Anticipated Outcomes

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- How will we know if we are successful?
  - Increased knowledge of current CBO successes, challenges, needs, and promising practices
  - Increased technical assistance and business acumen resources to support CBOs
  - Increase in learning collaborative participants' business capacity to engage with integrated care networks
  - The improvement of health care entities' awareness about the role CBOs can play in the health care system

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Driving Improvements

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- Monthly webinar series
  - http://nasuad.org/initiatives/business-acumen-disability-organizations-resource-center/webinars
- Learning Collaborative
  - 5 States: MD, MO, NH, NY, TX
- Business Acumen Toolkit
  - Stakeholder Engagement
  - Developing and Sustaining Relationships and Partnerships
  - Negotiating and Contracting
  - Pricing Services
  - Articulating Your Business Case
  - Successful Organizational Change While Maintaining Your Mission

Opportunities to Get Involved

- Contribute to the Business Acumen Resource Center
- Participate in ongoing feedback and dissemination
  - Webinars
  - Conference calls
  - Conference presentations
- Provide Technical Assistance
  - Short-term
  - Peer-to-Peer exchanges
  - Learning Collaborative

BUSINESS ACUMEN CENTER
Providing Resources to Sustain Disability Organizations

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

E-mail: businessacumen@nasuad.org

Or Call: 202.898.2583

BUSINESS ACUMEN CENTER
Providing Resources to Sustain Disability Organizations

NASUAD
National Association of States United for Aging and Disabilities

NASUAD
National Association of States United for Aging and Disabilities

Improving Quality in MLTSS

MLTSS Pre-Conference Intensive
August 28, 2017

Challenges to Effective Quality Measurement in LTSS

- LTSS does not have widely adopted or evidence-based guidelines, protocols or training standards
  - There are few professional norms, education, and bodies of knowledge
- State programs vary significantly depending upon the populations enrolled and the services offered
  - Diversity of populations
- States typically driven by HCBS waiver performance measures; same requirements don't exist for non-waiver (i.e. state plan) services

Challenges to Effective Quality Measurement in LTSS

- MANY small providers in historic FFS programs unable to collect and report reliably
  - Claims are NOT generally a good source of data
- States' data systems may be outdated
- Health plans use different technology from either providers or states
- These factors = lack of standardization in LTSS programs and barriers to effective QM

Challenges to Effective Quality Measurement in LTSS

- What are the ‘right’ outcomes?
  - Person-specific based on individual needs, desires and goals
- Consumer’s perspective even more critical in LTSS than in acute care settings
  - Quality of life equally if not more important than ‘satisfaction’
- Health plans offer better technology and data systems, but collecting and reporting remains significantly challenging
- Tension between individual outcomes and system performance

Considerations for MLTSS Measures

- Should be defined relative to the ultimate goals of or outcomes of LTSS
- Must be as applicable as possible to as many populations as possible
- Should be valid and reliable (ie. audited or otherwise vetted)
- Must address waiver assurances (if appropriate) or 1115 requirements

Considerations for MLTSS Measures

- Should address both quality of life and service delivery
- Need to be ‘doable’ for health plans, and focus on what the health plans can control
- Minimize case/record review to the maximum extent possible; focus on administrative data

Current State

- States are attempting to translate FFS waiver PMs to managed care environment – difficult
- Waiver performance measures are almost all structure and process measures:
  - # of providers trained
  - # of assessments completed
  - % of care plans completed timely
  - # of critical incidents reported and remediated
- While important, they do not lead to quality/performance improvement
- Consumer and advocacy groups – especially disability communities – want to see outcome measures

Current State

- Functional assessments are important source of data to benchmark improvements, but assessment tools vary by population
- "Easiest" measures focus on improved health outcomes
  - ↓ ED visits
  - ↓ Inpatient admits
  - ↑ Preventative services
- About half of MLTSS states are using quality of life surveys to assess quality

National Efforts to "Move the Needle"

- NQF issued HCBS measurement framework /domains in 2016
  - Committee spent 2 years sifting through measures, developing domain definitions and identifying needed next steps
  (http://www.qualityforum.org/Projects/h/Home_and_CommunityBased_Services_Quality/Final_Report.aspx)
  - Recommended domains of measurement:

- CMS contracted with Mathematica Policy Research/NCQA to develop and test MLTSS-specific measures in areas of care coordination and rebalancing
  - Measures testing completed
  (https://www.mathematica-mpr.com/our-publications-and-findings/projects/quality-measure-development-dual-enrollees-long-term-services-and-support)

- CMS contracted with NQF to recommend a 'menu' of measures for LTSS programs
  - Only 10 measures; fairly clinically-focused; not exhaustive
  (http://www.qualityforum.org/ProjectMaterials.aspx?projectID=83348)

National Efforts to "Move the Needle"

- University of Minnesota using NQF Framework to test domains with consumers and develop new measures to fill measurement gaps
  - https://ici.umn.edu/index.php?projects/view/189
- United Healthcare released quality framework for MLTSS programs in 2016 – being implemented voluntarily in all UHC
  - https://www.uhccommunityandstate.com/whats-new/medicaid-quality.html
- Expanded use of National Core Indicators – Aging and Disability in MLTSS states
  - Delaware, Kansas, New Jersey, Tennessee, Texas
  - Ability to hold plans accountable for improved results

Forward Progress

- All MLTSS states have reporting requirements which could be converted to performance measures
- Inventory of contract requirements done by ASPE in 2013 (https://aspe.hhs.gov/report/environmental-scan-mltss-quality-requirements-mco-contracts)
- UnitedHealthcare issued quality framework for their MLTSS plans in 2016
- National MLTSS Plan Association released earlier this month

NASUAD

National Association of States United for Aging and Disabilities

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

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

National MLTSS Health Plan Association

Model LTSS Performance Management Standards

August 28, 2017

Who we are

- Aetna
- Amerihealth Caritas
- Anthem, Inc.
- Centene Corporation
- Commonwealth Care Alliance
- Health Plan of San Mateo
- L.A. Care Health Plan
- Molina Health Care, Inc.
- Tufts Health Plan
- UPMC Health Plan
- WellCare Health Plans, Inc.

- 11 organizations
- In 18 states
- Nearly 1 million MLTSS members (70% of market)
- 175,000 MMP members (50% of market)

Why we started with a focus on measures

* Quality matters – MLTSS isn't just about saving money
* Gap exists – no nationally recognized measures (except NCI-AD and new CAHPS)
* Managed Care Rule– States are required to develop measures; new QRS system being developed
* Leadership – we felt a responsibility to help solve the problem

We tried to build on work already done…

NQF HCBS Addressing Gaps in Performance Measurement

Mathematica/NCQA HCBS measure development

NCI-AD measures

HCBS CAHPS measures

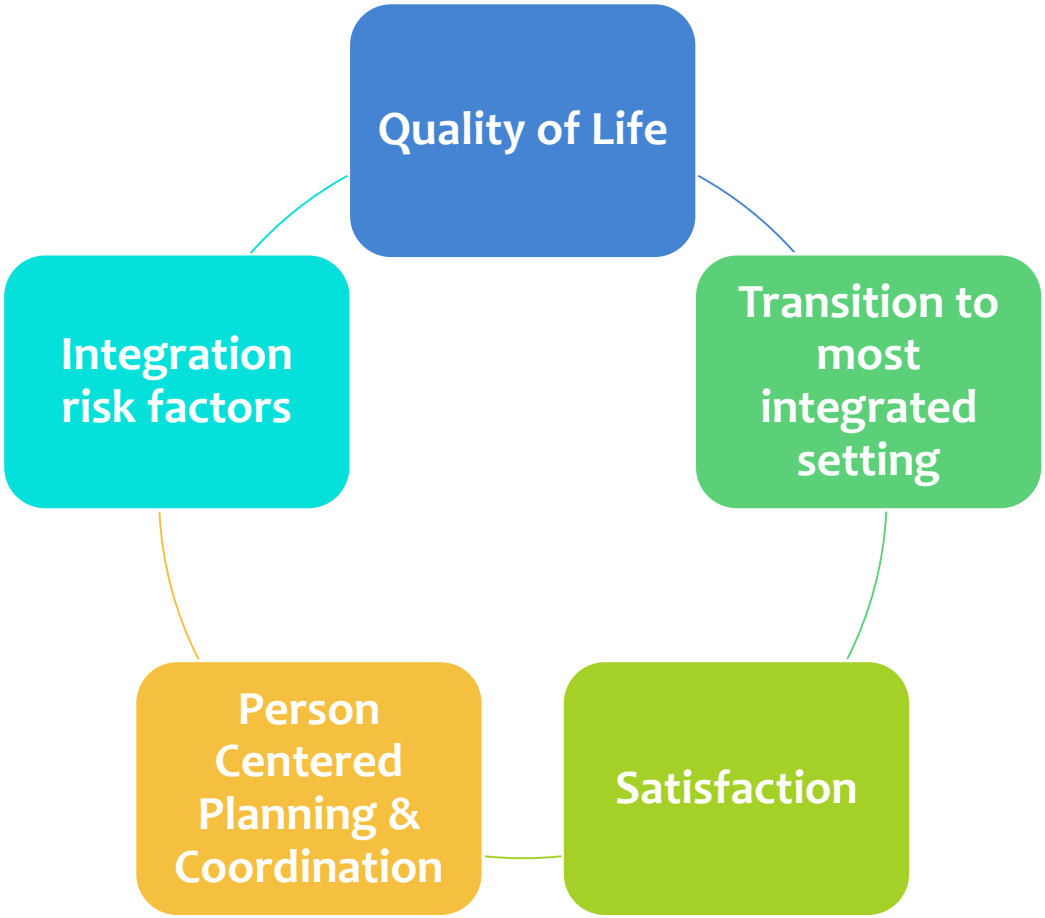
…And received guidance as we developed the framework

Members of NQF HCBS Measures Workgroup

Disability Advisory Councils

Measure Developers

We developed five main domains



National MLTSS Health Plan Association

Quality of life domain

Measures

1. % of members able to see their friends and family when they want, and proportion who are not lonely
2. % of members able to participate in activities outside of home when and with whom they want
3. % of members who are satisfied with where they live
4. % of members who are able to make decisions about their everyday lives
5. % of members who have a job or volunteer in the community
6. % of members who feel safe and know who to talk to if not

Transition to most integrated setting domain

Measures

1. Successful Transitions from Short-Stay Institution to Community Setting
2. Successful Transitions from Long-Stay Institution to Community Setting
3. Admission to an institution from the Community
4. Readmission within 30 Days of Hospitalization
5. HCBS vs. Institutional Services

Integration risk factors domain

Measures

1. Falls with or without injury
2. Wounds new or worsened
3. Urinary Tract Infections
4. Flu Vaccination
5. Pneumococcal Vaccination
6. Adherence to Medication Regimen
7. Members with Class Polypharmacy

Person centered planning and coordination

Measures

1. Timely Comprehensive Assessment and Update
2. Timely Comprehensive Care Plan and Update
3. Care Plan Shared Timely
4. Re-Assessment and Care Plan Update After Discharge
5. Transportation Service Level
6. Service Confirmation

Measures

7. Timeliness of Start of Attendant Services
8. % of members reporting care plan includes things important to them
9. % of members reporting they are the deciders of what is in their plan
10. % of care plans with services and supports that reflect the member's goals
11. % of members saying the help received from their care manage is excellent, very good, or good

Satisfaction domain

Measures

1. Overall Satisfaction with Health Plan
2. Overall Satisfaction with Care Manager
3. Overall satisfaction with Attendant
4. Overall Satisfaction with Institutional Provider
5. Overall Satisfaction with Assisted Living (ALF) Provider
6. Overall Satisfaction with Transportation Provider
7. Overall Satisfaction with Adult Day Care Provider
8. Overall Satisfaction with Fiscal Management Agency

Where we are in the process

Step	Status
Gained agreement from member plans on framework	Complete
Sharing with broader community	In process
Developing measure specifications & data collection methodology	In process
Data capture and reporting	To be completed

This is just the beginning

* Framework is meant to be a start not an end
* Attempted to develop measures relevant to *all* populations impacted but not complete for any one given group
* Many refinements required (e.g., risk adjustment, standardized data collection, etc.)

Appendix

Measure Sources

- CMS Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Home and Community-Based Services (HCBS)
- Council on Quality and Leadership (CQL)'s Personal Outcome Measures (POMS)
- Health Effectiveness Data and Information Set (HEDIS)
- Mathematica Quality Measures for CMS Programs Serving Duals and Medicaid-Only Enrollees
- Medicare Star Rating measures
- Minimum Data Set (MDS)
- National Core Indicators – Aging and Disability (NCI-AD)
- National Quality Forum (NQF) HCBS Final Report
- National Committee for Quality Assurance (NCQA) LTSS Accreditation Standards
- Outcome and Assessment Information Set (OASIS)
- State-defined MLTSS contractual measures

Tiered Implementation – Tier 1

Tier 1A: Initial Reporting on entire MLTSS Population

Domain	Indicator
# 2 Transition to Most Integrated Setting	2. Successful Transitions from Long-Stay Institution to Community Setting
	3. Admission to an Institution from the Community
	5. HCBS vs. Institutional Services
#4 Person-Centered Planning and Coordination	1. Timely Comprehensive Assessment and Update
	2. Timely Comprehensive Care Plan and Update

Tier 1B: Initial Reporting only on the MLTSS Populations for which the plan also holds the Medical risk.

Domain	Indicator
# 2 Transition to Most Integrated Setting	1. Successful Transitions from Short-Stay Institution to Community Setting
	4. Readmission within 30 days of hospitalization
#3 Transition-Related Acute Health and Functioning	4. Flu Vaccination
	5. Pneumococcal Vaccination
	6. Adherence to Medication Regiment
#5 Satisfaction	1. Overall Satisfaction with Health Plan Excellent or Above Average

Tiered Implementation – Tier 2

Tier 2: Later Reporting – Will Create and Produce Measures from Available Data

Domain	Indicator
# 1 Quality of Life	1. Percent of members able to see their friends and family when they want, and proportion who are not lonely
	2. Percent of members able to participate in activities outside of home when and with whom they want
	3. Percent of members who are satisfied with where they live
	4. Percent of members who are able to make decisions about their everyday lives
	5. Percent of members who have a job or volunteer in the community
	6. Percent of members who feel safe and know who to talk to if not
#4 Person-Centered Planning and Coordination	6. Service Confirmation
	7. Timeliness of Start of Attendant Services
	8. Percentage of members reporting care plan includes things important to them
	9. Percentage of members reporting they are the deciders of what is in their plan
	10. Percentage of care plans with services and supports that reflect the member's goals
	11. Percentage of members saying the help they received from their care manager is excellent, very good, or good

Tiered Implementation – Tier 3

Tier 3: Latest reporting – will need to create surveys to collect information or modify the output from existing data resources

Domain	Indicator
#3 Transition-Related Acute Health and Functioning	1. Falls with or without injury
	2. Wounds new or worsened
	3. Urinary tract infections
	7. Members with Class Polypharmacy
#4 Person-Centered Planning and Coordination	3. Care plan shared timely
	4. Reassessment and care plan update after change in setting
	5. Transportation service level
#5 Satisfaction	2. Overall satisfaction with care manager excellent or above average
	3. Overall satisfaction with institutional provider excellent or above average
	4. Overall satisfaction with assisted living provider excellent or above average
	5. Overall satisfaction with transportation provider excellent or above average
	6. Overall satisfaction with adult day care provider excellent or above average
	7. Overall satisfaction with fiscal management agency (FMA)

New Jersey's Incentivizing Quality Outcomes for Home and Community Based Services (HCBS)

Julie Cannariato, Policy Director
NJ Department of Human Services, Division of Medical and Health Services
HCBS Conference
Baltimore, Maryland
August 28, 2017

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Long Term Care Recipients Summary – May 2017

Total Long Term Care Recipients*	**51,257**
Managed Long Term Support & Services (MLTSS)	**35,566**
MLTSS HCBS	18,804
MLTSS Assisted Living	3,367
MLTSS HCBS/AL (unable to differentiate)	18
MLTSS NF	13,157
MLTSS Upper SCNF	138
MLTSS Lower SCNF	82
Fee For Service (FFS/Managed Care Exemption)	**14,749**
FFS pending MLTSS (SPC 60-64)	726
FFS Nursing Facility (SPC 65)	10,289
FFS SCNF Upper (SPC 66)	174
FFS SCNF Lower (SPC 67)	114
FFS NF – Other (Jan 2017)**	3,446
PACE	**942**

Source: NJ DMAHS Shared Data Warehouse Regular MMX Eligibility Summary Universe, accessed 6/12/2017.
Notes: Information shown includes any person who was considered LTC at any point in a given month and includes individuals with Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 03, 05, 06, 17, 32, 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE).
* 'FFS NF – Other is derived based on the prior month's population with a completion factor (CF) included to estimate the impact of nursing facility claims not yet received. Historically, 90.76% of long term care nursing facility claims and encounters are received one month after the end of a given service month.
** Includes Medically Needy (PSC 170,180,270,280,340-370,570&580) recipients residing in nursing facilities and individuals in all other program status codes that are not within special program codes 60-67 or capitation codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499.

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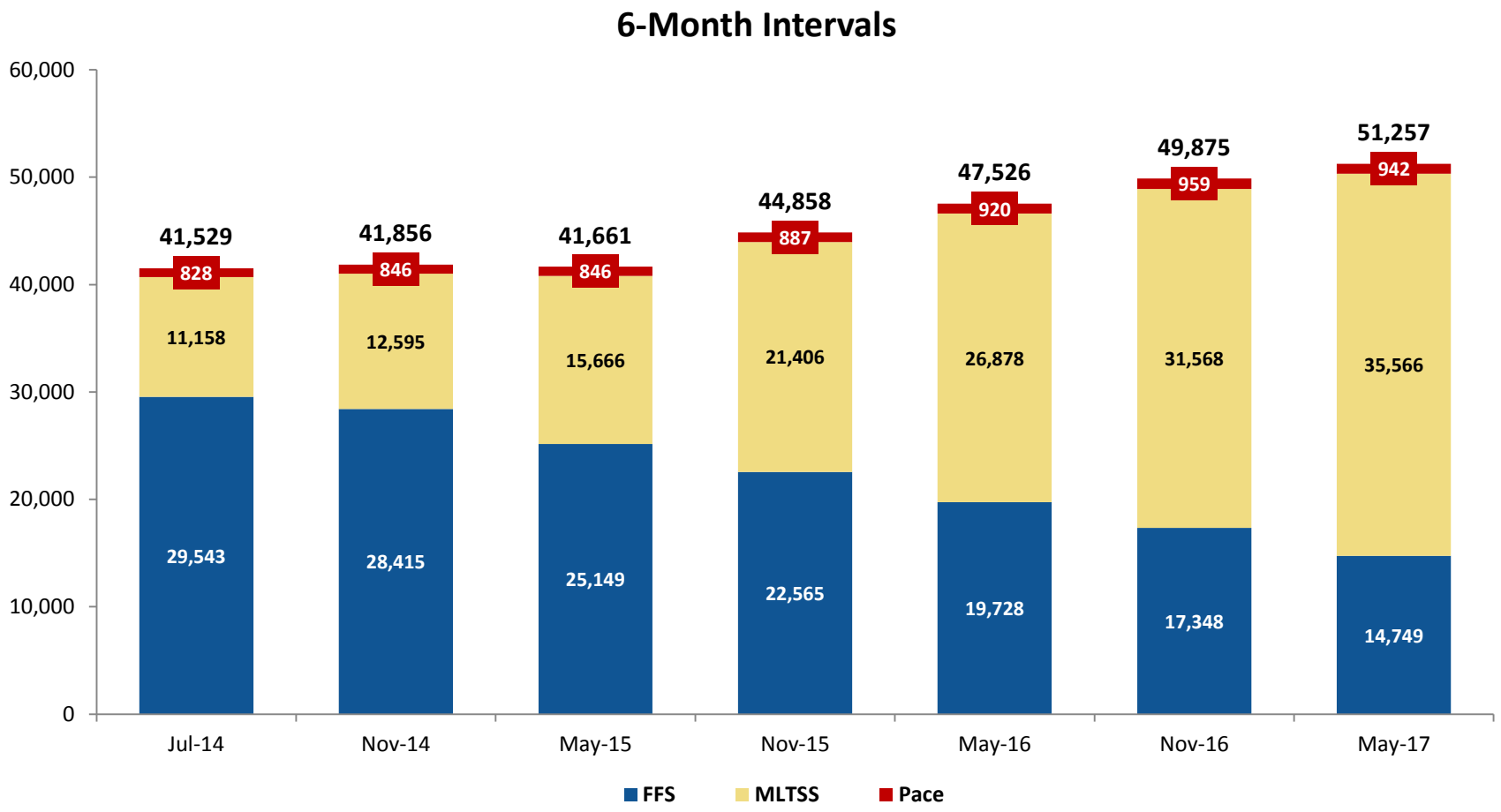
Long Term Care Population: FFS-MLTSS Breakdown



Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 6/12/2017.

Notes: Information shown includes any person who was considered LTC at any point in a given month based on: Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 03, 05, 06, 17, 32, 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE). All recipients with PACE plan codes (220-229) are categorized as PACE regardless of SPC, Capitation Code, or COS. MLTSS includes all recipients with the cap codes listed above. FFS includes SPC 65-67 and all other COS 07, which is derived using the prior month's COS 07 population with a completion factor (CF) included to estimate the impact of nursing facility claims not yet received. Historically, 90.76% of long term care nursing facility claims and encounters are received one month after the end of a given service month.

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Background and Historical Context

- ✓ With the launch of MLTSS on July 1, 2014, DMAHS implemented managed care performance measures to track service utilization. These measures are intended for both the Division of Medical and Health Services (DMAHS) and the managed care organizations to assess compliance, cost and develop best practices.

- ✓ After implementation DMAHS began to explore tying performance to a purchasing strategy and further innovation to improve quality outcomes with a focus on the home and community based population.

- ✓ In State Fiscal Year 2016 DMAHS funded a quality incentive program aimed at accelerating the transition of individuals in a nursing home to a safe and appropriate community based setting. Despite this funding, DMAHS saw little buy-in from the managed care organizations (MCOs) and very little movement of individuals into the community.

- ✓ DMAHS determined that moving from a performance incentive based on transitions to incentives based on performance of MLTSS home and community based services would be more beneficial and cost effective.

- ✓ DMAHS applied and was accepted to participate in the CMS sponsored Innovator Accelerator Program (IAP) for Incentivizing Quality Outcomes (IQO) technical assistance opportunity to redesign our value based purchasing strategy as well as improve quality care for the MLTSS home and community based population.

Medicaid IAP Opportunity

Develop an incentivized quality outcome program utilizing performance measures to encourage the MCOs to achieve program goals including maintaining community placements; appropriate services and supports to both Member and Caregiver; person-centered planning; and ensure quality of life and safety in the home.

Performance Measure Selection

An interdivisional quality workgroup was convened to review current quality measures for long term care programs (MLTSS, PACE, FIDE-SNP) in the following areas:

- Quality care domains and associated performance measures from 1915c waiver programs;
- MLTSS performance measures;
- NCI-AD survey results; and
- Other Nationally recognized measures, e.g. CMS,HEDIS, NCQA, NQF.

Performance Measure Selection Process – Initial Draft

Domains	Measure #	Measure Name / Description	Data Source
Clinical Assessment and Person Centered Planning	1	Plans of Care (PoC) are aligned with members needs based on the results of the NJ Choice assessment.	Annual MLTSS Performance Measure (PM) # 10 CM Audit - EQRO
	2	Plans of Care developed using "person-centered principles".	Annual MLTSS PM #11 CM Audit - EQRO
	3	Do you take part in making and/or updating your Plan of Care or plan for services?	NCI AD 2016-2017; NJ -7
	4	Not authorized Nursing Facility (NF) Level of Care (LOC) assessments by the Managed Care Organizations (MCO's) / Office of Community Choice Options (OCCO) Request For Information process to complete not authorized review and final determination activities.	OCCO Audit
Quality of Life / Degree of Integration	5	Proportion of people who have transportation when they want to do things outside of their home.	NCI AD (2015-2016); Graph 28
	6	Proportion of people who like how they usually spend their time during the day.	NCI AD (2015-2016); Graph 10
	7	Proportion of people who sometimes or often feel lonely, sad or depressed	NCI AD (2015-2016); Graph 7
	8	Proportion of people who feel in control of their life	NCI AD (2015-2016) Graph 112
	9	Proportion of people who like where they are living	NCI AD (2015-2016); Graph 8
	10	Do you need assistance to be able to stay in your current housing OR to find and maintain other, safer or more stable housing?	NCI AD 2016-2017

Performance Measure Selection Process – Initial Draft continued

Domains	Measure #	Measure Name / Description	Data Source
Health and Welfare	11	Needs assistance with food preparation, shopping and feeding.	Annual MLTSS PM CM Audit - EQRO
	12	Proportion of people who can eat their meals when they want.	NCI AD (2015-2016); Graph 4
	13	Place Holder: Falls measure Measures Reviewed: 1. NCQA 101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls 2. CMS 0537 Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate.	TBD
	14	Follow up after mental health hospitalization for HCBS MLTSS members: 7 day follow up.	MCO MLTSS PM #36
	15	Follow up after mental health hospitalization for HCBS MLTSS members: 30 day follow up.	MCO MLTSS PM #36
	16	Follow-up after Discharge from the Emergency Department for Mental Health.	NQF #2605 **HEDIS measure effective 1/1/2017
	17	MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a back-up plan.	Annual MLTSS PM #12 CM Audit - EQRO
	18	Number of readmissions of MLTSS HCBS members (not unique members) to the hospital within 30 days.	MCO MLTSS PM #28
	19	Number of ER utilization by MLTSS HCBS members (not unique members).	MCO MLTSS PM # 30

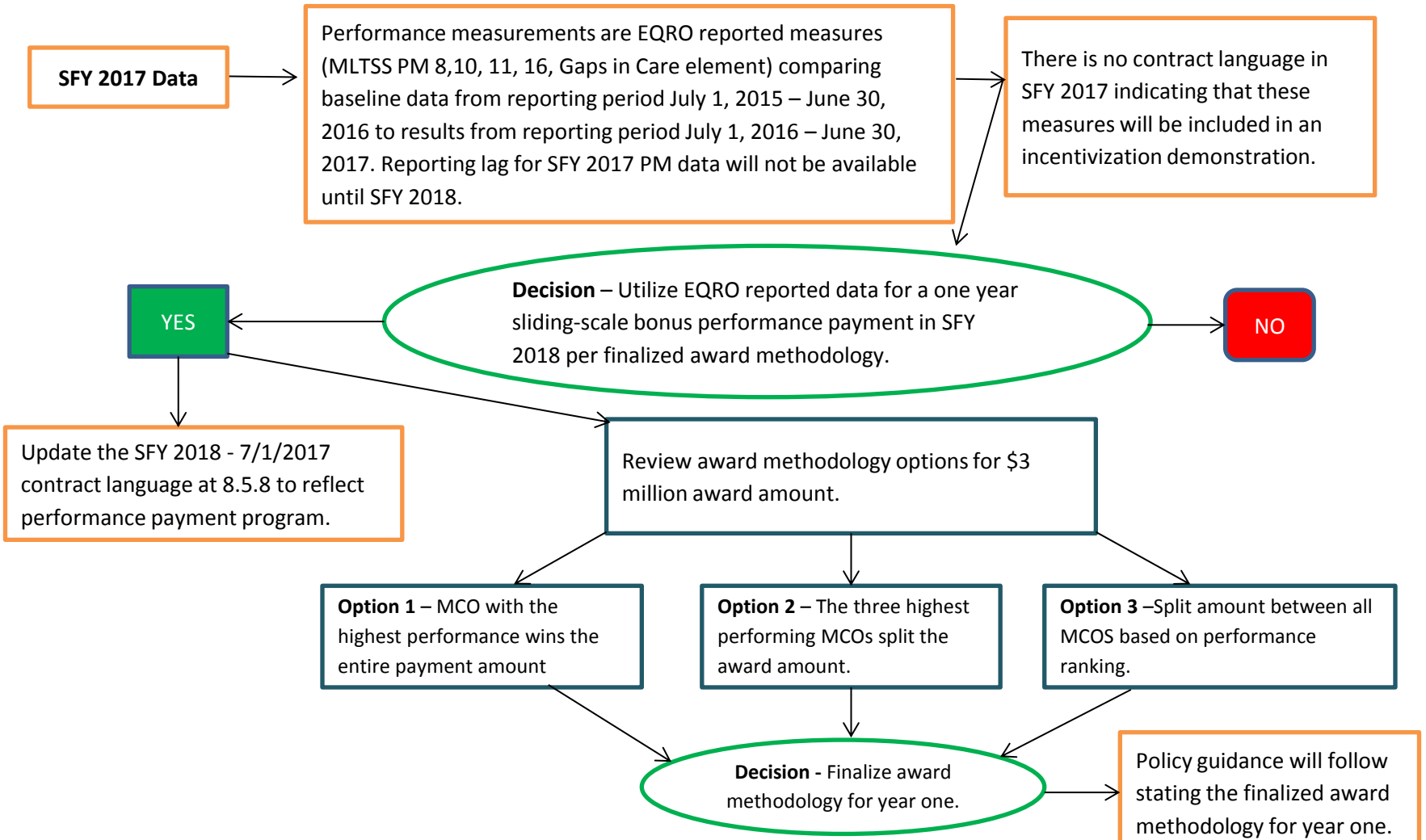
Data Source Reliability

Date Source	Review Result
MCO	Data analysis showed inconsistencies with service delivery coding among all MCOs in years one and two of MLTSS operations resulting unreliable and incomplete data for some of the HCBS population; determined inappropriate for the base year.
Office of Community Choice Options, (OCCO)	OCCO performance measure required refinement; determined inappropriate for the base year.
NCI – AD	Survey results are from the first year of operation; determined inappropriate for the base year.
External Quality Review Organization (EQRO)	**Data analysis determined that the EQRO provided performance measures for year two of MLTSS operations were consistent across all MCOs; determined appropriate chosen as the base year.**

Performance Measure Selection

DOMAIN	MEASURE #	MEASURE	DATA SOURCE
Clinical Assessment and Person Centered Planning	1	Plans of Care (PoC) established within 30 days of enrollment into MLTSS/HCBS	Annual MLTSS Performance Measure (PM) # 8 CM Audit - EQRO
	2	Plans of Care (PoC) are aligned with members needs based on the results of the NJ Choice assessment.	Annual MLTSS Performance Measure (PM) # 10 CM Audit - EQRO
	3	Plans of Care developed using "person-centered principles".	Annual MLTSS PM #11 CM Audit - EQRO
	4	MCO member training on identifying /reporting critical incidents	Annual MLTSS PM #16 CM Audit - EQRO
	5	Gaps in Care/ Critical Incidents	Annual MLTSS Performance Element CM Audit - EQRO

Funding and Award Methodology Decisions for Year One Performance Payment



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Funding and Award Methodology

Decisions Results
Final Performance Measure selection – APPROVED
Final Overall Award Amount of $3 million – APPROVED
Final Award Distribution – APPROVED The three (3) highest scoring Contractors will receive payment according to the following structure: 1. The highest Contractor will receive $1.5 million; 2. The second highest Contractor will receive $1 million; and 3. The third highest Contractor will receive $500, 000.

Performance Payment Scoring Methodology – SAMPLE

***Data does not reflect actual MCO information or scores. It is for informational purposes only.

				Year 1								Year 2			
	Measures and Plans	Plans of Care Established	Plans of Care Alignment	Plans of Care Person-Centered	Critical Incidents	Gaps in Care	sum			Plans of Care Established	Plans of Care Alignment	Plans of Care Person-Centered	Critical Incidents	Gaps in Care	sum
	PLAN A	0.5	0.92	0.85	0.85	0.55	3.67		PLAN A	0.65	0.95	0.9	0.5	0.45	3.45
	PLAN B	0.7	0.77	0.82	0.76	0.8	3.85		PLAN B	0.71	0.77	0.84	0.77	0.81	3.9
	PLAN C	0.2	0.6	0.1	0.55	0.69	2.14		PLAN C	0.6	0.69	0.35	0.6	0.65	2.89
	PLAN D	0.95	0.99	0.88	0.97	0.85	4.64		PLAN D	0.96	0.99	0.92	0.97	0.85	4.69
	PLAN E	0.7	0.81	0.87	0.55	0.81	3.74		PLAN E	0.75	0.82	0.86	0.86	0.85	4.14
CRITERIA 1	Level of Achievement (Summed Scores)				Raw Scores summed										
		Sum(Year 2)	Rank												
	PLAN A	3.45	4												
	PLAN B	3.9	3												
	PLAN C	2.89	5												
	PLAN D	4.69	1												
	PLAN E	4.14	2												
CRITERIA 2	Threshold Points		Points for reaching each threshold 0= <.55, 1=.55-.699, 2=.70-.85, 3=.85+												
		Plans of Care Established	Plans of Care Alignment	Plans of Care Person-Centered	Critical Incidents	Gaps in Care	Sum Threshold Points	Rank	Count # Over threshold	Rank					
	PLAN A	1	3	3	0	0	7	4	3	4					
	PLAN B	2	2	2	2	2	10	3	5	1					
	PLAN C	1	1	0	1	1	4	5	4	5					
	PLAN D	3	3	3	3	3	15	1	5	1					
	PLAN E	2	2	3	3	3	13	2	5	1					
CRITERIA 3	Improvement Year 2-Year 1			Amount of improvement Year 2 - Year 1 (not taking into consideration starting scores)											
		Plans of Care Established	Plans of Care Alignment	Plans of Care Person-Centered	Critical Incidents	Gaps in Care	Sum Improvement	Rank							
	PLAN A	0.15	0.03	0.05	-0.35	-0.1	-0.22	5							
	PLAN B	0.01	0	0.02	0.01	0.01	0.05	3							
	PLAN C	0.4	0.09	0.25	0.05	-0.04	0.75	1							
	PLAN D	0.01	0	0.04	0	0	0.05	3							
	PLAN E	0.05	0.01	-0.01	0.31	0.04	0.4	2							
COMBINATION		80% Attainment Average Score + 20% Improvement Average	RANK		Rank on Attainment	Rank on Improvement									
	PLAN A	0.5432	4		4	5									
	PLAN B	0.626	3		3	3									
	PLAN C	0.4924	5		5	1									
	PLAN D	0.7524	1		1	3									
	PLAN E	0.6784	2		2	2									

Performance payment scoring methodology developed by Teresa B. Gibson, PhD

NJ FAMILYCARE
Affordable health coverage. Quality care.

Stakeholder Feedback

Stakeholders:

- ✓ Prior to CMS submission the proposed contract language was shared with the MCOs.
- ✓ Regularly scheduled monthly MLTSS Quality Workgroup and MCO Contract Issues meetings are utilized to collaborate with the Managed Care Organizations about the program initiative.

Next Steps

Includes Developing:

- ✓ A Communication Plan;
- ✓ Frequently Asked Questions (FAQs);
- ✓ Policy Guidance; and
- ✓ Continued Stakeholder Engagement.

Questions?

For More Information

Julie Cannariato
Policy Director
New Jersey Department of Human Services
Division of Medical Assistance and Health Services (DMAHS)

Email: Julie.Cannariato@dhs.state.nj.us
Phone: 609.588.2600

A Commitment to Quality – Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL)

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

CHSRA™
Center for Health Systems Research & Analysis

Department of Health Services
State of Wisconsin

Covered Topics

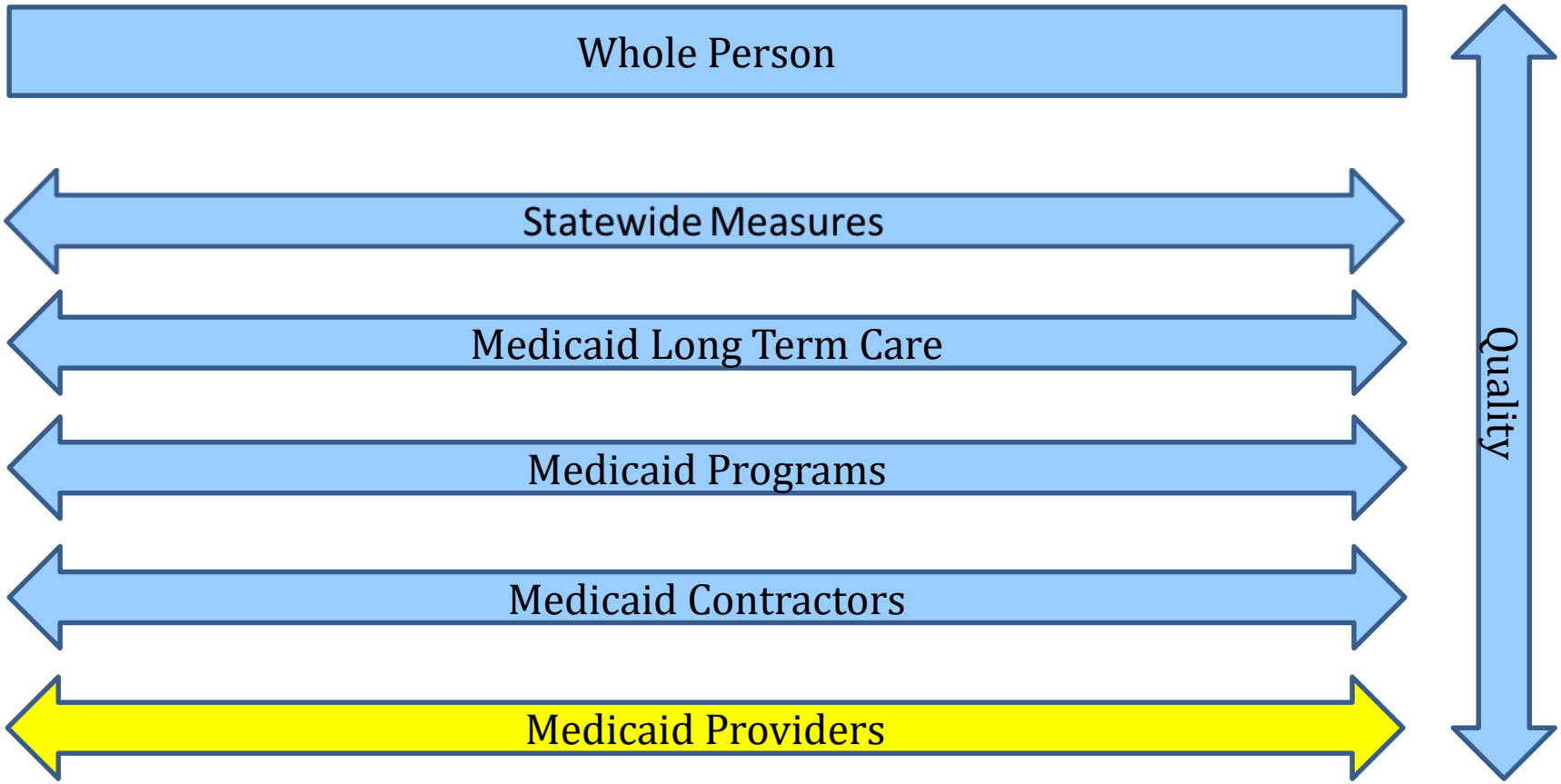
- Overview of the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL)
- WCCEAL potential as a national model
- Next Steps

History and Critical Events

Internal Quality Improvement

- Public/Private Collaboration
- Regulators, Public Funders, Advocates, Provider Associations
- Structure, process and outcome measures used to evaluate quality

Quality Strategy for People in Long Term Care



CHSRA
Center for Health Systems Research & Analysis

Wisconsin Board on
Aging and Long Term Care

WALA
Wisconsin Assisted Living Association

RSA WISCONSIN

LeadingAge Wisconsin
Better Services for Better Aging

WHCA / WiCAL
Wisconsin Health Care Association
Wisconsin Center for Assisted Living

Center for Excellence in Assisted Living

ARGENTUM
EXPANDING SENIOR LIVING

NCAL
NATIONAL CENTER FOR ASSISTED LIVING

LeadingAge

WCCEAL

- Provider association sponsored
- Department approved
- Comprehensive quality assurance and quality improvement (QA and QI)
- Includes 9 guiding values
  https://www.dhs.wisconsin.gov/publications/p01584.pdf

Provider Associations

WCCEAL Approved Program

- LeadingAge - LeadingAge Wisconsin Echelon
- WALA - Diamond Accreditation Program
- WiCAL - Performance Excellence in Assisted Living (PEAL) Program
- RSA of WI - STAR Accreditation

WCCEAL

Membership criteria

- The assisted living community is a member of a major association in good standing (Wisconsin Assisted Living Association [WALA], LeadingAge, Wisconsin Center for Assisted Living [WiCAL], RSA of WI).
- The community is licensed as an assisted living community.
- The community has implemented a provider association and department-approved quality improvement program.
- The provider has made a self-attestation that they are in substantial compliance with all regulations.

Government Oversight & Support for Quality

Program	Enforcement	QA & QI	Nursing Home	Assisted Living
Federal Regulations	✓		✓	
State Regulations	✓		✓	✓
Quality Improvement Organization (QIO)		✓	✓	
Advancing Excellence		✓	✓	
Nursing Home Quality Initiative		✓	✓	
AHRQ Nursing Home Consumer Assessment of Healthcare Providers and Systems (CAHPS)		✓	✓	
Medicare Quality Improvement Community (QIES)		✓	✓	
Nursing Home Compare – 5 Star		✓	✓	
Minimum Data Set		✓	✓	
Quality Assurance Performance Improvement (QAPI)		✓	✓	
Online Survey, Certification and Reporting (OSCAR)		✓	✓	
Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL)		✓		✓

Part of a Larger Community

- WCCEAL collaborative
- Access to resources and opportunities

Consumer Demand

- Consumers are more savvy today.
- Consumers demand quality.

Competition

- Raise the bar on quality.
- Positioned to compete better in the marketplace.

Regulations

- Proactive approach to regulatory compliance
- Sustained regulatory compliance
- Regulatory relief:
  - If qualified, then less frequent surveys

Insurance Companies

- Decrease risk
- Increase ability to obtain and retain liability insurance
- Discounts and reduced premiums

Medicaid HCBS

- Can WCCEAL be a "leading indicator" of good quality and high consumer satisfaction?
- We are exploring P4P with MCOs related to Provider networks

WCCEAL Aligns with CMS Guidelines for the States

- Greater emphasis on quality
- Sections 1915 (c), (i) and (k) of the Act all require states to demonstrate at the time of approval that they have a quality improvement strategy that includes performance and outcome measures for the Medicaid Home and Community Based Services (HCBS) waivers.
- In Wisconsin, 51% of Family Care (HCBS Waiver) service expenditure was for AL (RCAC, CBRF, and AFH). 39% of enrollees had some service cost during the year for AL.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

WCCEAL Aligns with National Quality Forum

Measuring HCBS Quality

This project developed a conceptual framework and perform an environmental scan to address performance measurement gaps in home- and community-based services to enhance the quality of community living.

- Create a conceptual framework for measurement, including a definition for HCBS.
- Perform a synthesis of evidence and environmental scan for measures and measure concepts.
- Identify gaps in HCBS measures based on the framework.
- Make recommendations for HCBS measure development efforts.

Calendar Year 2016 Highlights

- Growth continues - 10% (437 facilities)
- Members in Good Standing - 86%
- High Staff Retention - 65%
- High Staff Immunization Rate - 67%
- Low negative outcomes (annual average per thousand resident days)

	WCCEAL
Falls with injury	0.52
Infections – norovirus	0.08
Infections – influenza	0.03
Hospital Readmissions	0.13

Calendar Year 2016 Highlights

High Resident Satisfaction (range 1-5)

- Overall 4.44
- Staff 4.41
- Rights 4.43
- Environment 4.51
- Activities 4.26
- Meals and Dining 4.15
- Health Management 4.46

Screen Shot - Satisfaction

≤ 25th percentile | ≥ 75th percentile

Inclusion Criteria

PARTICIPATION SUMMARY +

SATISFACTION SURVEY RESULTS -

	2017			2016			2015			2014			2013
	Sample Community 16	Sample	WCCEAL	Sample Community 16	Sample	WCCEAL	Sample Community 16	Sample	WCCEAL	Sample Community 16	Sample	WCCEAL	WCCEAL
	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score
TOTAL	4.58	4.42	4.36	4.33	4.32	4.38	4.42	4.32	4.38	4.07	4.40	4.43	4.40
+ A. STAFF	4.61	4.42	4.39	4.37	4.29	4.41	4.49	4.34	4.42	4.10	4.41	4.47	4.44
+ B. RIGHTS	4.79	4.47	4.41	4.53	4.37	4.43	4.55	4.31	4.42	4.20	4.47	4.49	4.44
+ C. ENVIRONMENT	4.70	4.50	4.49	4.54	4.45	4.51	4.61	4.43	4.51	4.17	4.46	4.55	4.56
+ D. ACTIVITIES	4.42	4.37	4.26	4.16	4.25	4.26	4.32	4.24	4.27	4.11	4.31	4.29	4.25
+ E. MEALS AND DINING	4.19	4.21	4.12	3.95	4.11	4.15	4.01	4.12	4.16	3.64	4.18	4.20	4.17
+ F. HEALTH MANAGEMENT/CARE	4.66	4.50	4.45	4.42	4.40	4.46	4.48	4.40	4.47	4.18	4.50	4.51	4.49
+ G. OVERALL	4.70	4.43	4.43	4.40	4.37	4.44	4.47	4.39	4.45	4.08	4.48	4.50	4.49

Resident Rights

≤ 25th percentile | ≥ 75th percentile

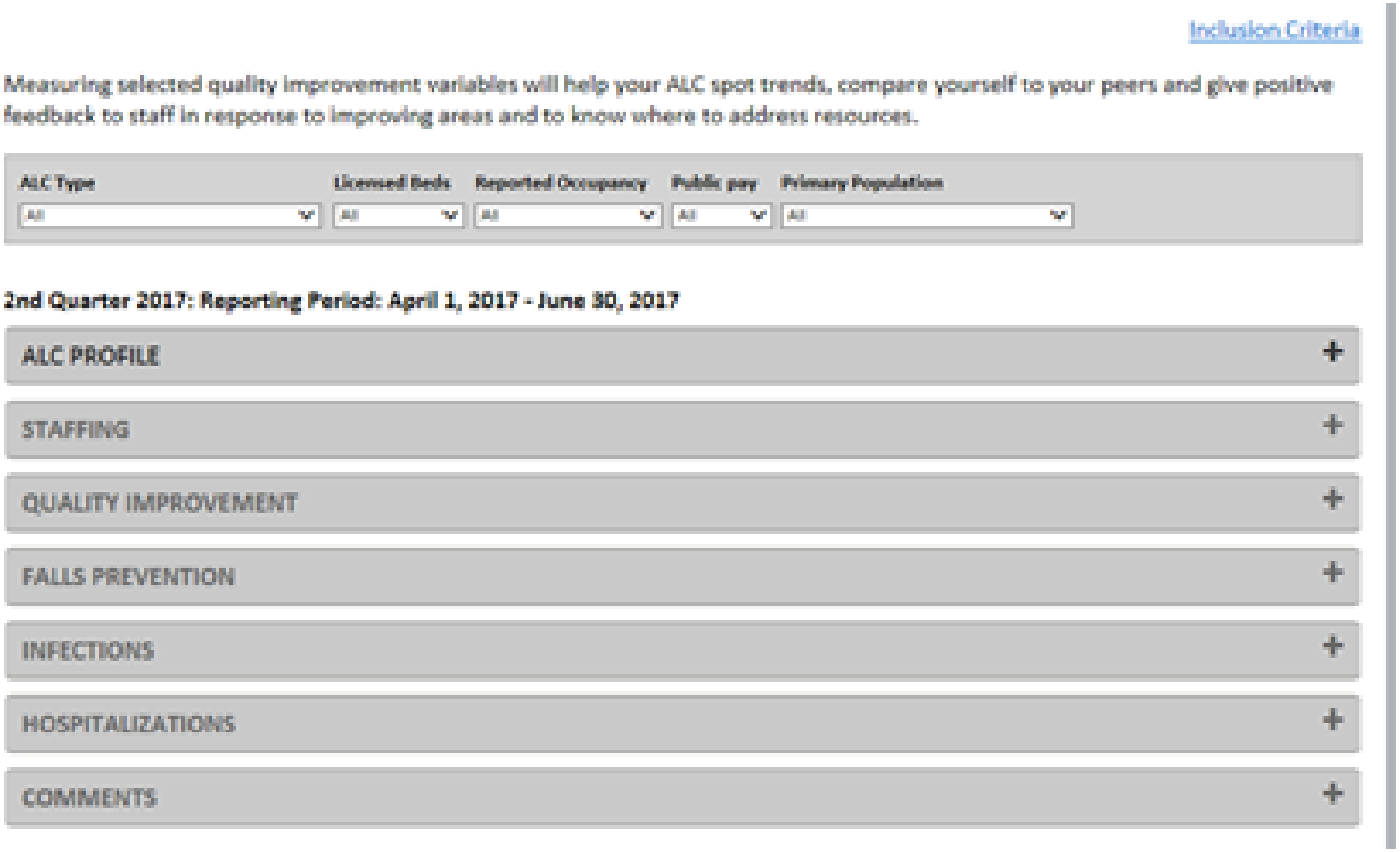
Inclusion Criteria

PARTICIPATION SUMMARY +

SATISFACTION SURVEY RESULTS -

	2017			2016			2015			2014			2013
	Sample Community 16 Score	Sample Score	WCCEAL Score	Sample Community 16 Score	Sample Score	WCCEAL Score	Sample Community 16 Score	Sample Score	WCCEAL Score	Sample Community 16 Score	Sample Score	WCCEAL Score	WCCEAL Score
TOTAL	4.58	4.42	4.36	4.33	4.32	4.38	4.42	4.32	4.38	4.07	4.40	4.43	4.40
+ A. STAFF	4.61	4.42	4.39	4.37	4.29	4.41	4.49	4.34	4.42	4.10	4.41	4.47	4.44
− B. RIGHTS	4.79	4.47	4.41	4.53	4.37	4.43	4.55	4.31	4.42	4.20	4.47	4.49	4.44
1. I was informed of my rights	4.68	4.49	4.40	4.70	4.40	4.42	4.64	4.27	4.41	4.30	4.45	4.47	4.41
2. The people who work here protect my rights	4.84	4.49	4.41	4.50	4.39	4.42	4.48	4.34	4.41	4.15	4.50	4.48	4.43
3. My privacy is respected	4.84	4.50	4.45	4.45	4.43	4.47	4.52	4.37	4.46	4.47	4.53	4.53	4.48
4. I am informed of rate and policy changes that might affect me	4.71	4.20	4.30	4.53	4.11	4.29	4.61	4.14	4.30	3.95	4.33	4.40	4.38
5. I am treated with dignity and respect	4.84	4.58	4.51	4.45	4.48	4.55	4.54	4.46	4.52	4.20	4.54	4.57	4.53

Screen Shot QI metrics



Current Projects

- Moved from pilot to statewide implementation
- Goal of 1,000 communities in 5 years
- Wisconsin Partnership grant
- Fall prevention grant
- Music & Memory grant
- Preliminary talks with AMDA (*The Society for Post-Acute and Long-Term Care Medicine)*

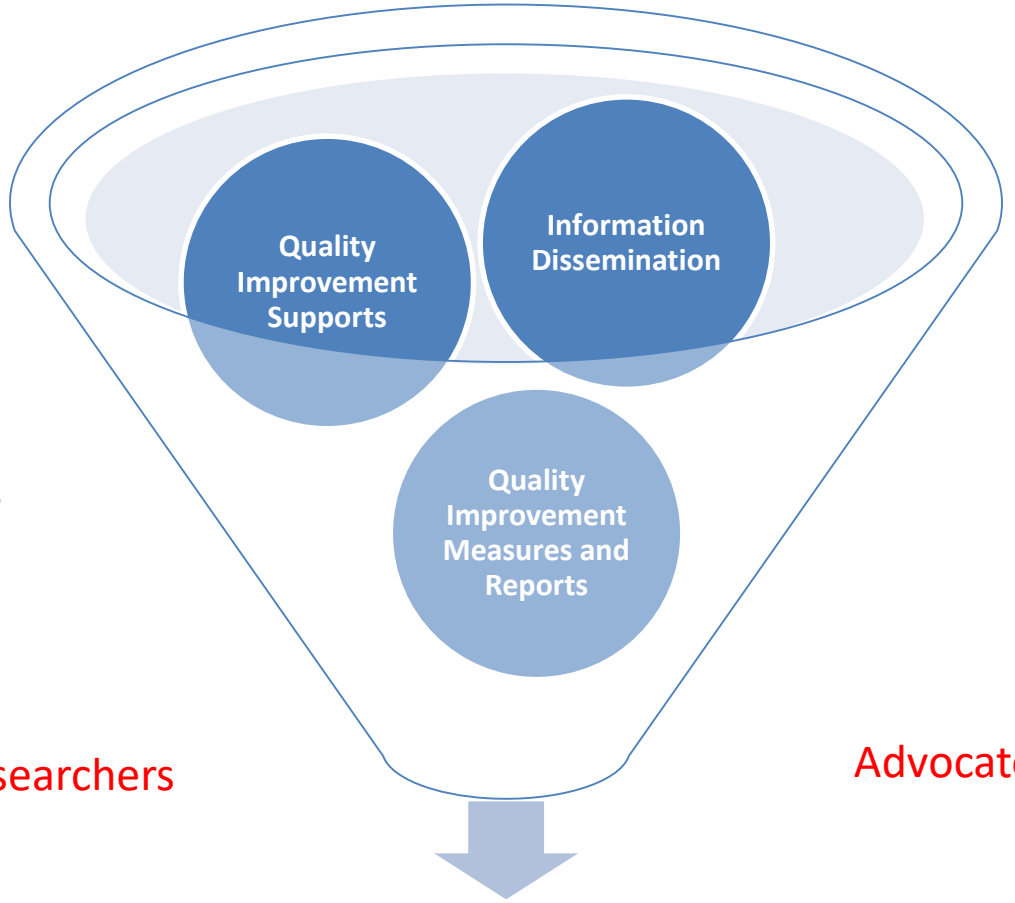
Current Projects cont.

- Expand the model:
  - Add more outcomes
  - Additional learning modalities
- P4P Managed Long Term Care Program
- Potential expansions to other states, or collaboration with national associations (Have had meetings with Argentum, NCAL, LeadingAge, Consumer Voice, Administration for Community Living)

Assisted Living Quality Collaborative Model with External Partners

Assisted Living Communities

Regulatory Entities



Managed Care Organizations

Provider Associations

Public Funding Agencies

Researchers

Advocates

Assisted Living Community Certification

National Recognition

2015 – Harvard Innovations in American Government Award Program, *Bright Idea Award*
https://ash.harvard.edu/bright-ideas-2015

2016 - Association for Health Facility Survey Agencies, *Promising Practice Award*
http://www.ahfsa.org/annual-conference/promising-practices

2017 – Pioneer Institute, Better Government Competition, Special Recognition Awardee
http://pioneerinstitute.org/better-government-competition/

2017 – Approval to claim Federal Matching funds

WCCEAL

- **Demo - Visitor Login Process**
  - https://wcceal.chsra.wisc.edu/
  - Username: wccealvisitor
  - New password is: blue123

Persistence is the twin sister of excellence. One is a matter of quality; the other, a matter of time. ~ Author Unknown.

Contact Information

- Curtis J. Cunningham

Assistant Administrator for Long Term Care Programs and Benefits
Division of Medicaid Services
Wisconsin Department of Health Services
curtis.cunningham@wisconsin.gov
(608) 261-7810

- Kevin Coughlin

Policy Initiatives Advisor-Advanced
Division of Medicaid Services
Wisconsin Department of Health Services
Kevin.coughlin@wisconsin.gov
(608) 266-6989

Improving Quality in MLTSS:

A challenge to *all* of us to think differently about quality

Our Focus; Our Challenge

- Defining *"**quality**"*
- Measuring ***quality***
  - Do we "*value*" what we can measure or measure what we value?

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

  - Creating a perfect method for measuring things that are not important is not the goal…get comfortable with **GRAY**.

- Improving ***quality***
- Incentivizing ***quality***
  - Linking ***quality*** to payment

"*Quality*" in Tennessee's MLTSS Programs

- My Division
- Our Contractor Risk Agreement
- Our "*Quality Strategy*"

Compliance in MLTSS Programs

- **What is compliance** in MLTSS programs?
  - Meeting contractual requirements
    - All MCOs must operate in **compliance** with the state's contracting standards
    - All providers must operate in **compliance** with their provider agreement
  - Compliance is really **a minimum standard**, not a sign of quality performance
- **Who is responsible for ensuring compliance** in MLTSS programs?
  - Ensuring compliance is the responsibility of the contract holder
    - The State for MCOs (contract monitoring)
    - MCOs for their providers (credentialing and re-credentialing)
- Defining expectations is important; monitoring to ensure they are met ("compliance") is also important…but it's not all that's important, and maybe not even the most important thing
- What good does it do to ensure **compliance** if we aren't also ensuring **quality**?

Compliance v. Quality: An Important Distinction

- Following the rules is **not** enough to excel at the game.

≠

No Penalties Does Not Equal Touchdowns

Traditional Quality Monitoring

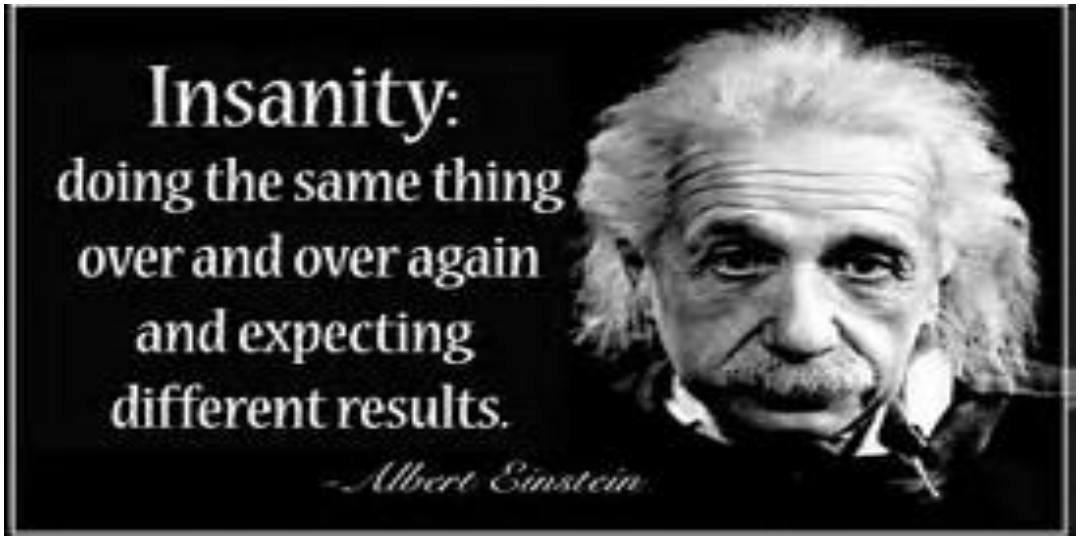
- We are weary of playing the never ending game of "Gotcha!" with health plans and providers (they are tired of it too)
- Simply policing health plans and providers is not consistent with the learning culture necessary for continuous quality improvement
- Too much focus on following rules undermines critical thinking
- Health plans and providers, including direct support professionals, don't understand *why* they are doing things, other than because it's a rule or a contract requirement, because *"they have to"*
- Health plans and providers, and in turn their staff, are hesitant (even fearful) of being truly person-centered for fear of being found ***"non-compliant"***

Traditional Quality Monitoring

- We want to change the game…we have to monitor compliance, but we want to also begin to:
  - **Measure *quality***
  - **Value *quality***
  - **Improve *quality***
  - **Incentivize *quality***
- Goal is to **make quality monitoring about *QUALITY*** and keep compliance monitoring part of MCO contract monitoring and provider credentialing/re-credentialing
- A **quality** health plan/provider is one that performs **above** *minimum* compliance requirements

Definition of Insanity

- Doing same thing, time after time, and expecting (BUT **NEVER** GETTING) a different result



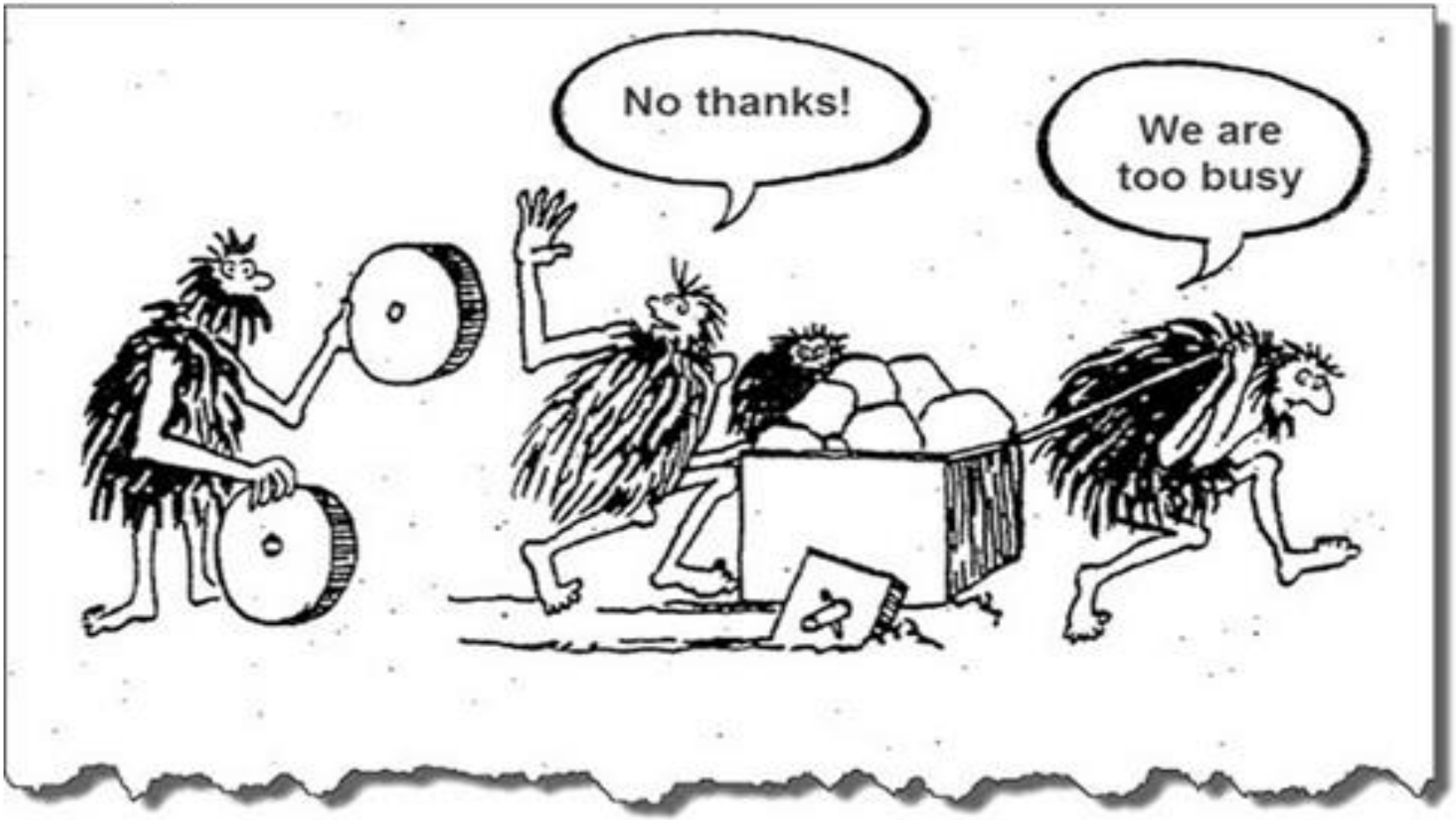
- If monitoring compliance must be done in perpetuity in order to ensure compliance, are our monitoring efforts really working?

Million Dollar Questions

- How do we incentivize and build **real quality** in MLTSS?
- Do the things we're measuring really really matter to the people we serve? Are they making a difference in anyone's life?
  - If not, ***why*** are we measuring them?

- **Why isn't quality monitoring focused on QUALITY?**
- What would happen if we started investing in health plans and providers to help them **improve *quality***?

The Biggest Barrier to Changes that Make Sense



Questions?....Let's talk