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

Camille Dobson, Deputy Executive Director
National Association of States United for Aging and Disabilities

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

Long-Term Services and Supports

- 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 LTSS

Speaker Disclosures

Camille Dobson has no financial relationship(s).
Long-Term Services and Supports

• States are making concerted efforts to maximize their ability to deliver LTSS services in the 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.”

Plan and Process

Year One
• Held 5 in-person meetings including 4 expert panels
• Reviewed documents and data from thought leaders
• Held 4 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

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

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
- Life stage
- Older adults
- Resource
- Solutions for society
- Part of a vibrant intergenerational community

Problem Based:
- Tsunami
- Challenge and burden of aging
- Aging
- Deficit
- Elderly
- Cost to taxpayers and a drain on society
- Older adults

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.
Recommendations to Facilitate Connection and Engagement

Council’s Initial Blueprint
Facilitate Connection and Engagement

Recommendations to Ensure Access and Affordability of Services

Council’s Initial Blueprint
Ensure Access and Affordability of Services

Recommendations to Promote Age-Friendly Communities

Council’s Initial Blueprint
Promote Age-Friendly Communities

Recommendations to Increase Economic Security

Council’s Initial Blueprint
Increase Economic Security

Recommendations to Increase Economic Security
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 (DA), Indiana FSSA

Integration Model

Strategies
1. Case Manager – Enhanced and New Roles
   a) Standardized caregiver assessment and documentation
   b) Application of Evidence-Based Clinical Protocols for standardized assessment, referral and care coordination
   c) Regular communication with PCP about waiver services
   d) Collaboration with hospital/SNF in care transitions including in-home visit post-discharge
   e) Collaboration with Healthcare Coordination Nurse

   Healthcare Coordination Nurse – Specified Roles
   a) Standardized medication management process and documentation
   b) Application of Evidence-Based Clinical Protocols for clinical evaluation and management of geriatric conditions
   c) Minimum of 1 face-to-face visit/month (office, home, video conf)
   d) Communication/coordination with physicians and HHA (e.g., PA services)
   e) Collaboration with hospital/SNF in care transitions including face-to-face visit post-discharge
   f) Collaboration with Waiver Case Manager
Integration Model

**Use of Evidence-Based Clinical Protocols**
- a) Person-centered care planning
- b) Geriatric syndromes of falls, depression, and dementia
- c) Medication management
- d) Caregiver burden
- e) Transitional care
- f) Advanced care planning

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

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

Integration Model

**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

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

Current vs. Sustainable System

<table>
<thead>
<tr>
<th>Current system</th>
<th>Sustainable system</th>
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<tr>
<td>Rewards volume</td>
<td>Rewards outcomes and value</td>
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<tr>
<td>Built to address emergency or short-term medical events, difficult for members to navigate the system</td>
<td>Member’s health managed and aligned across providers and over time (not visit by visit)</td>
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<td>Multiple doctors treating the same patient for the same condition without belonging to each other</td>
<td>Providers act as a team to ensure coordination of right services</td>
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<td>Limited transparency into quality and efficiency of care</td>
<td>Easy-to-understand quality and cost data made available</td>
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<td>Patient information often stored in silos or paper medical records</td>
<td>Appropriate electronic health information readily available across care teams</td>
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Current MassHealth Delivery System

MassHealth ACO Goals and Principles

- Materia[ly 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>
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<tr>
<th>ACO</th>
<th>Community Partners (CP)</th>
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<tr>
<td>ACHC (NH)</td>
<td>Community First (CBG)</td>
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<tr>
<td>Community Partners (CP)</td>
<td>Statewide Investments (3%)</td>
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<tr>
<td>Statewide Investments (3%)</td>
<td>Implementation (1%)</td>
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<tr>
<td>Implementation (1%)</td>
<td>ACO (NH)</td>
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- ACOs include range of providers (e.g., CHC).
- Includes ACO investments in primary care providers, infrastructure, and capacity building.
- Behavioral Health (BH) and Long Term Services and Supports (LTSS) Community Partners (CPs) and Community Services Agency (CSA).
- Includes BH and LTSS care coordination and CPA and CSA administration and capacity building.
- Examples include primary care, workforce, development, and training, and technical assistance to ACOs and CPs.
- Small amount of funding will be used for DSRIP operations and implementation, including vendor oversight.

1115 Waiver Updates

- Statewide investments - Delivery System Reform Incentive Program (DSRIP) high priority investments that will play a key role in efficiently equipping state health information and workforce capacity, examples of investments include:
  - Technical assistance (TA) for ACOs and CPs to identify and implement evidence-based and high-RIB interventions, establish new workflows and processes to improve care coordination and integration
  - Workforce development - Funding to support a scalable spectrum of health care workforce development and training to allow for 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 or licensed clinical social worker at a CHC, community health center, or an emergency service program
  - Initiatives to improve the availability and use of accessible medical and diagnostic equipment for people with disabilities
    - Funding to help with the purchase of items such as adjustable examination tables, chairs, automated weight scales, lift equipment, gowns, and digital mammography machines.
    - Funding to help purchase a computer directory where MassHealth members with disabilities can search for providers by preferred accessibility preferences.

1115 Waiver Updates

Risk Model Building

- Behavioral Health
- Serious Mental Illness, Substance Use Disorder

Housing Issues

- People with 3 or more addresses in a single calendar year OR with a V-code for homeless indicated on a claim or encounter record

Neighbor Stress Score

- A composite measure of “financial stress” from census data associated with addresses geocoded to the census block group (CBG)

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 service integration within MassHealth ACOs.
- Flexible Services will only be available for MassHealth members enrolled in an ACO.
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:
  - Invest in community expertise through LTSS CPs
  - 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

Enhanced Supports:

1. ACOs and/ or Enhanced Supports arrangements may be available through a competitive grant arrangement

CP Quality Measures Considerations

Goals for Measures:

- Integration of CPs with ACOs and MCOs
- Align with ACO quality measure slate
- CPs, along with ACOs, 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:
  - For BH CPs - members have comprehensive assessments completed and shared with the PCP
  - 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 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 five 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

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Managed Long Term Services and Supports

• Accountability rests with a single entity
  • Financial risk for health plan provides opportunity to incentivize/penalize performance
  • Plans can integrate siloed streams of care (primary/behavioral/long term care) more effectively

• Administrative simplification for state
  • Eliminates need to contract with and monitor hundreds/thousands of individual providers
  • Managed care plans take on claims payment, member management, utilization review, etc.

Managed Long Term Services and Supports

• Budget predictability
  • Capitation payments greatly minimize unanticipated spending
  • Can more accurately project costs

• Innovation and Quality
  • MCOs can deliver services more flexibly than states
  • They bring best practices from other states/product lines
  • 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 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 that MLTSS has promoted rebalancing the LTSS delivery system
    - FL – Goals for nursing facility settings
    - TN, AZ – Rebalanced spending and increased HCBS

2 NASUAD and CHCS, Demonstrating the Value of MLTSS Programs, May 2017 https://tinyurl.com/y9nkvgu6

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

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