SA9- What the Multidisciplinary Team in Nursing Homes Need to Know About Changing Models of Health Care in the Community

Saturday, March 24
11:00 AM- 12:30 PM

Session Description

This panel will discuss how changes in our care delivery systems across the country are integrating medical and social supports services for better outcomes for patients and families living in the community and skilled nursing facilities. A range of models will be discussed to better deliver care such as case managers for high risk patients and how different states are moving to managed LTC services and supports (MLTSS) which include services for those living in nursing homes. Topics include: 1) how different states are changing how LTC services are delivered and financed, 2) how high risk patients are being managed more in the community with waiver programs, 3) how one state is using a social justice model to help older adults live at home, and 4) how a state is making Accountable Care Organizations and incorporating LTC into the medical system.

Learning Objectives

Describe how different states are changing how long term care services are delivered and financed.
Discuss how high risk patients are being managed more in the community with waiver programs. Explain how one state is using a social justice model to help older adults live at home. Review how one state is making Accountable Care Organizations and incorporating LTC.

Presenter(s): Randi Berkowitz, MD; Alice Bonner, PhD, RN, GNP; Steven Counsell, MD; Camille Infussi Dobson

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
What the Multidisciplinary Team in Nursing Homes Need to Know About Changing Models of Health Care in the Community

Long-Term Services and Supports

• LTSS involve assistance with activities of daily living (ADLs) - bathing, dressing, toileting – and with instrumental activities of daily living (IADLs) – preparing food, managing finances - that older adults and people with disabilities need in order to live their lives
• In other words, non-medical services
• People who need LTSS typically have physical, cognitive, developmental, or other chronic health conditions

• LTSS can be delivered in nursing facilities or in home and community based (HCB) settings
• Once people need enough help to meet nursing home requirements (level of care), they can get Medicaid coverage.
• Medicaid law requires states to cover nursing facility services, but HCB services are optional
• States offer HCB services as a preferred, and cost-effective alternative to NFs

Medicaid is the primary third-party payer for LTSS in the country
• Private insurance rarely covers (unless long-term care insurance is purchased)
• Medicare covers only for limited duration- skilled nursing home services up to 100 days and home health visits
• Private pay makes up the rest
• The value of family caregiving was more than 50% higher than total formal spend on LTSS1

Note:1 AARP LTSS Fact Sheet, March 2017

Medicaid is the Primary Payer for Long-Term Services and Supports (LTSS), 2013

Nearly two thirds of Medicaid spending is for the elderly and people with disabilities, FY 2014.
Long-Term Services and Supports

- States are making concerted efforts to maximize their ability to deliver LTSS services in most cost-effective manner possible, while ensuring high quality
- States are responding to these imperatives:
  - "Whole person care" has been demonstrated to improve health outcomes
  - Increased demand for LTSS as population ages
  - Consumer preference to ‘age in place’ to maximum extent possible

Learning Objectives

By the end of the session, participants will be able to:
- Increase understanding of the current state of aging and goals for future
- Gain knowledge of Massachusetts’ work in aging through the Governor’s Council to Address in Massachusetts
- Explore opportunities where Massachusetts’ work can be expanded or utilized
- Recognize the importance of public-private partnerships

Governors’ Council to Address Aging in MA

Governor Charlie Baker signed Executive Order 576 establishing the Governor’s Council to Address Aging in Massachusetts on April 12, 2017.

According to the Order “the Council shall be responsible for advising the Governor on the development of governmental policies, community resources, best practices, and informal supports that will promote healthy aging in the Commonwealth. The Council will formulate a plan to achieve the goal of making Massachusetts the most age-friendly state for people of all ages.”
Governors’ Council to Address Aging in MA

Plan and Process

Year One
• Held 5 in-person meetings including 4 expert panels
• Reviewed documents and data from thought leaders
• Held 5 listening sessions across the state
• Invited input and recommendations via web portal
• Heard from over 500 individuals across the Commonwealth
• Drafted initial blueprint

Year Two
• Establish working groups to research, develop and explore potential initiatives
• Provide recommendations to Governor Baker
• Establish a plan for communications of the Council’s work and reports
• Develop metrics to evaluate outcomes and measure success

Guiding Beliefs

The Council is guided by the following beliefs:
• People want to age in community
• We must leverage public-private-community partnerships
• Massachusetts values access, equity, cultural competency and inclusion for all its residents
• Our innovation and technology sectors are key strengths
• We honor community and leverage best practices
• Embedding aging in all policies benefits residents of all ages
• We use community as the unit of analysis
• We must reframe the conversation: aging is an asset and something that you have to plan for

The Importance of Language

Asset based:
• Momentum
• Wisdom, experience
• Optimal aging
• Longevity
• Life stage
• Resource
• Solutions for society
• Part of vibrant intergenerational community

Problem based:
• Tsunami
• Challenge and burden of aging
• Deficits
• Elderly
• Cost to taxpayers and drain on society
• Burden

What the Council Heard

Over nine months the Council held five working meetings and convened four listening sessions throughout the state in addition to collecting public comment online. The result was input from more than 500 Massachusetts residents.

Our Future View

Future State
• People proactively plan for a 100-year life
• All Massachusetts communities are considered age-friendly. Aging is viewed as an asset.
• People of all ages have access to health and social supports and disparities are reduced
• Continuum of long-term care services is reimagined and integrated
• Aging is embedded in all policies
• Massachusetts is the Silicon Valley of innovation in aging and exports knowledge and services
• Every resident has the resources to live a meaningful life in the community they choose

Council’s Initial Blueprint

Create an Age-Friendly Commonwealth
### Council's Initial Blueprint

#### Increase Economic Security

**Recommendations to Increase Economic Security**

<table>
<thead>
<tr>
<th>Promotion of age-friendly employers</th>
<th>Create options for affordable senior housing</th>
<th>Increase savings and leverage assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support training for older workers and career centers to better serve older job seekers</td>
<td>Increase supply of affordable and support housing</td>
<td>Increase awareness and participation in employee sponsored retirement plans</td>
</tr>
<tr>
<td>Establish an age-friendly employer recognition program</td>
<td>Provide access to home equity with lower interest rates or limited property tax deferrals</td>
<td>Explore work to save plans, such as the Massachusetts CORE Plan, for those who do not have employer-sponsored retirement programs</td>
</tr>
<tr>
<td>Promote the benefits of hiring and retaining mature workers</td>
<td>Provide assistance to older people who are purchasing or refinancing their homes through reverse-improvement programs</td>
<td>Develop partnerships in in-home care programs to support older people and caregivers in their homes</td>
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#### Promote Age-Friendly Communities

**Recommendations to Promote Age-Friendly Communities**

<table>
<thead>
<tr>
<th>Establish state-wide initiative</th>
<th>Ensure communities are dementia capable</th>
<th>Change perceptions of aging and support retraining</th>
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</thead>
<tbody>
<tr>
<td>Include age-friendly best practices in Community Compacts</td>
<td>Promote language and communication training to change public perception of aging</td>
<td>Promote and expand opportunities for older adults to re-enter the workforce</td>
</tr>
<tr>
<td>Leverage partnerships to analyze the themes of community, economics and health services</td>
<td>Build on current national research to develop case studies of successful Age-Friendly communities</td>
<td>Build on existing partnerships and collaborations to support older workers and caregivers</td>
</tr>
<tr>
<td>4. Promote early life planning through educational and career services</td>
<td>Provide resources and retraining for older workers</td>
<td>Partner with local organizations, such as senior centers, to develop volunteer opportunities and engagement</td>
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#### Facilitate Connection and Engagement

**Recommendations to Facilitate Connection and Engagement**

<table>
<thead>
<tr>
<th>Support older workers</th>
<th>Minimize loneliness and isolation</th>
<th>Encourage life-long learning and training</th>
<th>Promote volunteerism and civic engagement</th>
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</thead>
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<tr>
<td>Establish an age-friendly employer recognition program</td>
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<td>Create a 60+ over 60 community</td>
<td>Build on successful new partnerships</td>
<td>Promote innovative programs that are inclusive and culturally competent</td>
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<tr>
<td>3. Include age-friendly best practices in Community Compacts</td>
<td>Create a 60+ over 60 community</td>
<td>Promote and expand programs that address all aspects of aging</td>
<td>Promote innovative programs that are inclusive and culturally competent</td>
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<td>Expand partnerships in in-home care programs to support older people and caregivers in their homes</td>
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#### Initial Priorities

1. Declare Massachusetts as an age-friendly state
2. Begin changing perceptions and address ageism with specific trainings and communication tools
3. Include age-friendly best practices in community compact program (new business, economic development, innovation and technology)
4. Promote the designation of age-friendly employers and practices that support mature workers and workers who are caregivers
5. Increase participation in employer sponsored retirement plans and explore options for those without access to employer sponsored plans
6. Support caregivers with an information and awareness campaign and decide 2018 as the “Year of the Caregiver”
7. Promote and modernize property tax deferment programs
8. Explore options to increase new production of housing with services
9. Quickly scale and replicate successful age-friendly pilots, such as ride-sharing
10. Become the Silicon Valley for innovative technology, products and services related to aging

### Council Members

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### Council's Initial Blueprint

**Ensure Access and Affordability of Services**

**Recommendations to Ensure Access and Affordability of Services**

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Redesign of Indiana’s Aged & Disabled 1915(c) Medicaid Home- and Community-Based Services (HCBS) Waiver

Steven R. Counsell, MD, AGSF
Medical Director, Division of Aging
Indiana Family and Social Services Administration
Mary Elizabeth Mitchell Professor
Indiana University School of Medicine

Speaker Disclosures

Dr. Counsell has no financial relationship(s).

Indiana A&D Waiver Program

- Waivers are a part of the federally and state funded Medicaid program that provides for reasonable and necessary medical care for persons meeting eligibility requirements.
- Waivers provide funding for children and adults with disabilities to receive support and services in the home and community rather than in an institutional setting.

Indiana A&D Waiver: Available Services

- Case Management
- Personal/Attendant Care
- Homemaker
- Home-Delivered Meals
- Home Modifications
- Pest Control
- Personal Emergency Response
- Transportation
- Vehicle Modification
- Adult Day Services
- Home Health Aide/Nurse
- Respite Care
- Healthcare Coordination
- Assisted Living

Waiver Case Management: Weaknesses

- Challenges encountered by CM and client related to Medicaid eligibility and enrollment.
- Workforce issues of waiver and PA service providers including capacity, turnover, training and pay.
- Limited communication and coordination between waiver and PA services.
- Limited communication and coordination between waiver services and healthcare (e.g., care transitions).
- Limited physician awareness and collaboration.
Waiver Integration Now (WIN) Workgroup

**Goal:** Redesign A&D Waiver for integration of medical and social care toward better health and utilization outcomes consistent with FSSA rebalancing initiative.

**Deliverables:**
1. Proposals for integration and payment model
2. Identify pilot AAAs and healthcare organizations

**Process:**
- Identified 14 representatives from 9 of 16 AAAs
- Held 7 conference calls, Sept-Dec 2016

A & D Waiver Redesign

**Goal:** To improve the health and quality of life of Aged & Disabled (A&D) Waiver clients and rebalance LTC expenditures through integration of social services and medical care.

**Partnerships:**
- Area Agencies on Aging (AAAs)
- Physician Organizations (POs)
- Division of Aging (OA), Indiana FSSA

Integration Model

**Strategies**
1. **Case Manager – Enhanced and New Roles**
2. **Healthcare Coordination Nurse –** Employed by Physician Practice (vs. Home Health Agency) and Specified Roles
3. Use of **Evidence-Based Clinical Protocols**
4. **Specific Qualifications** for AAAs and POs

**Case Manager – Enhanced and New Roles**
- Standardized caregiver assessment and documentation
- Application of Evidence-Based Clinical Protocols for standardized assessment, referral and care coordination
- Minimum of 1 face-to-face visit/month (office, home, video conf)
- Collaboration with hospital/SNF in care transitions including in-home visit post-discharge
- Collaboration with Healthcare Coordination Nurse

**Healthcare Coordination Nurse – Specified Roles**
- Standardized medication management process and documentation
- Application of Evidence-Based Clinical Protocols for clinical evaluation and management of geriatric conditions
- Communication/coordination with physicians and HHA (e.g., PA services)
- Collaboration with hospital/SNF in care transitions including face-to-face visit post-discharge
- Collaboration with Waiver Case Manager

**Use of Evidence-Based Clinical Protocols**
- Person-centered care planning
- Geriatric syndromes of falls, depression, and dementia
- Medication management
- Caregiver burden
- Transitional care
- Advanced care planning
### Integration Model

**Specific Qualifications for AAAs**
- NCQA Accreditation of Case Management for LTSS
- Health IT platform compatible with IHIE / CaMSS
- Case Managers successfully completed training

**Specific Qualifications for POs**
- NCQA Patient Centered Medical Home Recognition
- Healthcare Coordination Nurse supervised by waiver client’s physician and successfully completed training

### Payment Model

**AAA Payment for Waiver Case Manager**
- Enhanced CM monthly rate per waiver client

**PO Payment for Healthcare Coordination Nurse**
- Monthly rate per waiver client for activities that can be monitored by simple audit

Financial incentives to AAA and PO for achieving in waiver clients better quality of care and outcomes, and avoided or delayed institutional long-term care.

### Physician Outreach and Education

1. AAAs and POs form relationships around collaboration in care of shared patients/A&D Waiver clients.
2. AAAs each develop a physician champion from a local practice, and DA provide toolkit and guidance to facilitate greater collaborations between healthcare and AAA.
3. Create consistent message and educational materials for outreach to physicians and hospital staff that could be used statewide along with local AAA information.
4. Develop statewide network or “learning collaborative” of physician champions and AAA representative pairs for ongoing collaboration and DA advisory role.

### Speaker Disclosures

Dr. Berkowitz has no financial relationship(s).

### Learning Objectives

By the end of the session, participants will be able to:
- Understand how one state is changing Medicaid from fee-for-service into ACOs
- Understand how LTSS fits into the larger healthcare delivery system
- Understand how the federal government is supporting state healthcare transformation
- Understand how the landscape is changing for LTSS and shifting of resources to help Medicaid members live at home longer
Current MassHealth Delivery System

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<tr>
<th>MassHealth Only</th>
<th>MassHealth with Medicare or other TPL</th>
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<tr>
<td>inpatient (67%)</td>
<td>inpatient (87%)</td>
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<tr>
<td>outpatient (83%)</td>
<td>outpatient (90%)</td>
</tr>
<tr>
<td>LTSS fee-for-service program (73%)</td>
<td>LTSS Managed Care (60%)</td>
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<tr>
<td>Managed HI (25%)</td>
<td>Managed HI (15%)</td>
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<tr>
<td>FFS (6%)</td>
<td>SCO/PACE/One Care (4%)</td>
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Goals of MassHealth Restructuring

- Improve population health and care coordination through payment reform and value-based payment models
- Improve integration of physical and behavioral health care
- Scale innovative approaches for populations receiving long-term services and supports
- Ensure financial sustainability of MassHealth

MassHealth ACO Goals and Principles

- Materially improve member experience—ACOs are expected to innovate and engage members differently (e.g., better transitions of care, improved coordination between a member’s various providers)
- Strengthen the relationship between members and primary care providers by attributing members to an ACO through their selection of a primary care provider
- Encourage ACOs to develop high value, clinically integrated provider partnerships by expecting and allowing ACOs to define coordinated care teams and, for some ACOs, to establish preferred networks
- Increase behavioral health / long-term service and support integration and linkages to social services in ACO models through explicit requirements for partnering with BH and LTSS Community Partners

MassHealth Entered into Contracts with 17 ACOs

<table>
<thead>
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<th>ACOs Expected to cover over 80,000 MassHealth members total</th>
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<tr>
<td>Fallon Health with Fallon Community Health Plan</td>
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<td>Healthy Care Alliance with Health New England</td>
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<td>BHI Health Care Network with Fallon Community Health Plan</td>
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<td>BHI Health Care Network with Fallon Community Health Path</td>
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<td>Merrimack Valley ACO with Neighborhood Health Plan</td>
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<td>Patients HealthCare ACO</td>
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<tr>
<td>Reliant Medical Group with Fallon Community Health Plan</td>
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<td>signature Healthcare Corporation with Fallon Medical Center Health Plan</td>
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<td>Somnus Health Network with Fallon Medical Center Health Plan</td>
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<td>Steward Medical Care Network</td>
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1115 Waiver Updates

- Statewide Investments - Delivery System Reform Investment Program (DSRIP): high-needity investments that will play a key role in efficiently scaling up state-wide infrastructure and workforce capacity, examples of investments include:
  - Technical Assistance (TA): will focus on building technical assistance and integration of technology systems for improving care coordination and integration.
  - Workforce development - funding to support a wide-scope of health care workforce development and training to allow individuals to more effectively operate in a new health care system.
  - Student loan repayment program - repay a portion of a student’s loan in exchange for a two year commitment as a primary care provider at a community health center (CHC).
  - Behavioral health professional at foster youth adults at a CHC, community mental health center, or an emergency service program.

- Initiative to improve the availability and use of accessible medical and diagnostic equipment for people with disabilities:
  - Funding is available to allow individuals to purchase items such as: adjustable examination tables, chairs, assistive weight scales, ECG equipment, purifier, and digital mammography machines.
  - Funding to support or online provider directory whereby MassHealth members with disabilities can search for providers by preferred accessibility preferences.

Objectives for Community Partners (CP) Program

- Support members with high BH needs, complex LTSS needs and their families to help them navigate the complex systems of BH and LTSS in Massachusetts.
- Improve member experience, continuity and quality of care by holistically engaging members with high BH needs (SMI, SED, and SUD) and complex LTSS needs.
- Invest in the continued development of BH and LTSS infrastructure (e.g., technology, information systems) that is sustainable over time.
- Improve collaboration across ACOs, MCOs, CPs, community organizations addressing the social determinants of health, and BH, LTSS, and health care delivery systems in order to break down existing silos and deliver integrated care.
- Support values of Community First, SAMHSA recovery principles, independent living, and promote cultural competence.

Flexible Services Program

- Under the 1115 Demonstration Waiver, MassHealth received federal approval to provide DSRIP funds to ACOs for the purpose of funding flexible services.
- Flexible services funding will be used to address health-related social needs by providing supports that are not currently reimbursed by MassHealth or other publicly-funded programs.
- The proposed MassHealth Flexible Services Program will allow ACOs to utilize a portion of their Delivery System Reform Incentive Plan (DSRIP) funds to pilot innovative approaches to social services integration within MassHealth ACOs.
- Flexible Services will only be available for MassHealth members enrolled in an ACO.

DSRIP funds:
1. Perform outreach and orientation to assigned members.
2. Conduct LTSS care planning or care counseling to develop a LTSS Care Plan using person-centered practices.
3. Participate in the member’s care team, to provide LTSS expertise and support integration of LTSS services for the member's care, as directed by the member.
4. Facilitate member access to LTSS through care coordination and navigation.
5. Support transitions of care between settings.
6. Provide health and wellness coaching.
7. Qualify and submit claims for all applicable LTSS benefits, including federal and state LTSS benefits.
8. Support member transitions between LTSS and other services.
CP Quality Measures Considerations

Goals for measures:

- Integration of CPs with ACOs and MCOs.
- Align with ACO quality measure slate.
- CP, along with ACO, should be accountable for traditionally medical measures in order to promote integration of care.
- CP supports should impact avoidable utilization including ED and readmissions.
- Measures for engagement - CPs should ensure:
  o For BH CPs - members have comprehensive assessments completed and shared with the PCP
  o For LTSS CPs – person-centered LTSS care plan is developed under the direction of the member and shared with the PCP and integrated into the overall care plan

MassHealth’s Long-Term Services and Supports

Goals for LTSS: In addition to significant transformation in medical and behavioral health services, MassHealth also seeks to improve administration and delivery of LTSS:

- Integrated: MCOs and ACOs will begin taking responsibility for coordinating – and in some models, paying for – LTSS
- Increase SCO and One Care enrollment
- Community-Based:
  o Invest in community expertise through LTSS CPs
  o Target care coordination and CP resources to support care transitions
- Sustainable: Update LTSS policies and delivery systems to ensure services are matched to need
- Integrity: Improve LTSS administration and oversight to direct scarce resources to members who need them most

MassHealth’s Long-Term Services and Supports Roadmap

- LTSS is currently provided FFS for most members; integrated in One Care, SCO, and PACE
- Goal is to integrate LTSS into MCOs and ACOs in Year 3 or 4 of their five year contracts;
- MCOs and ACOs must undergo a thorough readiness review and demonstrate network adequacy prior to taking responsibility for LTSS
- MassHealth also plans measured expansion of One Care and SCO through outreach, marketing, and passive enrollment over the next few years; reprocure One Care for 2019
- FFS LTSS will be administered by a Third Party Administrator (TPA)

Managed Long Term Services and Supports

- An emerging trend for states is to deliver LTSS using managed care organizations
- LTSS benefits are the largest group of Medicaid benefits remaining in fee-for-service
- 39 states use managed care plans to deliver acute and primary care for most Medicaid consumers
- States seek to bring those same benefits to an unmanaged fee-for-service system

Managed Long Term Services and Supports

- Accountability rests with a single entity
  o Financial risk for health plan provides opportunity to incentivize/penalize performance
  o Plans can integrate siloed streams of care (primary/behavioral/long term care) more effectively
- Administrative simplification for state
  o Eliminates need to contract with and monitor hundreds/thousands of individual providers
  o Managed care plans take on claims payment, member management, utilization review, etc.
- Budget predictability
  o Capitation payments greatly minimize unanticipated spending
  o Can more accurately project costs
- Innovation and Quality
  o MCOs can deliver services more flexibly than states
  o They bring best practices from other states/product lines
  o Demonstrated improvement in quality outcomes (HEDIS) over FFS
Managed Long Term Services and Supports

- Consumer becomes the center of the system, not their services
  - LTSS interventions can lower acute care costs
- 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

Managed LTSS Programs, 2010

Managed LTSS Programs, 2018

Managed Long Term Services and Supports

- Achieving Rebalance of LTSS Spending
  - Rebalance Medicaid LTSS spending toward HCBS and providing more options for consumers to live in and receive services in the community—if that is consistent with consumer’s goals and desires
  - 8 states (AZ, FL, KS, MA, MN, NJ, NM, TN) reported\(^2\) that MLTSS has promoted rebalancing the LTSS delivery system
    - FL – Goals for nursing facility settings
    - TN, AZ – Rebalanced spending and increased HCBS

Managed Long Term Services and Supports

- Improving Member Experience, Quality of Life, and Health Outcomes
  - Ensuring effective care coordination to improve consumer experience and quality of life
  - 9 states conduct quality of life surveys
    - TX, TN, NJ – using NCI-AD to get MCO-specific results
  - 7 states (AZ, FL, KS, NJ, MA, MN, TN) reported that MLTSS has improved health outcomes
    - FL, TX – MLTSS has improved consumer quality of life

\(^2\) NASUAD and CHCS, Demonstrating the Value of MLTSS Programs, May 2017 [https://tinyurl.com/y9nkvgu6](https://tinyurl.com/y9nkvgu6)
Managed Long Term Services and Supports

- Reducing Waiver Waitlists and Increasing Access to Services
  Expand HCBS options and move consumers off waiting lists into service
  - 6 states (FL, IA, KS, NJ, NM, TN) reporting reducing waiting lists as a goal
    - TN – Used MLTSS savings to create targeted services to ‘pre-Medicaid’ at-risk consumers
    - FL – Used MLTSS savings to enroll wait-listed individuals with the most critical needs into its MLTSS program

Managed Long Term Services and Supports

- Increasing Budget Predictability and Managing Costs
  Better manage Medicaid budget and bend the cost curve for all services
  - 9 states (FL, IA, KS, MA, NJ, NM, RI, TN, VA) reported that MLTSS has stabilized their budget or slowed cost growth
    - FL – achieved five percent savings targets established by the legislature in 2013 and 2014
    - TN – Captured FFS baseline spending to compare to MCO spend