MACPAC

Stakeholder Experiences with Managed Long-Term Services and Supports

Medicaid and CHIP Payment and Access Commission

Kristal Vardaman

MACPAC Presentation

Managed Long Term Services and Supports: A Consumer Perspective

Dennis Heaphy M.Div., M.Ed., MPH
Disability Policy Consortium, Massachusetts
Contact: dheaphy@dpcma.org

MLTSS In Context: What is my future?

- What value(s) go into the cost benefit analysis that determines:
  - My basic rights?
  - Where I live?
  - My ability to participate in the community?
  - The services I can access?
  - The type of control I have over those services?
- Who does this analysis?
  - Do I have a voice?

“Everyone Just Wants to be Free”

For people who need assistance with ADLs and/or Instrumental IADLs, access to basic civil and human rights requires a HCBS delivery system that is:

- Free of forced incarceration in institutions and results in lower preventable morbidity and mortality rates (Community First).
- Free of restrictive rules that deny choice, control and dignity of risk (panspectron approaches including Electronic Visit Verification).
- Elastic and incorporates Social Determinants of Health factors.

“Everyone Just Wants to be Free” (cont.)

- Equitable at the state and federal levels (addresses disparities in benefits).
- Person-centered (advances consumer agency and goal setting).
- Adequate and culturally appropriate (integrates independent living and recovery principles).
- Supports the integrity of families (minimizes family burden).
- Measured using quality metrics that reflect consumer voice and values.

“You Make it Look too Easy”: Massachusetts

As a consumer, life is made easier:

- Consumer voices are present, respected, and heard from the start.
- Fundamental rights to consumer choice, control and dignity of risk remain at the forefront.
- Consumers, policy makers and other stakeholders work to create a shared vision.
- Relationship and long-term sustainability are a shared goal.
- Consumer engagement is reflected in final policy outcomes.

Massachusetts Best Practices

- Invested in external conflict-free Ombudsman entity.
- Established consumer-led Implementation Council.
- Conducts face-to-face Comprehensive Assessments.
- Requires use of least restrictive payer codes in prior-authorization contracts when determining authorization of LTSS.
- Gives greater authority to plans in offering LTSS not included in Medicaid benefit package.
- Doing away with low-expectation measures such as those that use contract fulfillment as a measure of quality.
- Creating a combination of validated and experimental quality measures.

Massachusetts Best Practices In Action

The One Care Implementation Council:

- Monitor access to health care.
- Ensure compliance with the Americans with Disability Act (ADA).
- Track quality of services.
- Provide support and input to EOHHS.
- Promote accountability and transparency.

MLTSS: Steps to fulfilling its Potential

Improve quality of care and quality of life for Medicaid beneficiaries with complex needs: medical, BH, SDOH and LTSS

- Consumer control and choice of services to reach goals.
- Increased consumer opportunity to participate in the community.
- Equity in access to services at the intrastate and interstate levels.

Realize greater cost efficiency

- Produce program efficiencies (care transitions).
- Rebalance services (investment in HCBS).

MLTSS: Limitations

Cannot solve problem of deficient benefit packages. This leads to:

- Limit ability of MLTSS to provide goal-centered care planning and implementation of LTSS.
- Lack appropriate definition of cultural competency in provision of LTSS.

Cannot increase quality of care or improve cost efficiencies, if under-resourced. This leads to:

- Low reimbursement rates that reduce access to competent providers and resources needed to live in the community, e.g. wheelchairs, medical supplies.
- Federal and state requirements support ongoing FFS contracting practices by plans rather than incentivizing Alternative Payment Methods (APMs) that support quality of life outcomes.

Current Barriers to Policy-Making

- Focus on ROI: Federal and state policymakers put ROI ahead of civil rights. ROI stands in the way of a real investment of resources that are needed to build a robust equitable HCBS system. It leads to higher inequities in access to LTSS at population level with growth in unmet need, increased burden on families, and institutionalization.
- Perpetuation of patient paradigm: Hospital-based and medical insurers lack competency and effective incentives to rebalance spending, perpetuating current prior authorization procedures and lack of investment into community-based, conflict free, and culturally-appropriate LTSS.
- Insufficient quality measures: Consumer involvement is woefully missing from the process, maintains the status quo of quality measures that lack real value(s).

Consumer Recommendations For Improvement

- Establish clear goals and quality measures of care integration.
- Work with consumers to establish person-centered quality outcome measures
- Establish person-centered prior authorization processes that give greater authority to care teams to address consumer goals.
- Bend the cost curve; not cutting costs.
- Remove access barriers (work req.)
- Do away with institutional bias
- Invest in equitable HCBS
- Do not conflate preserving program integrity with an agenda to cut costs and restrict services.
- Move away from FFS contracting and adopt alternative payment methods.
- Track rebalancing spending (direct per-person expenditures).

Molina Healthcare:
MLTSS Overview for MACPAC

Washington, D.C. **January 25, 2018**

Michelle Bentzien-Purrington
Vice President, MLTSS and Duals Integration

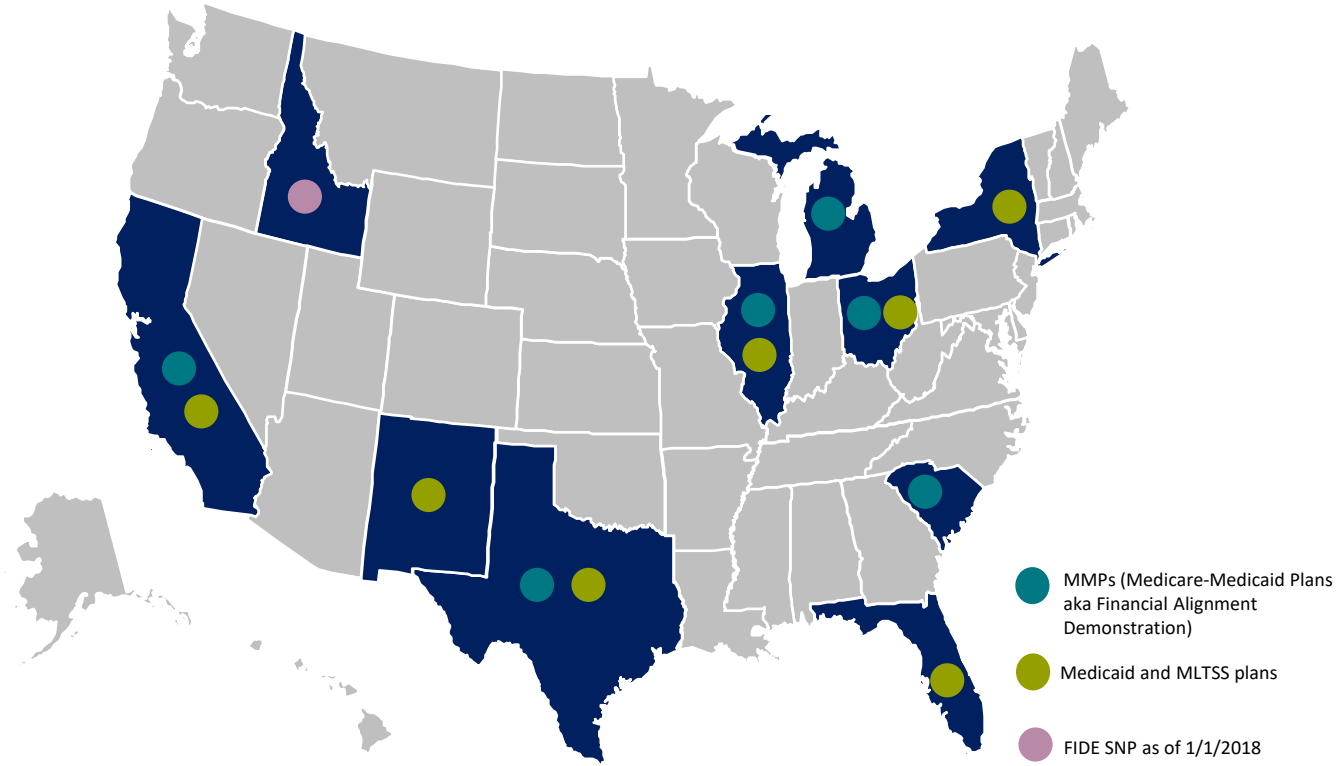
Overview

- National footprint: MLTSS and Medicare-Medicaid integration experience
- Goals and successes
- Recommendations

National Footprint: MLTSS and Medicare-Medicaid Integration Experience

- More than a decade of experience with MLTSS programs
- 10 states with MLTSS plans
- Nationwide leader in Medicare-Medicaid Plan (MMP) w/ >56K members in 6 states
- 239K members in MLTSS plans (includes MMP members)

Nationally, MLTSS plans serve >1.3M members in 21 states



2006 TX → 2012 FL → 2013 IL → 2014 CA, OH, NM → 2015 MI, SC → 2016 NY → 2018 ID

MOLINA HEALTHCARE

MLTSS Goals and Successes

Improving Member Experience, Quality of Life, Health Outcomes	Rebalancing MLTSS Spending	Reducing Waiver Wait Lists and Increasing Access to Services	Increasing Budget Predictability and Managing Costs
• Consumer feedback mechanisms and high customer ratings • Improved health outcomes demonstrated through quality measures and outcomes	• More people living in community settings • Nursing home transition prevented or delayed • Home and Community-Based Services (HCBS) spend now more than long-term care institutional spend	• Non-emergent transportation • Innovative programs and collaborations • Community collaborations	• Program costs reduced • Quality-based incentives • Administrative simplification and efficiencies

Source: Dobson, C., Gibbs, S., Mosey, A., and Smith, L. (2017). Demonstrating the Value of Medicaid MLTSS Programs. NASUAD and CHCS

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Recommendations

Enrollment	• Facilitated enrollment parity • Enrollment continuity • Streamlined enrollment • Seamless enrollment
Sustainability and Administrative Simplification	• Shared savings mechanism for plans serving dually eligible individuals (currently Medicare-Medicaid Plans only) • Rate adequacy and realistic savings assumptions • Integrate enrollment, appeals and grievances, coverage standards, marketing materials, quality standards
Integration Opportunities	• Biopsychosocial model without carve-outs • Programs serving dually eligible individuals that align Medicare and Medicaid programs • D-SNP and MMP permanency and expansion • Holistic program for dually eligible individuals

Contact Information

Michelle Bentzien-Purrington
Vice President, MLTSS and Duals Integration
Molina Healthcare, Inc.
Michelle.Purrington@molinahealthcare.com
562.951.1571

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MACPAC MLTSS Panel Presentation

Dave Totaro, Chief Government Affairs Officer

January 25, 2018

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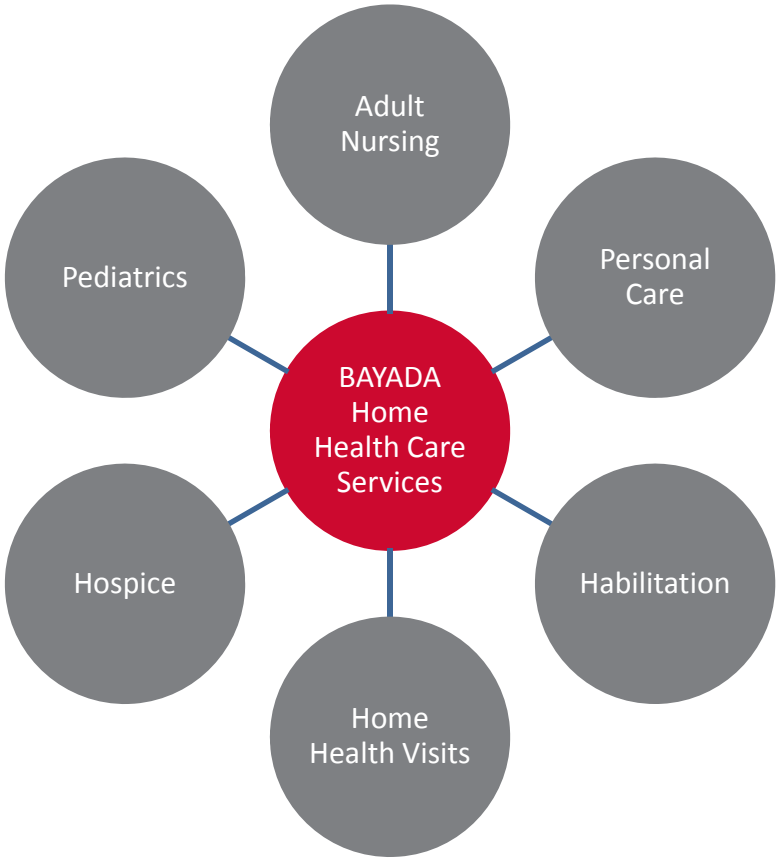
24 hours a day, 7 days a week



- 22 US States, 4 countries
- >25,000 employees
- 12 MLTSS states

Three-legged stool for MLTSS Success

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Adequate Rates and Regular Review

BAYADA® Home Health Care

1. Adequate rates must be established by the state

Uncompetitive rate (retail, hospitals) → Inability to recruit and retain staff → Unhealthy provider network → Access to care issue = State must protect beneficiaries by setting adequate rates

2. Rates must be protected and regularly reviewed

Set rate protected (rate floor) → Costs change (administrative, COLA) → Rates remain stagnant = Need for regular rate review and adjustment

State Supports for a Healthy and Robust Provider Network

BAYADA® Home Health Care

1. Limited oversight creates an unstable implementation environment

Added administrative burdens **−** State involvement & guidance **−** Stakeholder input **=** Beneficiaries placed at greater risk

2. Supported providers means focus remains on client care

State-directed, uniform MCO requirements **+** State enforcement of requirements **=** Supported providers **=** Focus on care delivery

Federal Process Changes and Improvements

BAYADA® Home Health Care

1. The federal government must level the playing field to equalize HCBS with nursing home care

Currently, nursing home care **>** HCBS → Institutional bias makes it easier to obtain nursing home services **=** LTSS individuals can access nursing home

2. The federal government should collect data to help support better care models

Data collection system developed & implemented **+** MCOs and providers use meaningful information to develop programs **=** Providers & MCOs close care gaps at lower cost

Conclusion

Recommendations

- Adequate rates
- Minimum rate floors
- Regular rate review & adjustment

- Uniform MCO requirements & enforcement
- Stakeholder engagement
- Thoughtful implementation timeline

- Level playing field with institutional care
- Gather data to address care gaps

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