MLTSS PROGRAMS:

SHARING DESIGN AND IMPLEMENTATION EXPERIENCES

AUGUST 29, 2017

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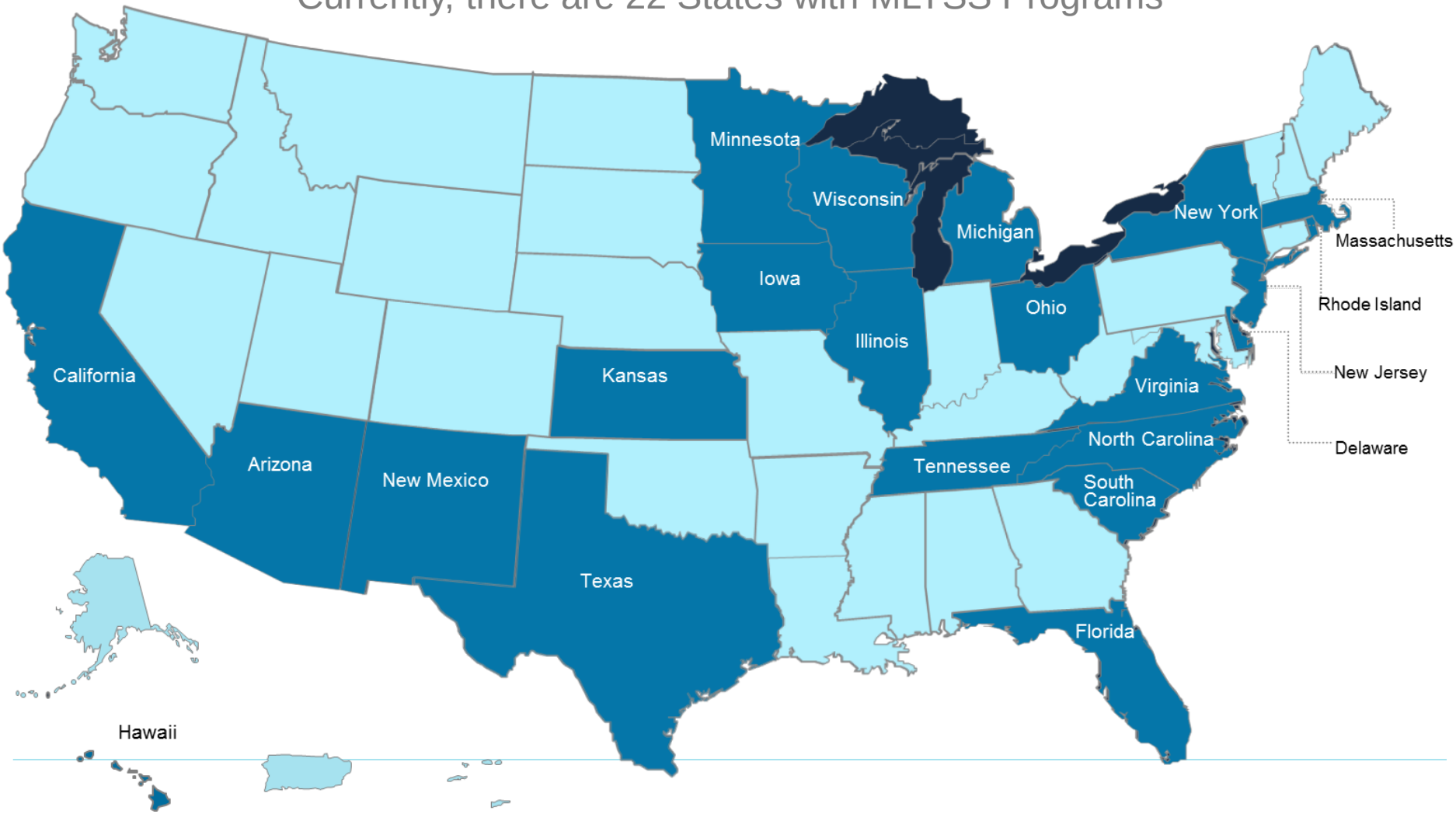
MLTSS PROGRAMS
NATIONAL PERSPECTIVE

Currently, there are 22 States with MLTSS Programs



Source: NASUAD and CHCS Report - *Demonstrating the Value of Medicaid MLTSS Programs* (May 2017)

MLTSS PROGRAMS
NATIONAL PERSPECTIVE

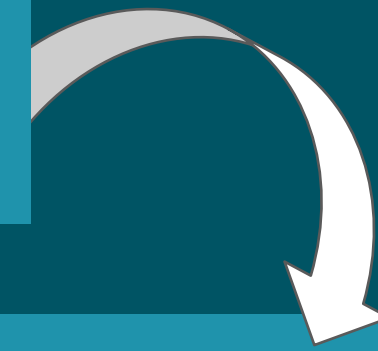
As states evaluate/implement MLTSS, common themes/goals in the design process emerge:

MLTSS PROGRAMS
TODAY'S SESSION

Overview 3 State MLTSS Experiences

Discuss Challenges faced & lessons learned

Identify Significant wins



Encourage interactive dialog with session participants:

What are your state's concerns?

What lessons did your state learn?

What are your greatest concerns moving in this direction?

MLTSS PROGRAMS
TODAY'S PANEL

State Partners

- Angela Medrano
  Deputy Medicaid Director
  New Mexico
- R. Neil Vance, PhD, FSA
  Actuary, NJ Medicaid
  New Jersey
- Kevin Hancock
  Chief of Staff, OLTL
  Pennsylvania

Mercer Team

- Deidra Abbott, MPH
- Kim Donica, Principal
- Bob Karsten, ASA, MAAA

MLTSS PROGRAMS
OVERVIEW

PROGRAM STATS	NEW MEXICO	NEW JERSEY	PENNSYLVANIA
Program Name	Centennial Care	NJ Family Care	Community HealthChoices
Program Effective Date	January 2014 (MLTSS since 2008 via CoLTS)	July 2014	January 2018
Waiver Authority	1115	1115	1915(b)/1915(c)
Population Served	702,000: ABD, WD, DE, Children, Expansion Adults	1,772,026: A BD, Expansion Adults, Adults, Children	420,618: 21+ Duals or meet NF LOC criteria
Services Included	NF, HCBS (including self-direction), AL, BH and Acute care	NF, HCBS, AL, Acute Care, BH supports	NF, HCBS, (including participant direction), Acute care
Population/Service Exclusions	I/DD carved-out	I/DD carved-out	I/DD population and BH services carved-out

NEW MEXICO

CENTENNIAL CARE

New Mexico Medicaid MLTSS

Angela Medrano

Deputy Medicaid Director

August 29, 2017

New Mexico Medicaid Overview

- Expansion State
- 915,000 enrolled in Medicaid
- 702,000 members enrolled in Managed Care – Centennial Care
- 270,000 members enrolled as a result of expansion
- 49,000 members receiving MLTSS
- MLTSS since 2008

MLTSS Successes

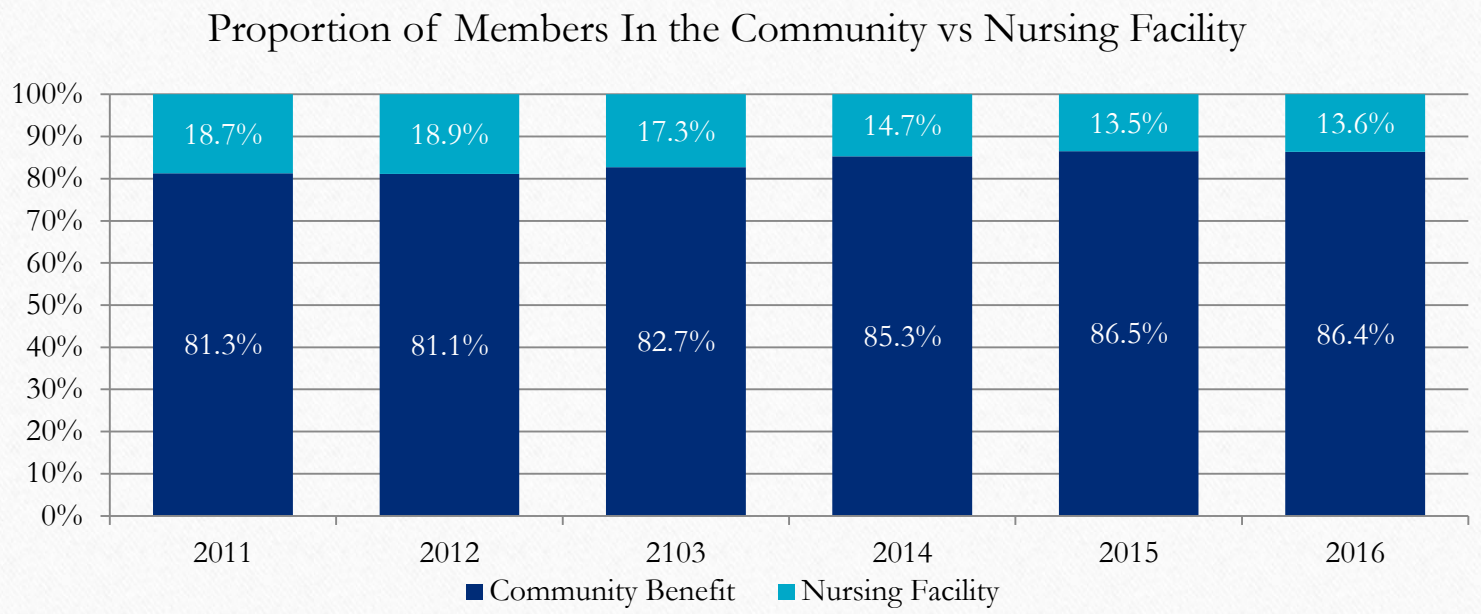
Increased number of Medicaid Members receiving Home & Community Based Services.

- Revised policy to allow all Medicaid members access home and community based services as long as they meet a Nursing Facility Level of Care (Assistance with 2 or more ADLs)
  - Members no longer need a waiver slot if they meet this criteria

	December 2013	CY2014	CY2015	CY2016
Agency Based & Self Directed HCBS	21,300	24,013	27,836	29,799
Nursing Facility (long term)	3,529	3,711	3,591	3,661

MLTSS Successes

Rebalanced Member Utilization of LTSS



MLTSS Successes

- New Mexico ranked in the 2nd best quartile in the 2014 national State Long Term Care Scorecard (published by AARP and the Commonwealth Fund)
- New Mexico's system is especially strong in terms of:
  - Affordability and access (top quartile)
  - Choice of setting and provider (top quartile)
  - Effective Transitions across settings of care (second quartile)

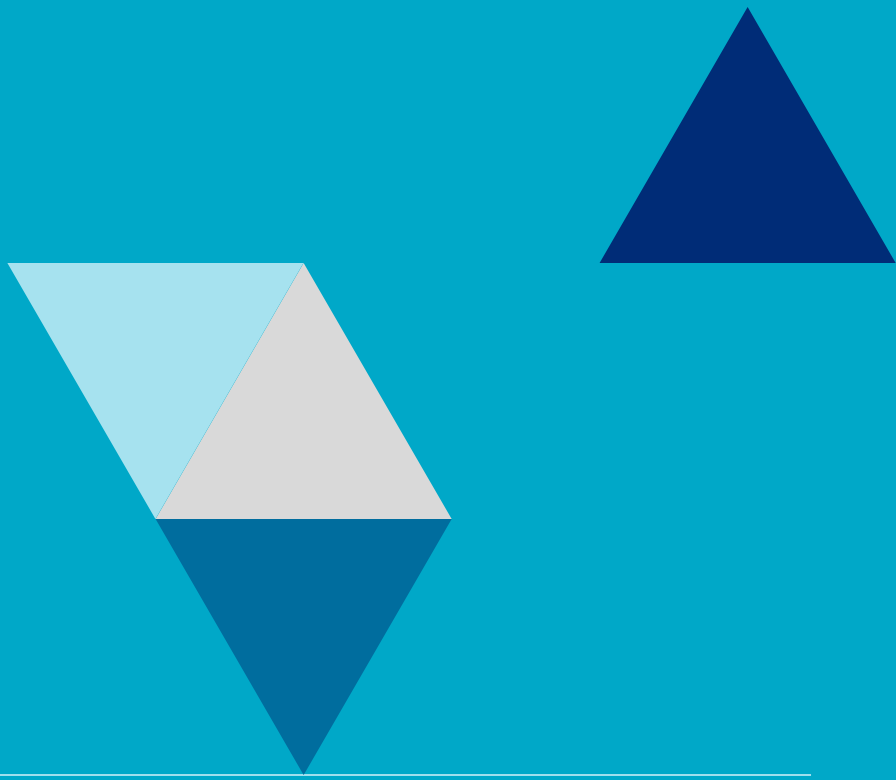
MLTSS Challenges

- Electronic Visit Verification implementation for Personal Care Services
- Budget Allotments for Members transitioning from Traditional Service Model (Agency Based) to Self-Directed Model
- Member Education on all Community Based Services
  - Development of Community Benefit Services Questionnaire
  - Required LTSS membership on MCO Advisory Boards

MLTSS Opportunities

- Medicaid Management Information System Replacement
  - Data Analytics for MLTSS Members
    - Member claims data for service utilization
    - Track Member Setting of Care
  - Improve the functionality of our LTSS wait list

NEW JERSEY FAMILYCARE



Implementation of MLTSS in New Jersey: Successes and Struggles

R. Neil Vance, PHD, FSA, Actuary
NJ Division of Medical Assistance and Health Services ("Medicaid")
NJ Dept. of Human Services

Overview

NJ Medicaid

Covers 1,760,000 people (over 20% of population), almost all (1,680,000) in Managed Care

Annual capitation is $10 billion (not including FFS and FFS Behavioral Health)

CHIP up to 350% FPL, Expansion, some integrated DSNP

MLTSS

- NJ MLTSS Background
- Operational July 2014
- Existing population was 30,000 FFS nursing facility and 12,000 receiving community supports in MC
- Former were grandfahered FFS, the latter went into MLTSS HCBS
- Now – 3 years later – 14,000 grandfathered NF, 14,000 MLTSS NF, 23,000 MLTSS HCBS
- We still provide home-based care to lower acuity ABD members
- Within DHS, but a cooperative effort of Division of Aging and DMAHS (Medicaid)
- Behavioral Health is carved in to MLTSS, although carved out for most other Medicaid

Successes

- Robust stakeholder input (MLTSS Steering Committee)
- NF population stabilized at under 30,000
- Care coordination – care in home or facility appropriate to their needs, wishes, and resources
- Rate Setting
- Statistical Reports
- Performance Metrics
- Interdivisional oversight (Aging, Medicaid) with Director involvement. Weekly oversight meetings

Struggles

- Grandfathered NF population
- Any Willing Provider for NF
- Unblended Rates (Lower for HCBS)
- Need to Assess Level of Care

Operational Issues

- Staffing Personal Care Assistance Hours
  - Compensation
  - Transportation
  - Other
- Self-Directed Services
  - Self-Directed is a significant source of assistance
  - Use of a single financial intermediary introduces operational complexity and risk
- Benefit Inconsistencies
  - BH in MLTSS (but not acute) may require provider change
  - Developmental Services not in MLTSS

Financial Issues

- Capitation Rates – No actual experience in early years
  - Data from support services in managed care; FFS NF data
  - Financials indicate a bit high in early years, quite close in SFY17

- Risk Adjustment – Pending for MLTSS; Challenges: Data, Model
  - RA is important for NJ non-MLTSS – significant and consistent risk score variation between MCOs
  - Model: UCSD model does not translate directly to MLTSS services
  - Data: Assessments for MLTSS eligibility; RUG scores

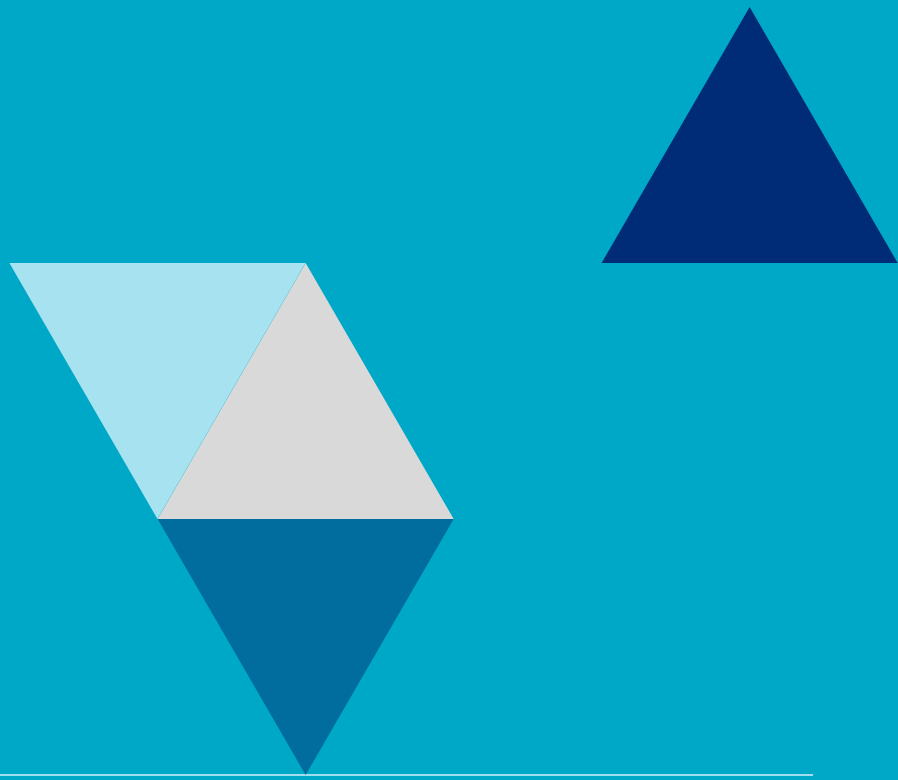
- Gain Sharing – Minimum loss ratio
  - For SFY 15 – 17, 85% HCBS, 90% NF
  - Some MCOs did not meet the HCBS minimum for SFY15
  - Starting SFY18 (blended rates) 90% for MLTSS

Would We Do It Again?

Yes

PENNSYLVANIA

COMMUNITY HEALTHCHOICES



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O V E R V I E W

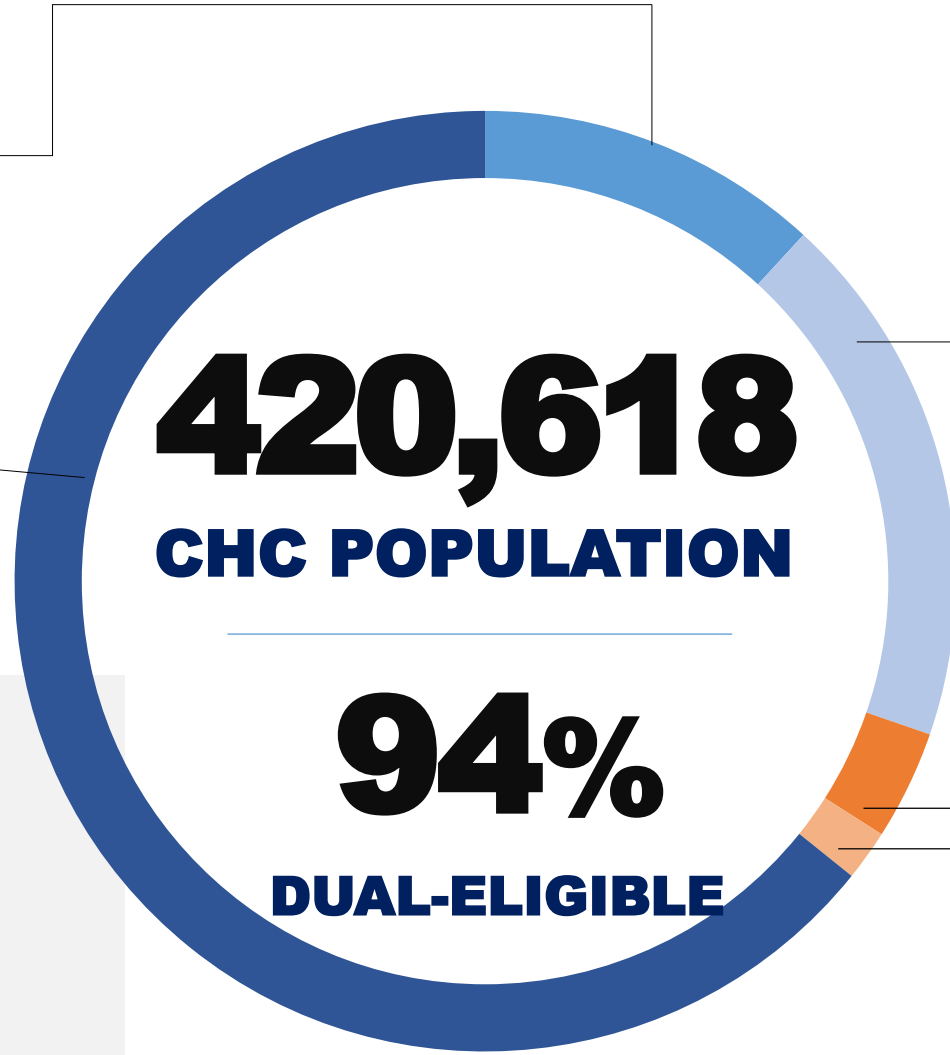
pennsylvania
DEPARTMENT OF HUMAN SERVICES

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).



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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HOW DOES CHC WORK?

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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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.

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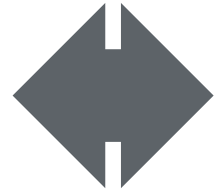
COMPARISON OF FFS VS. MANAGED CARE

FEE-FOR-SERVICE

- Providers enroll as Medicaid providers
- Providers contract with the Commonwealth
- Providers bill PROMISe



MANAGED CARE

- Providers enroll as Medicaid providers
- Providers contract with MCOs
- Providers bill MCOs

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.

COVERED SERVICES

FOR ALL PARTICIPANTS:

Physical health services

All participants will receive the Adult Benefit Package, which is the same package they receive today.

This includes services such as:

- Primary care physician
- Specialist services
- Please note: Medicare coverage will not change.

Behavioral health services

All participants will receive behavioral health services through the Behavioral Health HealthChoices MCOs.

This is new for Aging Waiver participants and nursing facility residents, who receive behavioral health services through the fee-for-service.

COVERED SERVICES

FOR PARTICIPANTS WHO QUALIFY FOR LTSS:

- Home and community-based long-term services and supports including:
  - ✓ Personal assistance services
  - ✓ Home adaptations
  - ✓ Pest eradication
- Long-term services and supports in a nursing facility
- Participant-directed services will continue as they exist today

CONTINUITY OF CARE

- 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 commonwealth will conduct ongoing monitoring to ensure the MCOs maintain provider networks that enable participants choice of provider for needed services.

IDENTIFYING NEEDS

SCREENING, COMPREHENSIVE NEEDS ASSESSMENT AND REASSESSMENT

- CHC-MCOs must:
  - Screen each new participant who are healthy duals within 90 days of the start date
  - Conduct a comprehensive needs assessment of every participant who is determined NFCE
  - Conduct a comprehensive assessment when the participant makes a request, self-identifies as needing LTSS, or if either the CHC-MCO or the Independent Enrollment Broker (IEB) identifies that the participant has unmet needs, service gaps or a need for service coordination
  - Conduct a reassessment at least every 12 months unless a trigger event occurs

PLANNING

CARE MANAGEMENT PLANS

A care management plan is used to identify and address how the participant's physical, cognitive, and behavioral health care needs will be managed.

PERSON-CENTERED SERVICE PLANS (PCSP)

All LTSS participants will have a PCSP. The PSCP includes both the care management plan and the LTSS services plan.

PCSPs are developed through the person-centered planning team process, which includes the participant, service coordinator, participant's supports, and participant's providers.

SERVICE COORDINATION OBJECTIVES

- Every participant receiving LTSS will choose a service coordinator.
- The service coordinator will coordinate Medicare, LTSS, physical health services, and behavioral health services.
- They will also assist in accessing, locating and coordinating needed covered services and non-covered services such as social, housing, educational and other services and supports.
- The service coordinator will also facilitate the person-centered planning team.
- Each participant will have a person-centered planning team that includes their doctors, service providers, and natural supports.

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WHERE IS IT NOW?

PRIORITIES THROUGH IMPLEMENTATION

ESSENTIAL PRIORITIES

- No interruption in participant services
- No interruption in provider payment

HOW WILL WE ENSURE NO INTERRUPTIONS?

- The Department of Human Services (Department) is engaged with the MCOs in a rigorous readiness review process that looks at provider network adequacy and IT systems.
- The Department of Health must also review and approve the MCOs to ensure they have adequate networks.

PRIORITIES THROUGH IMPLEMENTATION

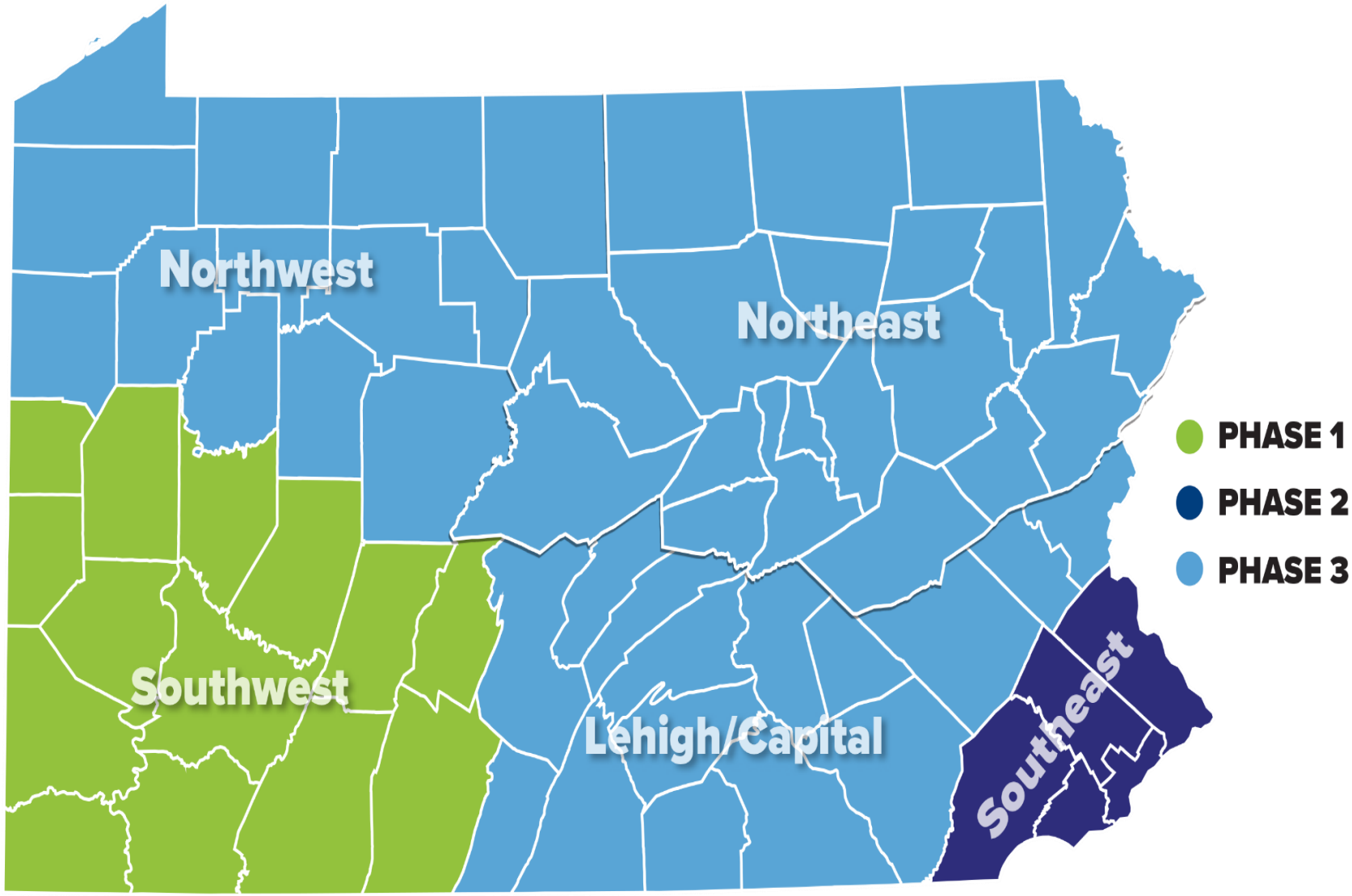
NETWORK ADEQUACY

PHYSICAL HEALTH

- CHC-MCOs will be required to meet the existing HealthChoices network adequacy requirements.

LTSS

- National MLTSS network adequacy standards aren't available.
- The Department is working with consumers to help develop standards.
- The Department is gathering information to establish a baseline of the number of full-time equivalents (FTEs) (i.e., personal assistance or nursing services) that are potentially needed to continue to provide services and meet the needs of the participants.
- The CHC-MCOs are asking providers for this information during a provider's initial enrollment with an MCO and on an ongoing basis.
- DHS will re-evaluate network adequacy at the end of the 180-day continuity of care period to ensure consumers have access to LTSS.
- The commonwealth will conduct ongoing monitoring to ensure the MCOs maintain provider networks that enable participants choice of provider for needed services.



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MANAGED CARE ORGANIZATIONS

- The selected offerors were announced on August 30, 2016.

AmeriHealth Caritas Pennsylvania	CHCProviders@amerihealthcaritas.com
pa health & wellness	information@pahealthwellness.com
UPMC Community HealthChoices	CHCProviders@UPMC.edu

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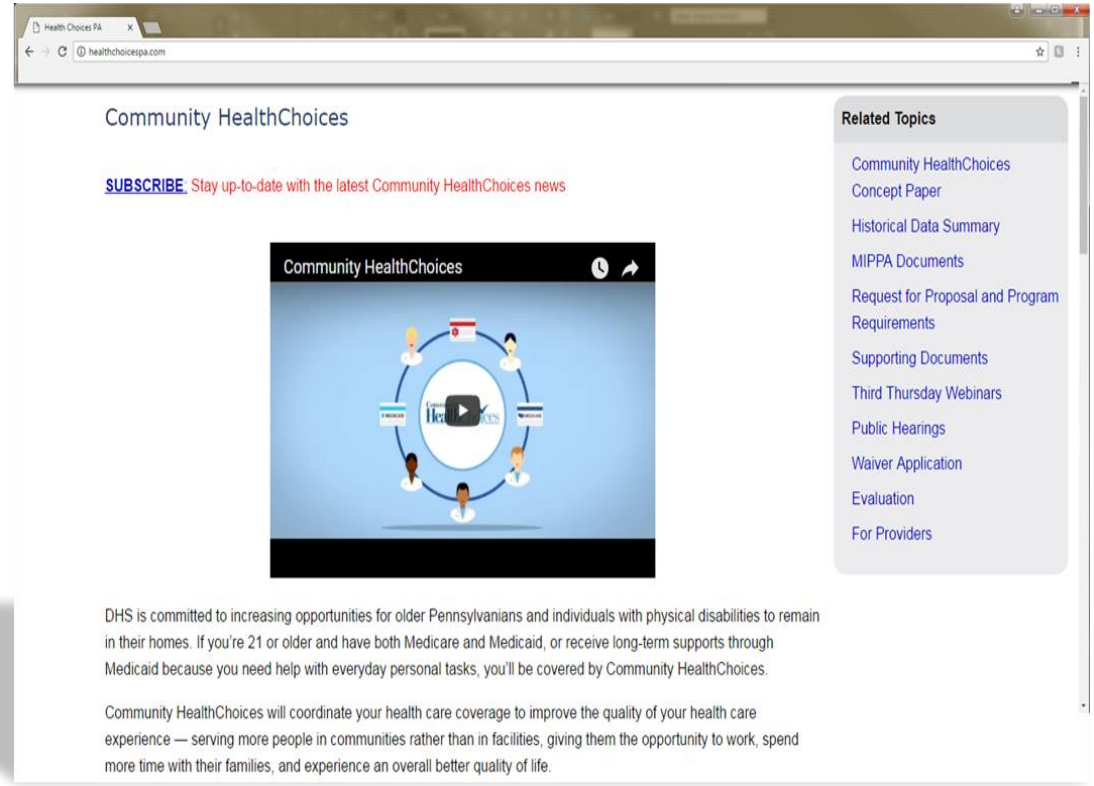
COMMUNICATIONS

CHC WEBSITE



www.HealthChoicesPA.com

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PARTICIPANTS

AWARENESS FLYER

- Mailed five months prior to implementation. Southwest: August 2017

AGING WELL EVENTS

- Participants will receive invitations for events in their area. Southwest: August 2017

SERVICE COORDINATORS

- Will reach out to their participants to inform them about CHC. Southwest: August 2017

NURSING FACILITIES

- Discussions about CHC will occur with their residents. Southwest: August 2017

PRE-TRANSITION NOTICES AND ENROLLMENT PACKET

- Mailed four months prior to implementation. Southwest: September 2017

PROVIDERS

- Bi-weekly email blasts on specific topics
  - ✓ Examples: Billing, Service Coordination, Medicare, HealthChoices vs. CHC, Continuity of Care
- Established provider webpage
- Provider events in local areas to meet with MCOs and gain information about CHC

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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MERCER
MAKE TOMORROW, TODAY