Are Managed Long-Term Services and Supports Expanding Access to Home and Community-Based Services?

Angie Amos & Kristen Pavle, IBM Watson Health
Devona Pickle, Florida Agency for Health Care Administration
Mike Randol, Iowa Medicaid Enterprise
Joe Bongiovanni, New Jersey Department of Human Services
Patti Killingsworth, Tennessee Bureau of TennCare

Home and Community-Based Services Conference
Tuesday August 28th, 2018
Agenda

I. Introductions (5)

II. 1115 Demonstration Evaluations: Rapid Cycle Reports (10)

III. Overview of Featured States’ Managed Long-Term Services and Supports Programs (30)
   - Florida
   - Iowa
   - New Jersey
   - Tennessee

IV. Moderated Panelist Discussion (20)

V. Audience Question and Answer + Discussion with Panelists (10)
## Introductions

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<tr>
<th>State</th>
<th>Panelist</th>
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<tbody>
<tr>
<td>Florida</td>
<td><strong>Devona, D.D., Pickle</strong>, AHC Administrator for Managed Care Policy and Contract Development, Florida Agency for Health Care Administration</td>
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<tr>
<td>Iowa</td>
<td><strong>Mike Randol</strong>, Medicaid Director, Iowa Medicaid Enterprise</td>
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<td>New Jersey</td>
<td><strong>Joe Bongiovanni</strong>, Director, MLTSS and Contract Logistics, New Jersey Department of Human Services</td>
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<tr>
<td>Tennessee</td>
<td><strong>Patti Killingsworth</strong>, Assistant Commissioner, Chief of Long Term Services and Supports, Bureau of TennCare, Division of Long Term Services and Supports</td>
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### IBM Moderators

**Angie Amos and Kristen Pavle**, Senior Research Leaders, Government Health and Human Services, IBM Watson Health
1115 Demonstration Evaluations: Rapid Cycle Reports
National Evaluation of Medicaid 1115 Demonstrations

• The Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research to conduct an independent evaluation of the implementation and outcomes of section 1115 Medicaid demonstrations*
  – One of the four categories of demonstrations featured in the evaluation is managed long-term services and supports (MLTSS)
  – IBM Watson Health produces one of the research products: a series of rapid-cycle reports, or RCRs, that feature key aspects of MLTSS

*contract number HHSM-500-2010-0026I
MLTSS Rapid Cycle Reports

• A qualitative approach to evaluating MLTSS programs through both 1115 and 1915 Medicaid authorities
  – Offers a deep-dive into states MLTSS programs through key-informant interviews and analysis of state MLTSS documentation
• RCR topics selected based on identified priorities for MLTSS programs
• 4 RCRs completed to date
  – Who Enrolls in Medicaid Managed Care Programs that Cover Long-Term Services and Supports (LTSS)?
  – Do Managed Care Programs Covering LTSS Reduce Waiting Lists for Home and Community-Based Services (HCBS)?*
  – How MLTSS Programs Interact With Federal LTSS-Related Initiatives
  – The Impact of MLTSS on Access to LTSS*

*Featured in our presentation today
Rapid Cycle Reports on Access

“Do Managed Care Programs Covering LTSS Reduce Waiting Lists for HCBS?”

• 8 states
  - Delaware
  - Florida*
  - Michigan
  - New Jersey*
  - New Mexico
  - Tennessee*
  - Texas
  - Wisconsin

*Participating on today’s panel
Rapid Cycle Reports on Access

“The Impact of MLTSS on Access to LTSS”

- 4 featured states:
  - Delaware
  - Iowa*
  - New Jersey*
  - Tennessee*

- 4 policy areas featured:
  - Network adequacy standards
  - Transition of care
  - Provider reimbursement
  - Level of care criteria

*Participating on today’s panel
Most States Eliminated or Reduced Waiting Lists for HCBS

Change in Waiting Lists for Applicable HCBS Programs Since MLTSS Implementation in Eight States

<table>
<thead>
<tr>
<th>Change in Waiting Lists</th>
<th>Number of States</th>
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<tbody>
<tr>
<td>Decreased number of people on HCBS waiting lists</td>
<td>4</td>
</tr>
<tr>
<td>Eliminated HCBS waiting lists</td>
<td>2</td>
</tr>
<tr>
<td>No HCBS waiting list before or after MLTSS</td>
<td>1</td>
</tr>
<tr>
<td>No change in HCBS waiting list</td>
<td>1</td>
</tr>
</tbody>
</table>
HCBS waiting list reductions have been observed in MLTSS programs but other access measures are preferred

- Waiting list data are generally not reliable
  - Not comparable across states and sometimes not comparable within states

- States believe MLTSS can decrease waiting lists but cite additional factors that affect access to HCBS, such as:
  - Expanded state funding and/or new federal opportunities (e.g., MFP)
  - State policy changes making HCBS an entitlement (e.g., personal care services)
  - Improved front door via aging and disability resource center (ADRC) development
Access-related MLTSS policies have been effective during FFS-to-managed care transitions but longer-term impacts are unknown

- Continuity of Care policies have preserved LTSS access during the move from FFS to managed care
  - Transitional periods ranged from 30-180 days in our 4 study states
- Any Willing Provider policies continue to protect access to nursing facilities and HCBS
  - More common for nursing facilities
- State-established minimum managed care rates tied to FFS implemented for both nursing facilities and HCBS
  - More common for nursing facilities
Stakeholders support access protections, but measuring access remains a challenge

• Providers are concerned that access will be impacted if transitional policies expire
• States support transitional policies but believe that plans must have flexibility to manage network in order to improve quality in the longer-term
• States are moving toward “achieved access” standards
  – For example, the time it takes from authorization to delivery of services.
Overview of Featured States’ MLTSS Programs
Florida: MLTSS and Access to LTSS

Devona, D.D., Pickle, AHC Administrator for Managed Care Policy and Contract Development, Florida Agency for Health Care Administration
## Florida Medicaid Managed Care: Long Term Care Program—A Snapshot

<table>
<thead>
<tr>
<th>Program Enrollment</th>
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<tbody>
<tr>
<td>Recipients are mandatory for enrollment if they are:</td>
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<tr>
<td>• 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.</td>
</tr>
<tr>
<td>• Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening program to require:</td>
</tr>
<tr>
<td>• Nursing facility care as defined in s. 409.985(3); or</td>
</tr>
<tr>
<td>• Hospital level of care, for individuals diagnosed with cystic fibrosis.</td>
</tr>
<tr>
<td>• 100,000 recipients currently enrolled in LTC health plans</td>
</tr>
<tr>
<td>• New Population have been added to LTSS in 2 phases: 2013 and 2018</td>
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<thead>
<tr>
<th>Mechanisms for Expanding Access</th>
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<tr>
<td>• Blended capitation rates and other rate incentives for transition to the community</td>
</tr>
<tr>
<td>• Community High Risk Pool (CHRP) to avoid plan disincentives for transition of high cost enrollees</td>
</tr>
<tr>
<td>• Expanded benefits provided by plans at no additional cost to the state</td>
</tr>
<tr>
<td>• Consumer Direction</td>
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Florida’s LTC Rate Methodology

• Methodology for blending Nursing Facility vs. HCBS rate also incentivizes transition
• The law requires that base rates be adjusted to provide an incentive for plans to transition enrollees from nursing facilities (NF) to the community (HCBS).

An enrollee who starts the year in a nursing facility is treated as NF for rate blending for the entire year, even if they are transitioned to the community. A similar situation applies for enrollees starting the year in the community.

• Plans “win” financially if they beat the target transition percentage, “lose” if they do not meet the target.
LTC Transition Incentive Success

![Bar chart showing the comparison between Community and Nursing Facility locations from July 2013 to July 2017. The chart illustrates an upward trend in both categories, with a noticeable increase in Nursing Facility locations.](image)
Avoid Disincentives to Transition: Florida LTC Community High Risk Pool (CHRP)

- Community High Risk Pool Put in Place to Assist Plans with High Cost Members in the Community
  - To re-allocate funds among the LTC plans to account for HCBS high cost recipients whose average monthly HCBS claims exceed a threshold of $7,500 per month during each quarterly disbursement period.
  - Capitation dollars are withheld from the HCBS rate on a per member per month basis.
  - Those dollars are re-distributed to plans based on the risk of the plan enrollment as determined by their claims exceeding a dollar threshold.
  - Revenue Neutral to State – The dollars distributed do not exceed the dollars withheld.
Expanded Benefits: Additional Services Provided at No Additional Cost to the State

• Under the current contracts, Florida’s LTC plans offer specific Expanded Benefits to the LTC enrollees. These are benefits provided above the “normal” Medicaid HCBS benefit at no cost to the state.

• Under the NEW contracts, all plans that provide LTC services with ALSO provide MMA services to their enrollees. All enrollees will be offered a rich Expanded benefits package including more than 55 benefits.
Participant Directed Option (PDO)

• A services delivery model in which participants hire, train, supervise, and dismiss their direct service worker(s). Available to:
  – All LTC enrollees who live in their own home or family home, AND
  – Who have at least one of the following services on their care plan
    • Adult Companion Care
    • Attendant Care
    • Homemaker
    • Intermittent and Skilled Nursing
    • Personal Care
PDO Enrollment Success

Number of LTC Enrollees in PDO by Year

- 2015: 1841
- 2016: 3423
- 2017: 4349
- 2018: 5385
Iowa Health Link

Director Mike Randol
mrandol@dhs.state.ia.us
MLTSS Population in Iowa

- 37,412 – as of March 2018
  - About 60 percent are receiving Community Based Services
  - 40 percent are receiving Facility Based Services – ICF/ID, Nursing Facility, PMIC
- Two MCOs; Third to join July 2019
- Iowa currently has seven HCBS Waivers
Network Adequacy

- Iowa has a large rural population which has always been a challenge in both FFS and Managed Care
- Access standard: 1 primary care provider within 30 miles
- There are a limited number of specialty providers across the state
  - 1 provider within 60-90 miles
Care Coordination Model

• When managed care started in Iowa in 2016, MLTSS members were free to choose the care coordination model of their choice
• Two MCOs provided an in-house model; the third allowed members to keep their existing care coordinators in community agencies
• Majority of members chose the community based approach
Care Coordination Continued

• MCO that had community based approach ended up leaving Iowa
• Members were then transitioned to the other two MCOs
• Lesson learned:
  • Maintaining access to specific care coordinators is important to HCBS members
Access to HCBS in MLTSS
NASUAD HCBS Conference
August 2018

Joseph Bongiovanni
NJ Department of Human Services
Division of Medical Assistance and Health Services
NJ Comprehensive Medicaid Waiver (CMW)

- NJ CMW is an 1115 demonstration that was renewed effective 8/1/2017-6/30/2022 to continue:
  - Implementing statewide health reform through our current managed care programs to include MLTSS and expand home and community based services (HCBS)

- Managed Long Term Services and Supports (MLTSS) is a component of the NJ Comprehensive Medicaid Waiver
What is MLTSS?

• MLTSS Philosophy:
  • To Maintain Individuals in the Community Through:
    o Improved care coordination and better health outcomes (breaking down silos: physical health, mental health/substance abuse, long-term care)
    o Cost reduction
    o Consumer choice and home-based care
What is MLTSS? continued

- **NJ FamilyCare Managed Long Term Services and Supports (MLTSS) include the following services:**
  - Personal Care; Respite; Personal Emergency Response System (PERS); Home and Vehicle Modifications; Home Delivered Meals; Assisted Living; Behavioral Health Services; Community Residential Services; and Nursing Home Care

- **Individuals are able to access:**
  - Health care providers and services within managed care networks to meet identified needs; and
  - A care manager to help coordinate medical, long term services and supports, behavioral health services and NJ FamilyCare state plan services, such as medical day care and personal care assistance, through an individualized plan of care.
An individual is eligible for the MLTSS program when he or she meets nursing home level of care (LOC) determined by the pre-admission screening (PAS) completed by the MCO or the Office of Community Choice Options (OCCO)

- **Clinical Eligibility**
  - A person meets the qualifications for nursing home LOC, when s/he requires limited assistance with a minimum of three (3) activities of daily living (ADLs) such as bathing, toileting and mobility; or the consumer has cognitive deficits and ADL needs of supervision in greater than 3 ADL areas

- **Categorical Eligibility**
  - Aged – 65 years old or older, or
  - Blind or Disabled – Under 65 years of age and determined blind or disabled by the Social Security Administration or the State of New Jersey
Eligibility for MLTSS Continued

• **Financial** Eligibility

  • Institutional Medicaid
    • Apply at the CWA

  o **Income** for one person can be equal to or less than $2,250 per month (2018)
  o Income for a couple can be equal to or less than $3,375 per month (2018)
  o All income is based on the gross amount
  o **Resources** must be at or below $2,000 for an individual and $3,000 for a couple
MLTSS provides enrollees a care manager to help coordinate medical, long term services and supports, behavioral health services and NJ FamilyCare (Medicaid) State Plan services, through an individualized plan of care.

MCOs care manage NJ FamilyCare state plan benefits, MLTSS and behavioral health:
- Primary Care
- Acute Care
- LTSS
- Substance Abuse Services
- Mental Health Services
NJ Self-Direction: Personal Preference Program

• Medicaid State Plan
  o Budget Authority: Cash value of assessed hours of PCA service
  o Employer Authority: Member or authorized representative is employer of record
  o Currently evaluating how to leverage managed care
Providers and Network Adequacy

TRADITIONAL PROVIDERS

• Home health agencies
• Home care agencies
• Assisted living facilities
• Community residential facilities
• Therapists

NON-TRADITIONAL PROVIDERS

• Home modification contractors
• Furniture stores
• Neighbors/relatives (PCA)
• Cleaning service (chore care)
Providers and Network Adequacy Continued

• Any Willing Provider

• Any Willing and Qualified Provider
MLTSS Headlines

• July 2014 (Inception of MLTSS )
  • 29.4% of NJ FamilyCare LTC population is in Home and Community Based Services
• October 2015:
  • 36.3% of the NJ FamilyCare LTC Population is in Home and Community Based Services
• April 2018:
  • 49.4% of the NJ FamilyCare LTC Population is in Home and Community Based Services

• Number of Recipients Residing in Nursing Facilities is Down Over 1,600 Since the July 2014 Implementation of MLTSS
Expanding Access to HCBS in Tennessee
Service Delivery System in Tennessee

• TennCare managed care demonstration began in 1994
• Operates under the authority of an 1115 demonstration
• Entire Medicaid population (1.4 million) in managed care since 1994 (including dual eligibles and people with disabilities)
• Three health plans (MCOs) operating statewide
• Physical/behavioral health integrated beginning in 2007
• Managed LTSS began with the Statewide CHOICES program in 2010
  – Older adults and adults with physical disabilities only
• 3 Section 1915(c) waivers and ICF/IID services for individuals with I/DD carved out; operated by State I/DD Department (people carved in for physical and behavioral health services)
• New Statewide MLTSS program for individuals with I/DD began July 1, 2016: Employment and Community First CHOICES
Program Objectives (Baseline Data Plan)

#1: Expand access to HCBS
  • # receiving HCBS versus NF services
    (point in time and unduplicated across the year)

#2: Rebalance LTSS spending
  • Total HCBS versus NF expenditures

#3: Provide cost-effective HCBS as an alternative to institutional care
  • Average per person NF versus HCBS expenditures

#4: Delay or prevent institutional placement
  • Average length of stay in HCBS
  • Percent of new LTSSSS members admitted to NFs

#5: Facilitate transition from NF to HCBS
  • Average length of stay in NF
  • # NF-to-community transitions
Strategic Program Design Elements

- Nursing facility services **and** HCBS carved in
- MCOs at full risk for all services, including NF (not time-limited)
- Blended capitation rate for NF eligible population (even if receiving HCBS)
- Higher level of care standards for NF services, access to HCBS for “at-risk”
- Contractual requirements regarding nursing facility diversion and transition processes and timelines
- MFP Rebalancing Demonstration **and** incentive payment structure
  - Every transition under MFP
  - Upon completion of the 365 day MFP participation period
  - MFP transition targets
  - HCBS vs. institutional expenditures
  - HCBS vs. institutional participants
  - Development of community based residential alternatives
  - Participation in consumer direction
Access to HCBS before and after...

- No state-wide HCBS alternative to NFs available before 2003.
- CMS approves HCBS waiver and enrollment begins in 2004.
- Slow growth in HCBS – enrollment reaches 1,131 after two years.
- HCBS enrollment at CHOICES implementation.
- Well over twice as many people who qualify for nursing facility care receive cost-effective HCBS without a program expansion request; additional cost of NF services if HCBS not available approx. $250 million (federal and state).

Global budget approach:
- Limited LTSS funding spent based on needs and preferences of those who need care.
- More cost-effective HCBS serves more people with existing LTSS funds.
- Critical as population ages and demand for LTSS increases.

HCBS waiting list eliminated in CHOICES

* Excludes the PACE program which serves <300 people almost exclusively in HCBS, and other limited waiver programs no longer in operation.
CHOICES Outcomes

- # of persons receiving HCBS in CHOICES increased by nearly 170% in first 5 years (from 4,861 to 13,240, as of 6/30/15); HCBS enrollment 12,385 as of 6/30/18
- # of persons receiving NF services in CHOICES has declined by more than 6,600 people (from 23,076 to 16,439, as of 6/30/18)
- % of people coming into LTSS in a NF declined from 81.34% in the year preceding CHOICES implementation to less than 50% during FYs 2013, 2014, and 2015, with more than 50% of people choosing HCBS upon enrollment in CHOICES for 3 consecutive years
- More than 4,000 individuals transitioned from NFs to HCBS as of 6/30/17, an average of almost 600 per year, compared to 129 people in the baseline year immediately preceding CHOICES
Employment and Community First CHOICES
**HCBS enrollment for individuals with I/DD**

- **2,062** – Total new enrollment into 1915(c) waivers prior to implementation of MLTSS - FY 2011-2016 (6 years)
- **2,539** – Total enrollment in Employment and Community First CHOICES (MLTSS) as of July 2018

- We have enrolled more people with I/DD into HCBS in the last *24 months* than in the previous *6 years*

- For the first time in the State’s history, people with developmental disabilities *other than an intellectual disability* have access to HCBS
<table>
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<tr>
<th>Priority Category</th>
<th>Target Population</th>
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<tbody>
<tr>
<td><strong>A</strong></td>
<td>Individuals who have a job but need help keeping their job.</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Young adults (18+), preparing to transition from education or training to the workforce, who have a job offer but need supports to accept the offer.</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Individuals who have lost their job and need help finding and keeping a new one.</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>Young adults (18-22) preparing to transition from education or training to the workforce, who need help finding and keeping a job.</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>Individuals who do not have a job, but want to work and need help finding and keeping a job.</td>
</tr>
<tr>
<td><strong>F</strong></td>
<td>Youth (14-22) in school and living at home who need help preparing to transition to the workforce.</td>
</tr>
<tr>
<td><strong>G</strong></td>
<td>Individuals (14-62) who do not have a job but are open to the possibility of working and agree to participate in career exploration services.</td>
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* Reserve capacity based on caregiver age/health, emergent circumstances, etc.*
Flexible employment-focused benefit design

- **Tiered benefit packages** target resources more efficiently; serve more people, reduce waiting list over time
- Array of **14 different Employment Services** create a pathway to employment even for people with significant disabilities
- **Employment Informed Choice** process ensures that employment is the *first* option considered for every person of working age *before* non-employment day services are available
- **Comprehensive and flexible wrap around and supportive services**, including self-advocacy and family supports, and self-directed options to support active community participation and independence
- **Value-based payment** aligns incentives with employment goals
  - *Outcome-based reimbursement* for pre-employment services
  - *Tiered outcome-based reimbursement* for Job Development and Self-Employment Start-Up based on person’s “acuity” level and *paid in phases* to support retention
  - *Tiered reimbursement for Job Coaching* based on person’s “acuity” level, length of time employed, and amount of support as a % of hours worked
  
  *Payment is higher per hour if fading achieved is greater.*
Facilitated Panelist Discussion
Question #1

If you could change anything in your MLTSS program to improve access to HCBS, what would it be? Why?
Question #2

Were there any unexpected outcomes related to access to HCBS that resulted from the implementation of your MLTSS program(s)?
Question #3

What concerns did you have or do you currently have about MLTSS potentially limiting access to HCBS?

– How did you overcome these challenges?
Question #4

What are the next steps in your state for addressing key HCBS access policies in your MLTSS program(s)?
Questions from the audience

• What additional questions do you have for our panelists?
Thank you for your time today!

• A big thank you to our state panelists—thank you for sharing your experience and expertise
  – For more information on the 1115 Demonstrations Evaluation and to find the MLTSS related reports, please visit: https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/index.html

• Feel free to reach out to Angie Amos or Kristen Pavle for more information on our MLTSS work
  – aamos@us.ibm.com or kpavle@us.ibm.com