MLTSS in a Dynamic Health Care Arena

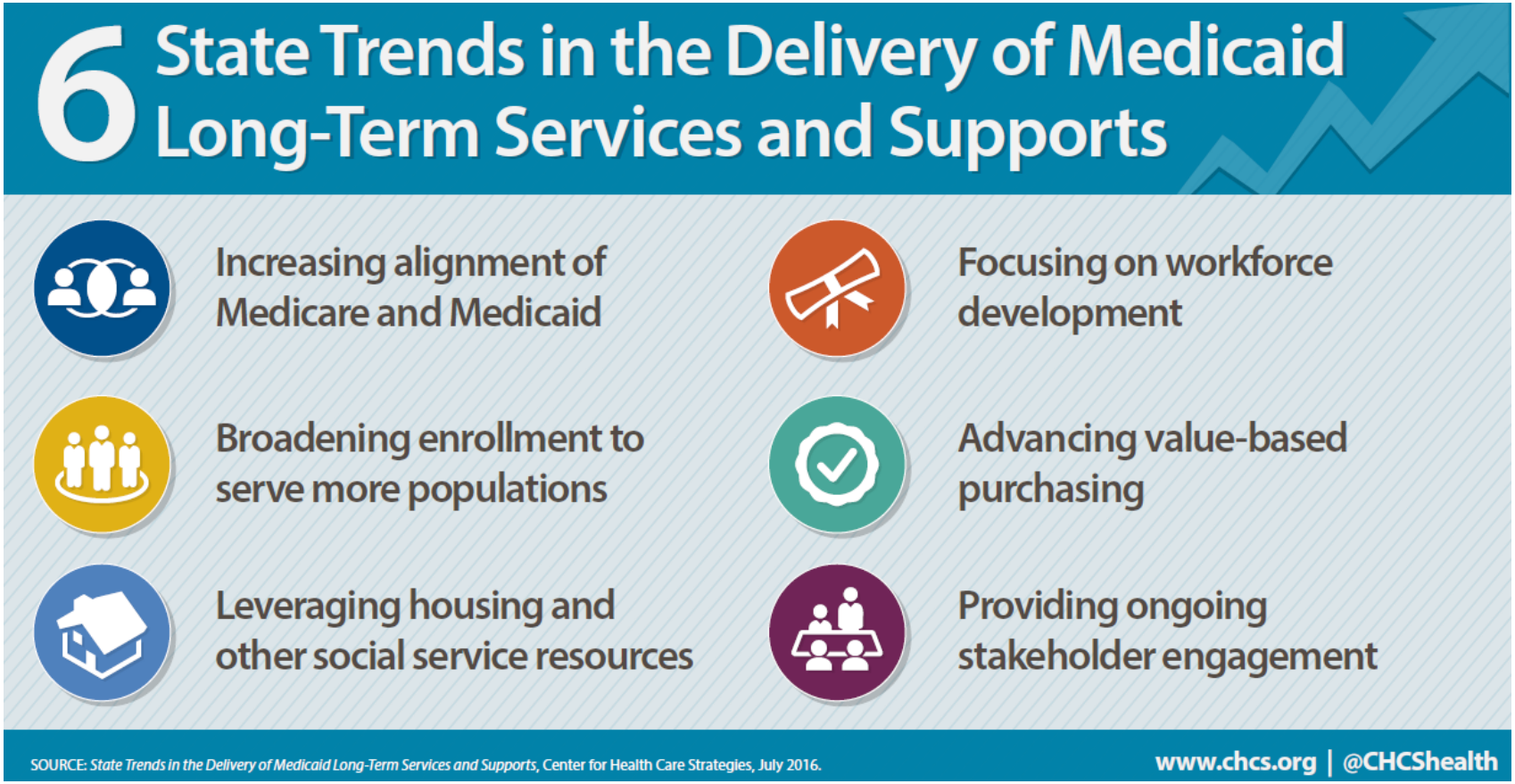
NASUAD 2017 Conference

Kenneth J. Smith

August 29th, 2017

UnitedHealthcare®
COMMUNITY & STATE

Trends



Why Are States Pursuing MLTSS?

UnitedHealthcare COMMUNITY & STATE

- In FFY 2015, LTSS expenditures represented about 34% of all Medicaid expenditures (~$158B up from $146B in 2014) [1]
  - These services constitute the largest group of Medicaid services remaining in traditional fee-for-service system
  - Fragmented approach to the 'whole person'
  - Of note: managed care expenditures have DOUBLED since FY 2012 (to 18% of all LTSS expenditures)

- In CY 2014, Medicaid financed almost one-third of nursing facility services and over half of the category of other health, residential, and personal care, a category that includes a variety of home and community-based services

[1] Truven Health Analytics, June 2017

[2] MACPAC, 2016 Report

Why Are States Pursuing MLTSS?

UnitedHealthcare COMMUNITY & STATE

- Budget Predictability
  - Capitation payments greatly minimize unanticipated spending
  - 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

Why Are States Pursuing MLTSS?

UnitedHealthcare COMMUNITY & STATE

- Accountability rests with a single entity
  - Integrating acute and long-term care makes the consumer (rather than their ‘services’) the focus
  - Financial risk for health plan provides opportunity to incentivize/penalize 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

MLTSS Activity

SOURCE: NAUSAD

Quality in MLTSS

The MLTSS Quality Framework

UnitedHealthcare COMMUNITY & STATE

Domains	Example Measure
Access	• Proportion of individuals who indicate that their service plan includes things that are important to them (HCBS Experience Survey).
Health Status / Medical Care	• Percentage of MLTSS members who transitioned from nursing facility to the community (State Measure).
Living Independently / Choice and Decision-Making	• Proportion of people who have adequate support to perform activities of daily living and IADLs (NCI-AD).
Service / Care Coordination	• Proportion of people who know how to manage their chronic conditions (NCI-AD).
Community Integration	• Proportion of individuals who report they can see or talk with family as often as they want to (NCI-AD).

Quality Framework Update: Where are we?

UnitedHealthcare COMMUNITY & STATE

In partnership with our health plans, the Clinical Strategy Team has lead the data source identification work to actively implement the LTSS Quality Framework in our 13 MLTSS plans.

- ✓ All 54 elements now have a data source
- ✓ We are converting to using the CAHPS HCBS survey in 12 of 13 markets in 2017 to gather experience information for 21 elements
- ✓ We are able to obtain some data from the Adult Core Assessment for 6 elements; Business Intelligence is assisting in obtaining the information for all markets
- ✓ We have obtained information on 4 elements from EQRO reports and may use HCBS network data going forward. 4 elements will be measured using data directly from the health plans
- ✓ Business Intelligence has begun pulling data for 19 elements; health plan leadership is being consulted to verify the data
- ✓ We are preparing market specific LTSS Quality Reports, which will be updated and refreshed on an ongoing basis

Next Steps:

1. Produce follow up White Papers on the implementation process and initial findings from the Framework measures
2. Actively measure and evaluate measures in all 13 markets

What We've Learned

UnitedHealthcare COMMUNITY & STATE

- Difficult to measure at this level and degree of quality, but possible
- Value in consistency market to market is real
- With a significant percentage of the LTSS programs, this effort represents significant market implementation
- The need to understand all tools available (e.g. HCBS CAHPS survey) and ensure full vetting to use
- These sea-change efforts take time, persistence and resources
- Defining quality and securing accurate, reliable data must happen before substantive progress can be made on value based arrangements

Questions or Comments

Kenneth Smith
UnitedHealthcare Community & State
ken_j_smith@uhc.com

CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

Advancing Value in Medicaid Managed Long-Term Services and Supports (MLTSS)

August 29, 2017
2017 NASUAD HCBS Conference

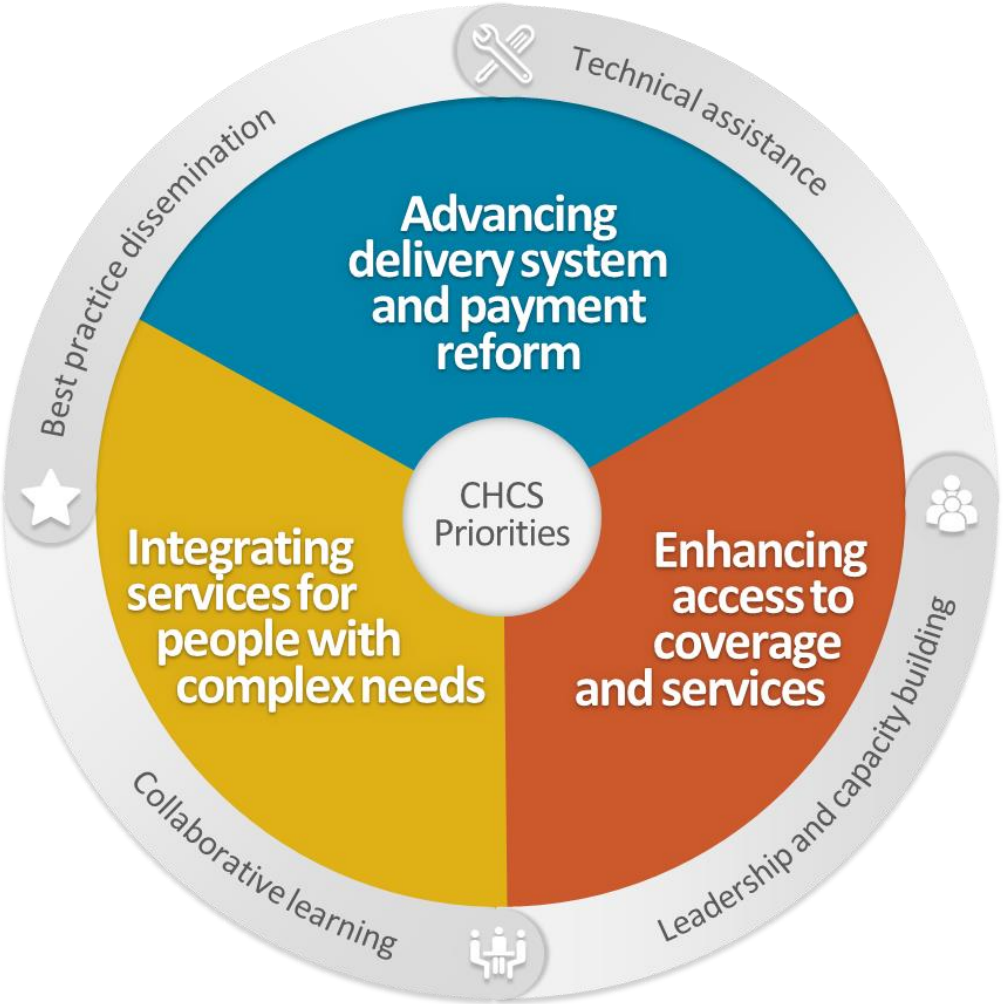
Michelle Herman Soper, Director of Integrated Care
Center for Health Care Strategies

Presentation Overview

- Introduction to CHCS and West Health
- *Advancing Value in Medicaid Managed Long-Term Services and Supports*: Project Overview
- Initial Findings: Common themes in value-based payment (VBP) and states and health plan progress
  - » Defining "value" in community-based care
  - » Program examples
  - » Challenges
  - » State considerations

About the Center for Health Care Strategies

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



Overview of West Health

westhealth

GARY & MARY west foundation™ EST. 2006

GARY & MARY westhealth™ institute

GARY & MARY westhealth™ policy center

West Health Mission:

To help seniors successfully age in place, with access to high-quality, affordable health and support services that preserve and protect their dignity, quality of life and independence.

Project Context and Overview

Context: VBP in Medicaid Managed Long-Term Services and Supports (MLTSS)

- More than 20 states have or will soon establish MLTSS programs to:
  - Rebalance care toward the home and community
  - Improve quality
  - (Ideally) reward high-quality care for LTSS users
  - Control costs
- Public payers are driving efforts to increase VBP across most health care sectors
  - Medicare: 50 percent of payments tied to value by 2018
  - Medicaid: 2016 Medicaid Director survey reported nearly half planned to expand VBP arrangements in 2017
- Continued growth expected in both the number of states with MLTSS and VBP arrangements, but few VBP arrangements will include LTSS

Advancing Value in Medicaid Managed Long-Term Services and Supports: Project Overview

- **Goal**: Advance the adoption of operational strategies that promote high-quality MLTSS programs and support individuals living in their communities
- **Parties**: The Center for Health Care Strategies (CHCS), in partnership with Mathematica Policy Research and Airam Actuarial Consulting, and the West Health Policy Center
- **Main activities**
  - Environmental scan (in process)
  - State learning collaborative (Fall 2017-Spring 2018)
  - Publication: *A Roadmap for Achieving Value in Medicaid MLTSS*
- **Funder**: West Health Policy Center

Initial Findings from the Environmental Scan

Significant Variation in How Stakeholders Define and Identify Goals of "High-Value" MLTSS

- Two components: **Quality** (focus of discussion) and **Cost-effectiveness**
- **Quality** may include all or some of the following :
  - *Health and program indicators*: medical outcomes of LTSS users; rebalancing targets and transitions
  - *Quality of life indicators:* consumer satisfaction; person-centeredness care planning; social determinants of health; increased independence
- **Cost-effectiveness** is difficult to determine:
  - Community-based care is usually the goal but may not be cheaper or require less utilization
  - "Efficiency" in LTSS is difficult to define in a person-centered model
- One consistent response: LTSS VBP differs from medical models

Current MLTSS VBP Landscape

- Few state efforts; most are tied to broad contract requirements
- More, albeit still limited, activity from health plans
- Most LTSS activities are in nursing facilities
- Examples include:
  - Broad-based state contract requirements
  - Discharge and emergency protocols in community-based settings
  - Transition and service coordination supports
  - Employment-based outcomes
  - Early identification/change in condition
  - "Non-financial" incentives; e.g., workforce development, preferred networks

Provider Capacity Was Largest Reported Challenge

- Limited provider capacity (capital and infrastructure)
- Limited managed care experience and related business acumen
- Small providers (small "n")
  - Economies of scale
  - Small denominators
  - Understanding case mix
- Lack of return on investment
- Low wages
- Suggestions to mitigate include:
  - Robust stakeholder engagement processes
  - State and/or health plan investment, financial or otherwise
  - Power in numbers

Other Challenges

Issue	Challenges	Suggestions to Mitigate
Quality	• Measure "overload" • Data collection: capacity, reliability, consistency	• Advance national efforts that align with state policy goals • State-established templates to collect person-centered information (e.g., TN)
Efficiency	• May contradict person-centered goals • Not always about less services	• Reassess regularly; trust and consistency to motivate efficiency; empower caregivers and individuals • Close monitoring of care plan
Plan and provider rates	• Upfront capital • Rate methodologies: plan concerns and low provider rates	• State or plan investments • Differential rates for high performing providers; upside shared savings; different payment strategies targeted to other provider characteristics

Key Considerations for States Embarking on these Efforts

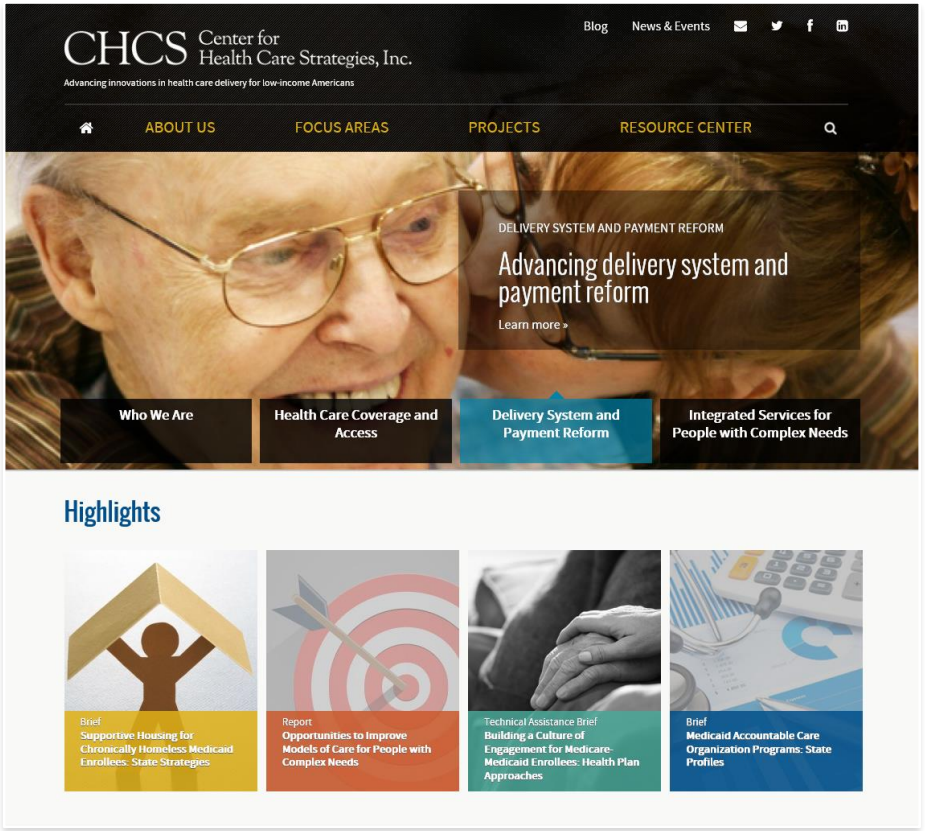
- Consequences of too much "squeeze": Go slow
- Appropriate guard rails: Flexibility vs. prescriptiveness
- Effect of other state or industry policies (e.g., Any Willing Provider; opportunities to support Medicare-Medicaid integration)
- Potential perverse incentives and complications (e.g., self-direction models)
- Opportunities for states to support programs:
  - Direct capital or other investments
  - Thoughtful contract design
    - Targeted RFP questions about plan investments
    - Promotion of plan innovation
  - Education and data sharing

Next Steps and Discussion Questions

- Next steps:
  - State learning collaborative
  - Apply learnings from related VBP models
- Audience questions for discussion:
  - How do you define "high-value" MLTSS?
  - What are other examples of VBP arrangements in states, plans, elsewhere focused on improving community-based care?
  - What are the biggest challenges with implementing VBP arrangements in community-based care in MLTSS?
  - What should states designing or implementing these efforts consider before launching or working to improve them?

Visit CHCS.org to…

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



Contact Information

Michelle Soper, Director of Integrated Care
msoper@chcs.org