LTSS in an Environment of Health Reform

BARBARA COULTER EDWARDS, MANAGING PRINCIPAL
HEALTH MANAGEMENT ASSOCIATES
LTSS: Total National Financing (2013)

$310 Billion

Medicaid, 51%

Other Public, 21%

Private Ins., 8%

Out-of-Pocket, 19%

## What’s in a Name?

<table>
<thead>
<tr>
<th>LTC</th>
<th>LTSS</th>
</tr>
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<tbody>
<tr>
<td>• Custodial Nursing Facility</td>
<td>• Non-emergency medical transportation</td>
</tr>
<tr>
<td>• ICF/IID</td>
<td>• Nursing facility services (custodial)</td>
</tr>
<tr>
<td>• Home Health/DME</td>
<td>• Nutritional assessment and risk reduction</td>
</tr>
<tr>
<td>• Therapies</td>
<td>• Occupational, physical and speech therapies to maintain function</td>
</tr>
<tr>
<td></td>
<td>• Personal care</td>
</tr>
<tr>
<td></td>
<td>• Personal emergency response systems</td>
</tr>
<tr>
<td></td>
<td>• Respite care</td>
</tr>
<tr>
<td></td>
<td>• Supported employment</td>
</tr>
<tr>
<td></td>
<td>• Supported housing</td>
</tr>
<tr>
<td></td>
<td>• Vehicle modification</td>
</tr>
</tbody>
</table>

- Adult Day Services
- Assistance with ADLs/IADLs (at home, in assisted living settings)
- Attendant services
- Case management, service coordination
- **Chores**
- Consumable medical supplies
- Environmental accessibility and adaptation
- Extended home health
- Habilitation
- Home delivered meals
- Home health/DME
- Homemaker
- ICF/IID
- Non-emergency medical transportation
- Nursing facility services (custodial)
- Nutritional assessment and risk reduction
- Occupational, physical and speech therapies to maintain function
- Personal care
- Personal emergency response systems
- Respite care
- Supported employment
- Supported housing
- Vehicle modification
A Movement with Inspired Beginnings
That Created a Revolution in Care

Medicaid HCBS Expenditures as a Percentage of Total Medicaid LTSS Expenditures, FY 1995–2013

Source: CMCS, Truven Health Analytics
A Movement Now Imbedded in Civil Rights

Americans with Disabilities Act (1995)

Interpreted by Supreme Court in *Olmstead*:
- Individuals have the right to receive public services in the most integrated community setting...
- It is discrimination to require individuals to be institutionalized to receive public services that can be provided in community based settings
That Has Impacted People of All Ages and Types of Disabilities

**Elderly*** with aging- or disease-related frailty or disabilities

Non-aged adults* with **physical disabilities**

Children and non-elderly* with **intellectual and/or developmental disabilities**

Non-aged adults* with **behavioral health needs**

Children with **complex medical/behavioral needs**
What Katie wanted: to be normal and fit in

Person-centered planning and self-direction are foundations for Medicaid LTSS

Care planning: to reflect the individual’s goals, needs, and preferences; what’s important **to** the individual as well as **for** the individual.

Nothing About Us Without Us!
A New Reform Revolution is Underway

CONTINUED LTSS SYSTEM TRANSFORMATION

- To support most integrated setting of care
- To encourage lower cost alternatives
- To raise the bar on outcomes, quality

HEALTH SYSTEM REFORMS TO DRIVE VALUE

- Integration of services across physical, behavioral and LTSS
- Accountable care
- Value-based payment and delivery models
- Recognition of the role of LTSS and social determinants of health
Systems Still Vary Widely Across States

Medicaid HCBS Expenditure as % of Total LTSS Expenditures, 2013 – ranged from 27% to almost 80% across states

Source: CMCS, Truven Health Analytics
And Across Populations

Figure 5
Home and Community-Based Services (HCBS) Use and Total Medicaid Spending Varies by Medicaid Long-Term Services and Supports (LTSS) Beneficiary Subpopulation, 2010

<table>
<thead>
<tr>
<th></th>
<th>All LTSS Beneficiaries</th>
<th>Elderly LTSS Beneficiaries</th>
<th>LTSS Beneficiaries with Disabilities Under Age 65</th>
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<tr>
<td><strong>Institutional Services</strong></td>
<td>36%</td>
<td>51%</td>
<td>21%</td>
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<tr>
<td><strong>HCBS</strong></td>
<td>64%</td>
<td>49%</td>
<td>79%</td>
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<tr>
<td><strong>Total:</strong></td>
<td>50%</td>
<td>29%</td>
<td>65%</td>
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<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Expenditures</th>
<th>Enrollment</th>
<th>Expenditures</th>
<th>Enrollment</th>
<th>Expenditures</th>
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<tr>
<td>3.9M</td>
<td>$159.6B</td>
<td>2.0M</td>
<td>$67.3B</td>
<td>1.6M</td>
<td>$86.2B</td>
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</table>

NOTE: Individuals who used both institutional and community-based services in the same year are classified as using institutional services in this figure. Enrollment and spending figures for child and non-disabled adult beneficiaries are not shown.

SOURCE: KCMU and Urban Institute estimates based on data from FY 2010 Medicaid Statistical Information System (MSIS) and Centers for Medicare and Medicaid Services (CMS) Form 64 reports. Because the 2010 data were unavailable, 2009 data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS Form 64 spending levels.
Affordable Care Act and LTSS

New service design options to promote community based care and “whole person” integration of care

Enhanced funding opportunities for states to invest in state capacity and community infrastructure
Transformation Grant Programs

Money Follow the Person expanded, extended – addition $2.25 B through 9-30-2016
  ◦ Participation grew to 44 states plus DC

Balancing Incentive Program
  ◦ 21 states approved for enhanced funding for HCBS (2011-2015)
  ◦ CMS encouraged states to leverage with MFP and other funding

Congressional views of HCBS evolving; BIP requires:
  ◦ No Wrong Door
  ◦ Functional assessments throughout LTSS systems (can’t target)
  ◦ Conflict free case management
Improved State Plan Options for HCBS

Amended Section 1915(i) state plan option to allow targeting to specific populations; provides HCBS to individuals:

- With an institutional LOC and
- With less than an institutional LOC

Added Section 1915 (k), Community First Choice, to provide community attendant services (and other LTSS) at a permanent 6% enhanced federal matching rate

- Institutional LOC only
- Must be offered to all who meet functional need
Health Homes: Integration option

New state plan option for individuals with 2 or more chronic conditions; with 1 chronic condition and at risk of another; or with SMI

Goal: to integrate physical, behavioral and long term services and supports

Health home services: comprehensive care management, care coordination, individual and family supports, transition services, referrals to community/social services

90% enhanced federal matching rate first 8 quarters
Raising the Bar: New HCBS Rules (2014)

Goal: maximize opportunities for individuals to have:
  ◦ Access to the benefits of community living
  ◦ Opportunity to receive services in the most integrated setting

Defines person-centered planning requirements for Home and Community-Based Services: 1915 (c), (i), (k)

Defines, describes, and aligns HCBS setting requirements across 3 Medicaid authorities
Person-Centered Planning

Driven by the individual; includes people chosen by the individual
Reflects cultural considerations; uses plain language
Includes strategies for solving disagreement
Offers choices to the individual regarding services the individual receives - and from whom
Conducted to reflect what is important to the individual
Includes risk factors and plans to minimize them
HCBS Settings Requirements

Integrated in and supports access to the greater community

Provides opportunities to engage in community life, seek employment and work in competitive integrated settings, control personal resources

Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services
HCBS Settings Requirements

Is selected by the individual from among setting options, including non-disability specific settings

Ensures an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint

Optimizes individual initiative, autonomy, and independence in making life choices

Facilitates individual choice regarding services and supports, and who provides them
If Provider Owned or Controlled Residential Setting

Legally enforceable lease or other written agreement (same responsibilities/protections from eviction as all tenants under local landlord tenant law)

Privacy in their sleeping or living unit

Choice of roommates, freedom to furnish and decorate their units

Freedom and support to control their schedules and activities; access to food and visitors at any time
Presumed NOT to be Home and Community

Settings in a facility providing inpatient treatment

Settings on grounds of, or adjacent to, a **publicly owned or operated** institution

Settings which have the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

State can request “heightened scrutiny” from CMS for these settings if the state has evidence they meet the settings requirements and do not have the characteristics of an institution/are not isolating
Input from Assisted Living Providers and HUD Changed the Final Regulations

Dropped any reference to “complexes”

Narrowed the presumption of “NOT home and community”

- Included “campuses with institutions only if the institution is publicly owned or operated (i.e., does not presume that privately owned or operated CCRCs are not home and community based)

Allowed for a person-centered plan to reflect when an individual’s health and welfare needs should restrict one of the otherwise required characteristics of “home and community based”
Transition Plans: Biggest Challenges

Day programs and services
- Move away from 5 day a week facility-based activity; more community engagement, volunteering, individualized activities
- Moving away from sheltered work; a new emphasis on trying competitive employment first

Memory care: the use of secured (locked) units
Services delivered in settings within the same building as institutional services (e.g., adult day or assisted living)
Gated communities or other segregated/isolated developments for people with disabilities
A Quieter (R)evolution in Institutional Care

A continued blurring of the lines between assisted living and nursing facility care

Growing interest and investment in more home-like models of care (Eden Alternative, small-house models) and in re-thinking aging in place to encompass whole communities

New federal nursing home regulations (conditions of participation) adopting more person-centered expectations for care planning and delivery

More explicit recognition of the role that NFs (and potentially other providers) can play in improving acute care system performance

Focused quality improvement efforts (e.g., dementia care)
LTSS Reforms Also Driven by Pursuit of Accountable Care in the Larger Health System

HHS Triple Aim

- Seeking Integration across health care
- Linking payment to performance: value, quality metrics
- Recognizing impact of social determinants of health
Other LTSS Connections: Accountability

Social Determinants of Health

Medical

Behavioral

LTSS
Many Models

Patient-Centered Medical Home (PCMH)
Health Homes
Accountable Care Organizations
Value-based payments: episodes of care, bundled payments, shared savings

CMS supporting Medicaid reforms through:
• Delivery System Reform Incentive Payment (DSRIP) Program
• CMMI State Innovation Models (SIM) Initiative
• Dual Eligible Financial Alignment Demonstrations
A New Look at PACE

A model of true Medicare/Medicaid integration

Provides community-based alternative to nursing home for seniors

Traditionally built around an adult day care center, has its own primary care staff

PACE receives monthly capitation payments from Medicare and from Medicaid (or private payments for non-Medicaid eligible enrollees)
- Medicaid capitation negotiated separately with each state
- Medicaid statute/regulations set Medicare capitations
## Current PACE Programs by State

<table>
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<th>PACE?</th>
<th>Programs</th>
<th>Enrollment</th>
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## Sponsorship of PACE Programs

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<tr>
<th>Program Sponsor</th>
<th>Number of PACE Programs</th>
<th>Percentage by Sponsor Type</th>
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<tr>
<td>Hospital-Only</td>
<td>31</td>
<td>34%</td>
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<tr>
<td>Community Organization</td>
<td>16</td>
<td>18%</td>
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<tr>
<td>LTC</td>
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<tr>
<td>Other</td>
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<tr>
<td>Partnership, including Hospital</td>
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<tr>
<td>Federally Qualified Health Center</td>
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<td>Hospice</td>
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<td><strong>Total PACE Programs</strong></td>
<td><strong>91</strong></td>
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PACE Experiencing New Opportunities

The PACE Innovation Act of 2015 allows pilots to test PACE models for new populations: people under age 55 and people “at risk” of needing nursing facility care.

Recent CMS guidance makes it easier for PACE to serve seniors in alternative care settings (ACS): allows PACE expansion without building new Centers.

For-profit pilot (1997 BBA) judged a success: significant market interest.
Medicaid Managed Long Term Services and Supports (MLTSS): Growth Continues in 2016-17
New Federal Regulations: MLTSS

Defines LTSS to include full continuum of services and supports

Requires stakeholder engagement

Establishes beneficiary protections (Ombudsman-like function)

Requires states to establish network adequacy standards for in-home as well as in-office/facility care

Requires a state quality framework that includes LTSS-relevant measures: must reflect goal of community integration, choice

Phases out “pass through” financing arrangements; allows quality improvement initiatives (5 years for NFs, ICFs/IID)
Implications for Providers

More transparency in rate setting, contract standards for LTSS, but pass through financing arrangements must phase out

Increased attention will be paid to LTSS performance, especially in Home and Community Based Settings (national metrics anticipated)

Health plans will become engaged in new areas, especially housing

New MCO/provider partnerships to assure access, share risk on performance targets

Providers need to be engaged: network standards, plan readiness reviews, performance metrics, communications to enrollees
An Increased Focus on Performance

National Quality Forum developing consensus LTSS measures for CMS across 11 Domains:

- Workforce/providers
- Consumer voice
- Choice and control
- Human and legal rights
- System performance
- Full community inclusion

- Caregiver supports
- Effectiveness/quality of services
- Service delivery
- Equity
- Health and well-being
The Future of MLTSS

LTSS is not a “medical model” - comprehensive care management model is high-touch, person-centered, person-driven

Provider Networks must include a broader range of services, non-traditional providers, and community partners to address social determinants of health

MCOs must become partners in system transformation: housing, employment, effective treatment of dementia

Competitors may arise: Medicare MA/SNP plans, ACOs and other alternative models