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Framework for MLTSS Quality in Pennsylvania and Virginia

Paul Saucier
Senior Director
August 31, 2017

National HCBS Conference

Connecting the silos for a broader view of quality.

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Partnering with and overseeing accountable entities.

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Our Panelists

Fuwei Guo, CCC Plus Operation Supervisor

Virginia Department of Medical Assistance Services

Jen Burnett, Deputy Secretary for Long-Term Living

Wilmarie Gonzalez, Director, Bureau of Quality Assurance and Program Analytics

Pennsylvania Department of Human Services, Office of Long-Term Living

FRAMEWORK OF MLTSS QUALITY IN VIRGINIA

NASUAD HCBS Conference 2017

Fuwei Guo

Agenda

- Overview: from CCC to CCC Plus
- Lessons learned from quality approach used in CCC
- Framework for quality in CCC Plus
- External evaluator role
- Approach to internal stakeholders
- State agency capacity: how has it changed?

Virginians covered by Medicaid/CHIP

1 in 8 Virginians rely on Medicaid

1 in 3 Births covered in Virginia

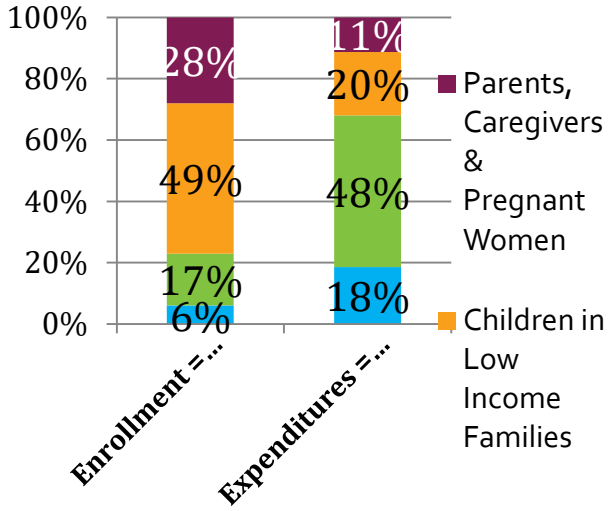
2 in 3 Nursing facility residents are supported by Medicaid

Medicaid is primary payer for **Behavioral Health** services

50% of Medicaid beneficiaries are children

62% of Long Term Services & Supports spending is in the community

Medicaid Expenditures



Older adults and individuals with disabilities
23% of the Medicaid population = 66% of expenditures

Commonwealth Coordinated Care Overview

CCC is…

- Demonstration program blending Medicare & Medicaid into one health plan
- Goal: Improve health outcomes through more coordinated care
- Benefits: One system, one card, care coordination, expanded benefits

Participating Plans

- Anthem
- Humana
- VA Premier

Population

- Full Duals 21 & older
- Live in one of 5 CCC region: 102 participating urban and rural localities
- Includes: EDCD & NF

Status

- Enrollment phased in regionally Apr. 2014-Nov. 2014
- Automatic assignment ended March 2017
- Beneficiaries may no longer opt-in or change plans
- Enrollment has averaged 30, 000 for 2017

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

Commonwealth Coordinated Care Plus Overview

CCC Plus is…

- New statewide Medicaid managed care program through CMS 1915 (B) and (C) combo waiver authority
- Goal: To improve health outcomes & provide care coordination
- Benefits: Person centered care and supports, care coordination, expanded benefits such as dental and hearing

Participating Plans

Aetna	Optima
Anthem	United
Magellan	VA Premier

Population

- 65 and older
- Adults and children living with disabilities
- Individuals living in Nursing Facilities and in one of five Virginia HCBS waivers

Status

- Enrollment phased in regionally Aug. 2017-Jan. 2018
- Continuous automatic assignment of newly eligible beneficiaries
- Beneficiaries enrollment locked 90 days after enrollment; annual open enrollment (October-December starting in 2018)
- Projected Enrollment after full implementation: 215, 000 Virginians

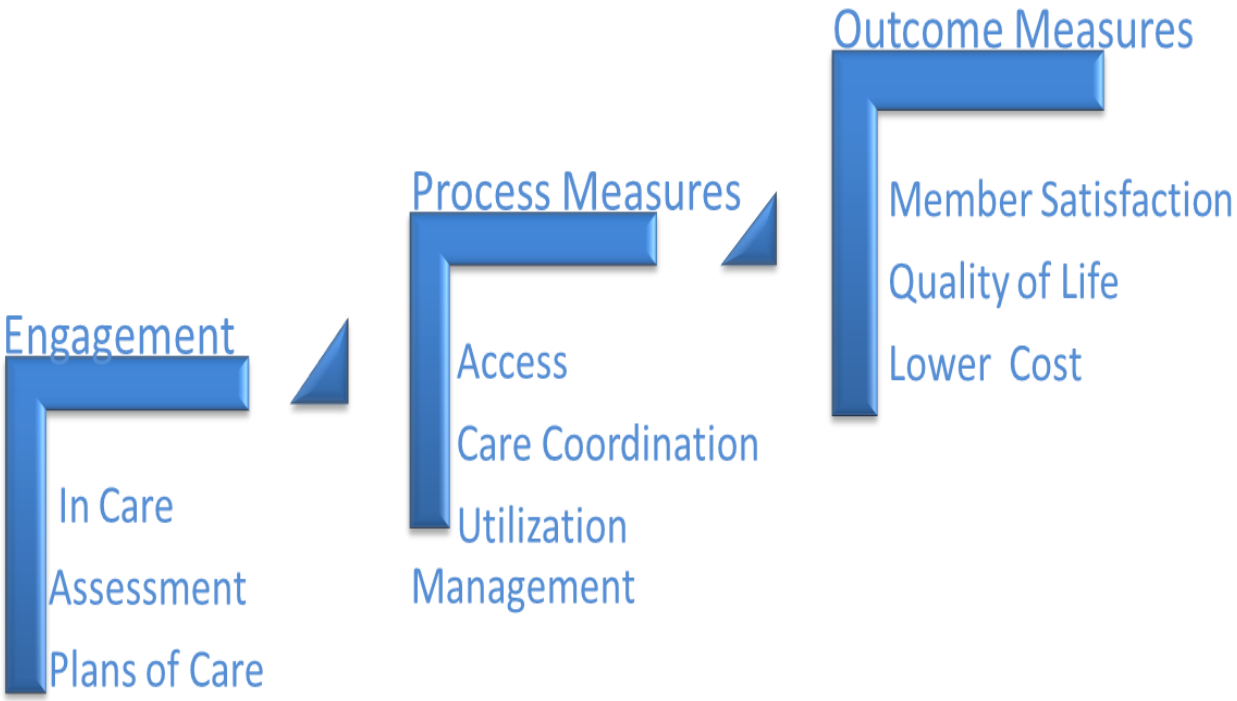
CCC Plus
Commonwealth Coordinated Care Plus
Your Health. Your Care.

DMAS

Key Differences

CCC Plus	CCC
Statewide in 6 regions	Not Statewide: 5 of the 6 regions
Required Enrollment	Optional Enrollment
Duals/non-duals, children/adults, NF and 5 HCBS Waivers	Full Dual adults; including NF and EDCD HCBS Waiver
6 Health Plans	3 Health Plans
Coordination of Medicare benefits through companion DSNP or MA Plan	Coordination of Medicare benefits through same Medicare Medicaid Plan
Continuity of care period is 90 days	Continuity of care period is 180 days

CCC Care Continuum and Initial Finding



Lessons Learned from CCC

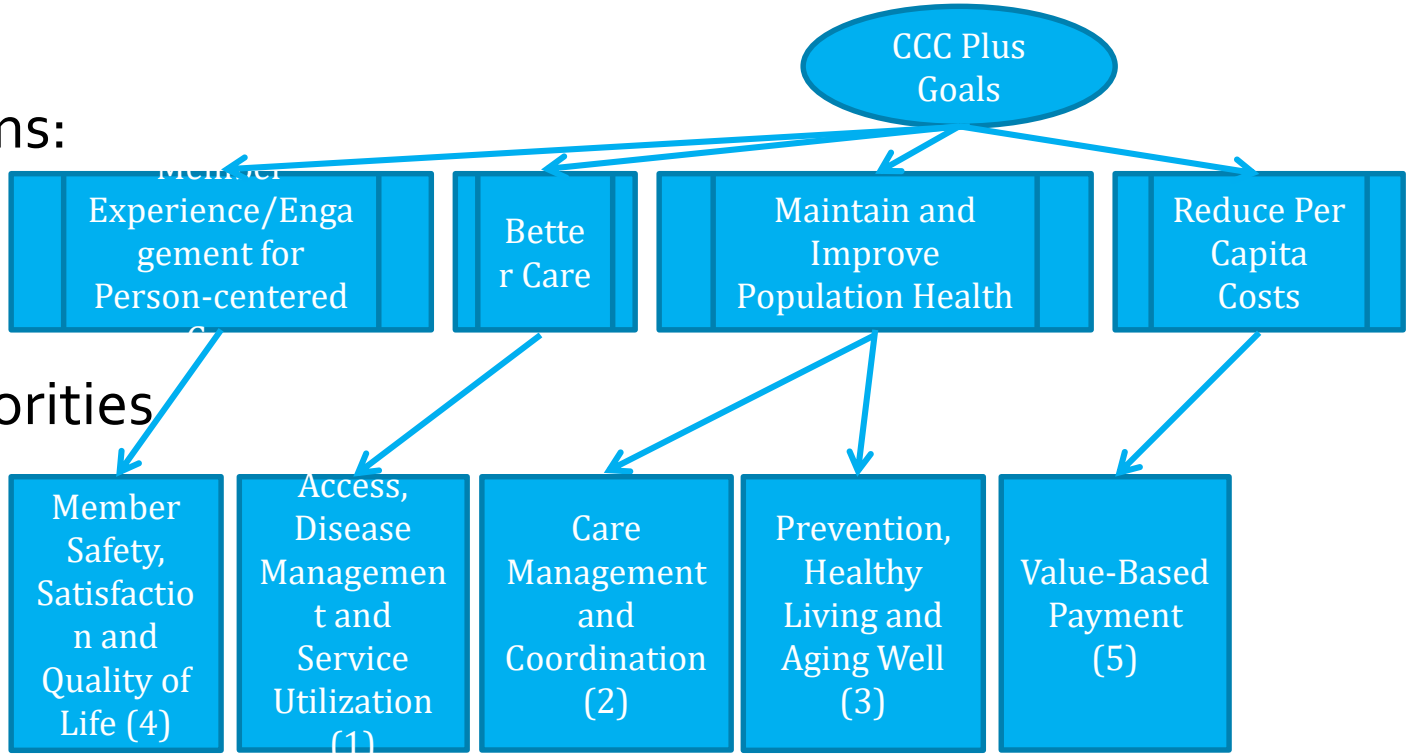
- ✓ Mandatory enrollment with limited open enrollment period for MLTSS stability
- ✓ Tighten care management contractual requirements for MLTSS
- ✓ Continue partnering with CMS and Ombudsman for intensive contract and quality monitoring
- ✓ Using intelligent assignment to place members in the best plan
- ✓ Restructured Quality Framework

Lessons Learned from CCC - Quality

- ✓ Ensure access, choice and beneficiary protection
- ✓ Align with national and state quality strategy and initiatives
- ✓ Measure beyond HEDIS and CAHPS
- ✓ Use value-based payment program to drive improvement

CCC Plus Quality Framework

- Aims:
- \
- Priorities



CCC Plus Quality Measurement

External Evaluator Role

- ✓ Contribute to ongoing managed care monitoring and oversight with objective facts and analytical insights
- ✓ Foster transparency and external stakeholder involvement
- ✓ Identify program implementation themes and effectiveness

Approach to Internal Stakeholders

- ✓ Training and education (e.g. brown bag lunches)
- ✓ Team up and lever on internal experts and SMEs

DMAS Agency Capacity Changes

Internal Restructure for better Managed Care Oversight

MMIS Redesign and Advanced Data/Analytics

Better Staffed and Equipped Integrated Care Division

More Collaborations and Less Silos

Agency Wide Quality Strategy (in development)

Thank You!

For More Information . . .

Additional Virginia MLTSS Program information is available at:

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

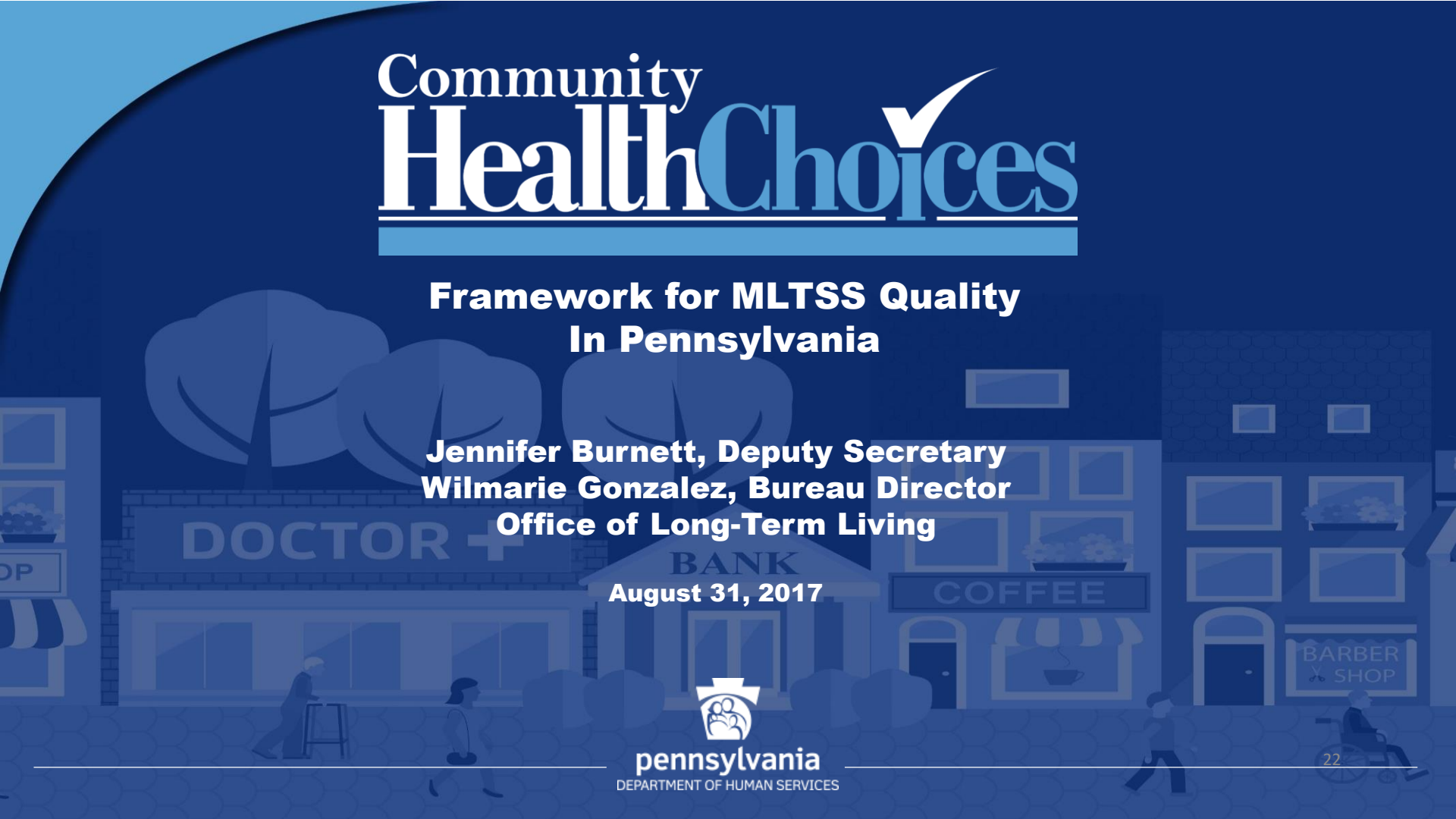
Fuwei Guo, MPH
CCC Plus Operation Supervisor
Virginia Department of Medical Assistance Services
Richmond, Virginia
(804) 625-3690
Fuwei.Guo@dmas.virginia.gov

Community HealthChoices

Framework for MLTSS Quality In Pennsylvania

Jennifer Burnett, Deputy Secretary
Wilmarie Gonzalez, Bureau Director
Office of Long-Term Living

August 31, 2017



pennsylvania
DEPARTMENT OF HUMAN SERVICES

WHAT IS COMMUNITY HEALTHCHOICES (CHC)?

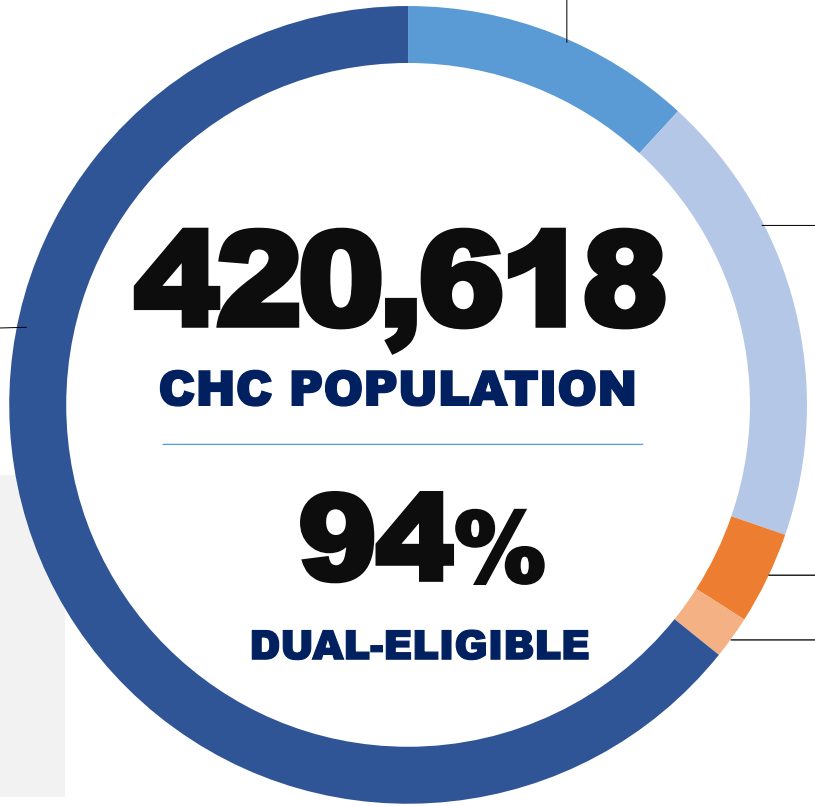
A Medicaid managed care program that will include physical health benefits and long-term services and supports (LTSS). The program is referenced to nationally as a managed long-term services and supports program (MLTSS).

WHO IS PART OF CHC?

- Individuals who are 21 years of age or older and dually eligible for Medicare and Medicaid.
  - ✓ Individuals with intellectual or developmental disabilities who are eligible for services through the Office of Developmental Program will not be enrolled in CHC.
- Individuals who are 21 years of age or older and eligible for Medicaid (LTSS) because they need the level of care provided by a nursing facility.
  - ✓ This care may be provided in the home, community, or nursing facility.
  - ✓ Individuals currently enrolled in the LIFE Program will not be enrolled in CHC unless they expressly select to transition from LIFE to a CHC managed care organization (MCO).

CURRENT BARRIERS TO LTSS

- Participants show a tendency to under-plan and under-insure for long-term care until there is a crisis.
- Confusing information about how to receive services.
- The system is difficult to navigate, particularly when transitioning between care delivery systems.
  - ✓ Lack of coordination between primary, acute, and LTSS organizations
  - ✓ Limited coordination between Medicare Special Needs Plans and LTSS organizations
- There is limited availability of long-term care insurance products. Available products limit coverage and are costly.



12%
49,759
Duals in Waivers

64%
270,114
Healthy Duals

18%
77,610
Duals in Nursing Facilities

4%
15,821
Non-duals in Waivers

2%
7,314
Non-duals in Nursing Facilities

16%
IN WAIVERS

20%
IN NURSING FACILITIES

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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.

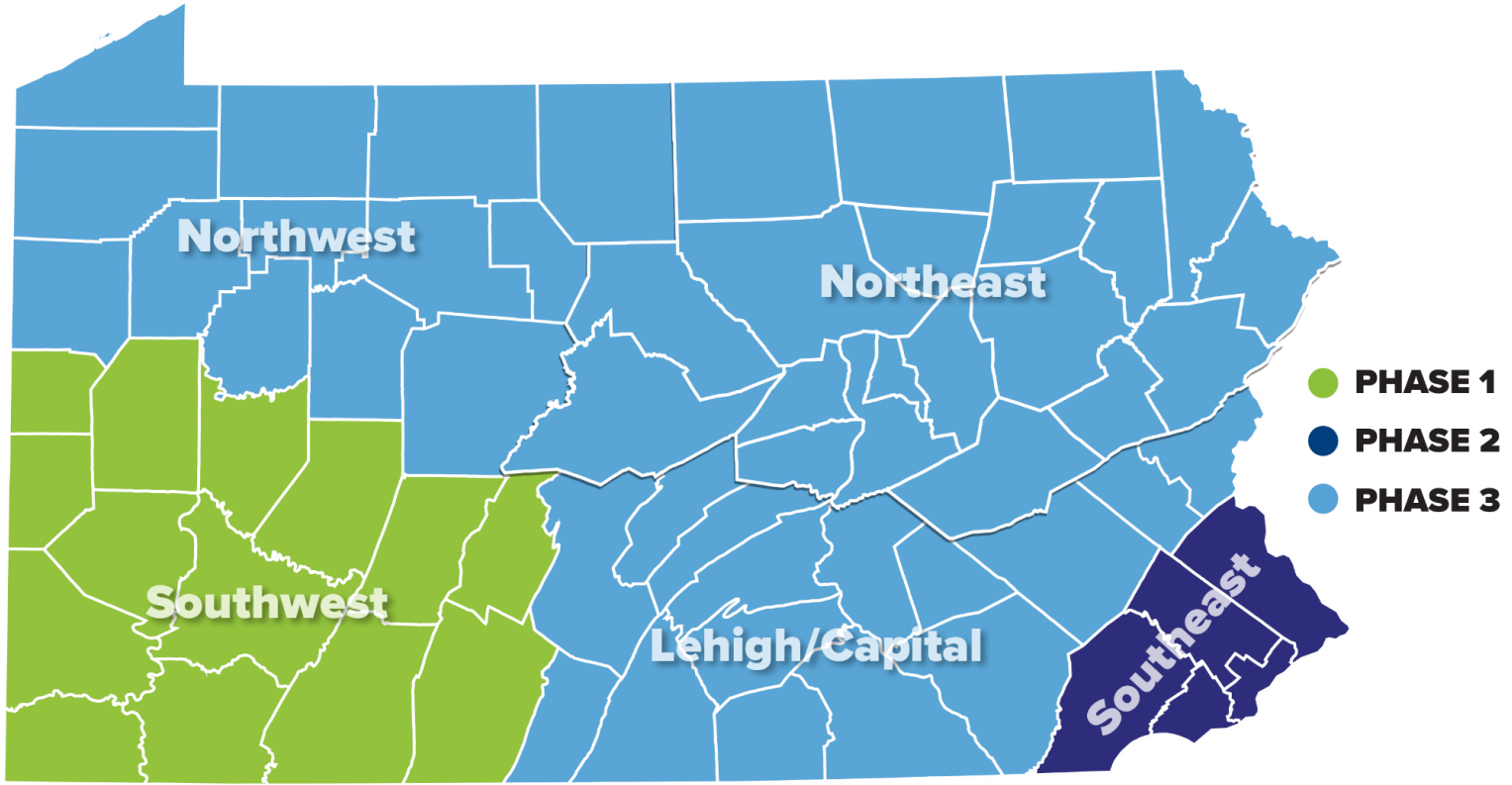
GOAL 4

Advance program innovation.

GOAL 5

Increase efficiency and effectiveness.

CHC IMPLEMENTATION PHASE APPROACH



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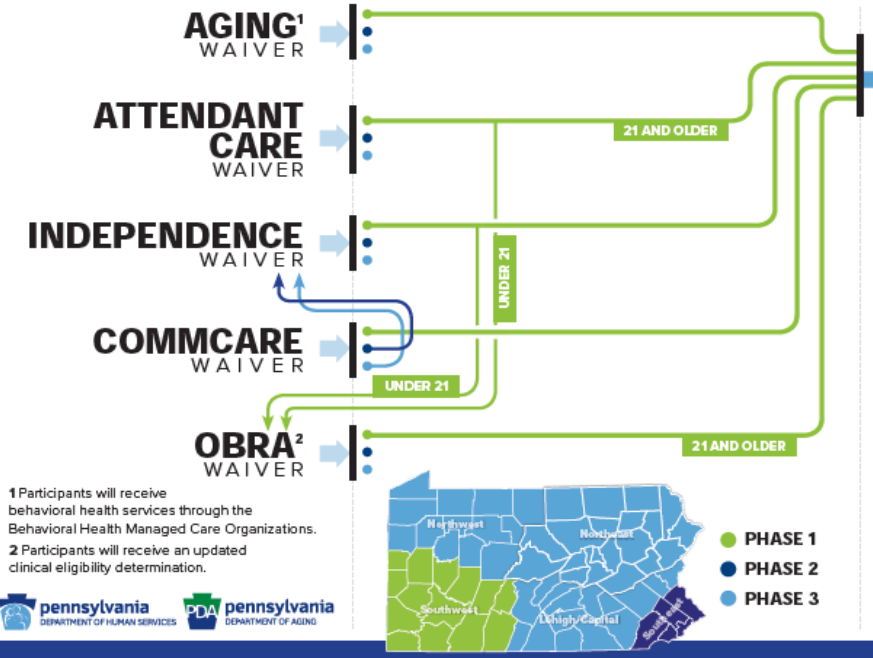
WAIVER TRANSITIONS JANUARY 2018



Transitioning to the CHC Waiver:

- Phase 1 Aging Waiver participants.
- Phase 1 Attendant Care Waiver participants ages 21 and older; participants under 21 will transition to the OBRA Waiver.
- The COMMCARE Waiver will become the CHC Waiver; Phase 2 & 3 COMMCARE participants will transition to the Independence Waiver.
- Phase 1 Independence Waiver participants ages 21 and older; participants under 21 will transition to the OBRA Waiver.
- Phase 1 OBRA Waiver participants ages 21 and older who are nursing facility clinically eligible; participants under 21 or ***not*** nursing facility clinically eligible will remain in OBRA.

Transitioning to LIFE:

Participants 55 and older who are nursing facility clinically eligible may choose to enroll or remain in a LIFE program instead of CHC.

1 Participants will receive behavioral health services through the Behavioral Health Managed Care Organizations.

2 Participants will receive an updated clinical eligibility determination.

pennsylvania DEPARTMENT OF HUMAN SERVICES

pennsylvania DEPARTMENT OF AGING

HOW DOES CHC

DHS

- Pays a per-member, per-month rate (also called a capitated rate) to MCOs
- Holds the MCOs accountable for quality outcomes, efficiency, and effectiveness

MCO

- Coordinates and manages physical health and LTSS for participants
- Works with Medicare and behavioral health MCOs to ensure coordinated care
- Develops a robust network of providers

Participants

- Choose their MCO
- Should consider the provider network and additional services offered by the MCOs

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STAKEHOLDER ENGAGEMENT

- Public Forums
  - Participants
  - Providers and Associations
- MLTSS Subcommittee (monthly meetings)
- Monthly Third Thursday Webinars
- Legislators
- CHC Website

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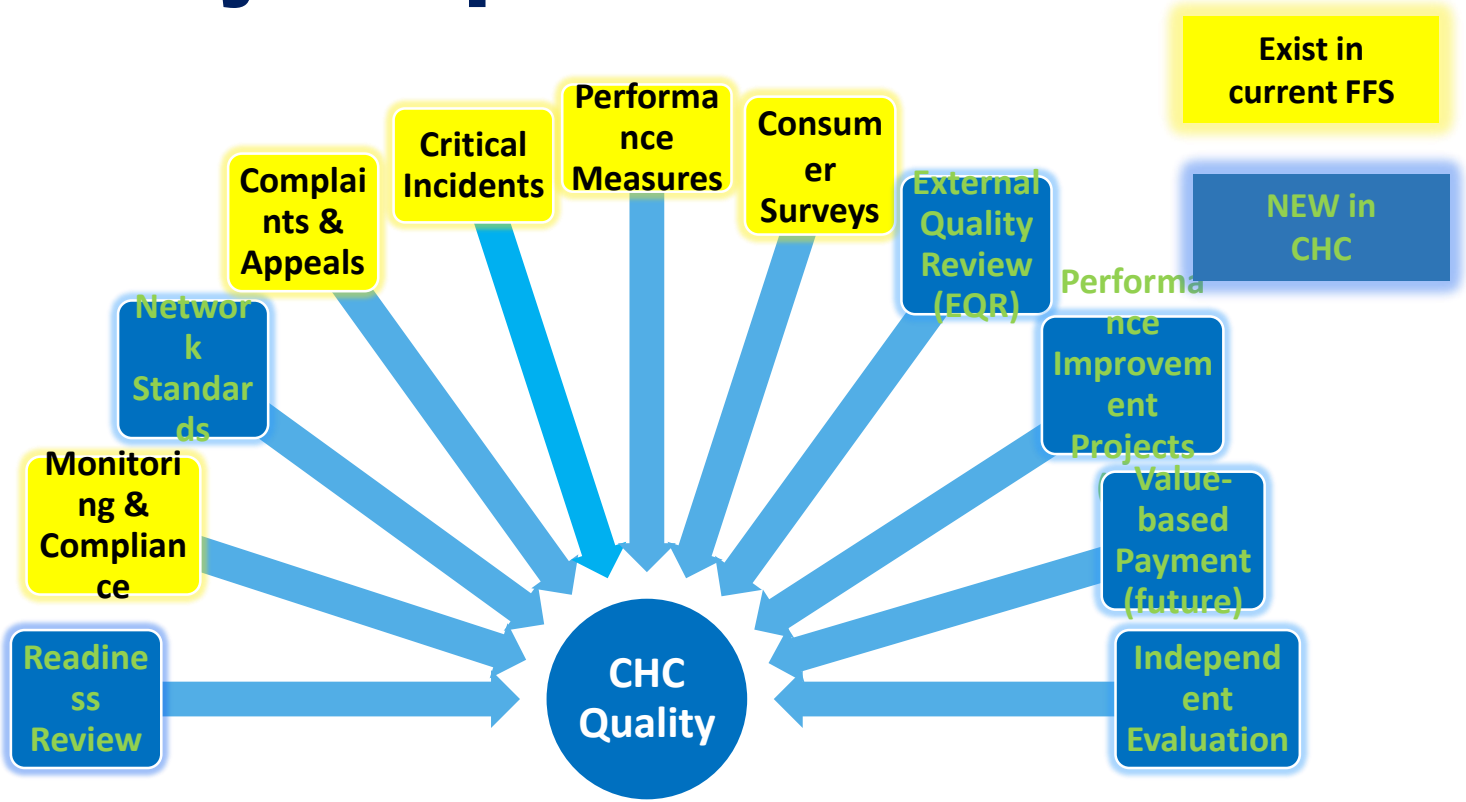
Quality Framework

Stakeholder Feedback on PA Draft Quality Strategy (Themes)

- Ensure that **participants AND providers** have mechanics in place to include:
  - An independent system (Beneficiary Support System, as defined under the managed care final rule).
  - Participant and provider hotline numbers continue at the state level.
  - Continuous communication
- Continue to **promote stakeholder engagement** among:
  - DHS
  - MCO
  - Providers
  - Participants
  - Advocates
- Continue to have **program transparency**:
  - Report on performance measures and outcomes to stakeholders:
  - Consumer and provider satisfaction surveys
  - Critical incidents / reports of abuse
  - Incorporate pay for performance initiatives
  - Monitoring of program
- Ensure **participant choice**
  - Community living
  - Nursing home
  - Service providers
- **Diversity inclusion**
  - Ethnicity
  - LGBT population
  - Various translations available

CHC Quality Components



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CHC Performance Measures

National

- Healthcare Effectiveness Data & Information Set (HEDIS)(Adults)
- CMS Adult Core
- CMS Nursing Facility
- Consumer Assessment of Healthcare Providers & Systems (CAHPS)
- CMS Medicare measures for Dual Eligible Special Needs Plans

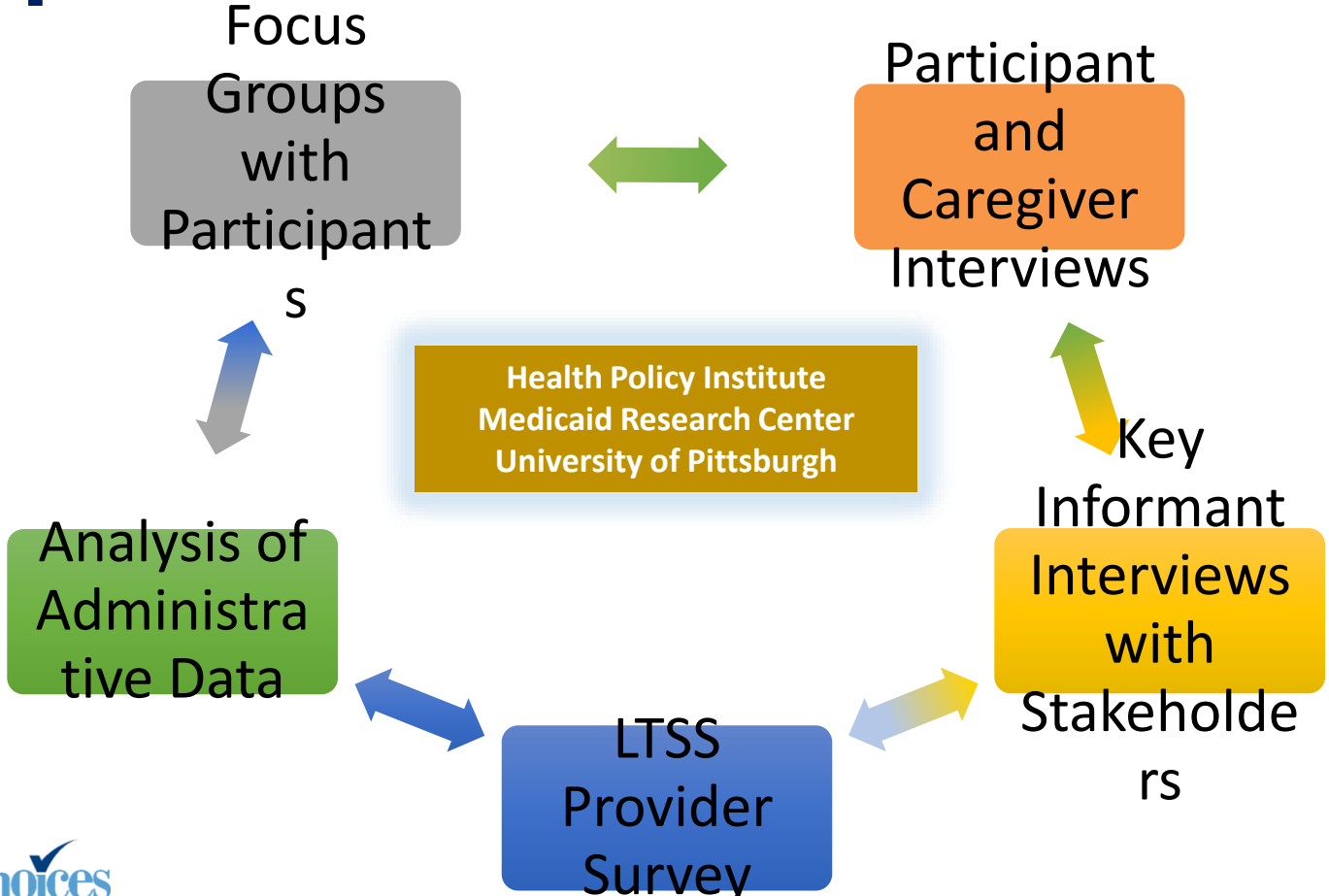
State

- LTSS Community Based Services
- **Service Coordination and Care Coordination**
- **Grievances, Appeals & Critical Incidents**
- **Rebalancing**
- **CHC HCBS Waiver Assurances**

Launch Indicators

- Key data points provided frequently during launch
- Focus on:
  - Continuity of Services (Participants & Providers)
  - LTSS Provider Participation
  - Key Information Transfers (IT Systems)

Independent Evaluation of CHC



PRIORITIES THROUGH IMPLEMENTATION

READINESS REVIEW

- Information systems
- Network adequacy
- Member materials and services

STAKEHOLDER COMMUNICATION

- Participants and caregivers
- Providers
- Public

DHS PREPAREDNESS

- General Information
- Training
- Coordination between offices
- Launch indicators

CONTINUITY OF CARE (COC)

- MCOs are required to contract with all willing and qualified existing Medicaid providers for 180 days after CHC implementation.
- Participants may keep their existing providers for the 180-day continuity of care period after CHC implementation.
- For nursing facility residents, participants will be able to stay in their nursing facility as long as they need this level of care, unless they choose to move.
- The launch indicators focus on continuinty for Participants and Providers during the COC period.

RESOURCE INFORMATION

COMMUNITY HEALTHCHOICES WEBSITE

www.healthchoicespa.com

MLTSS SUBMAAC WEBSITE

www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/mltss/

CHC LISTSERV // STAY INFORMED

http://listserv.dpw.state.pa.us/Scripts/wa.exe?SUBED1=oltl-community healthchoices&A=1

EMAIL COMMENTS TO: RA-MLTSS@pa.gov

PROVIDER LINE: 1-800-932-0939

PARTICIPANT LINE: 1-800-757-5042

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QUESTIONS