The Impact of Managed Care on the Delivery of Medicaid Long Term Services and Supports

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Introduction

Across the country, Medicaid managed care has increasingly played a pivotal role in the delivery of Long Term Services and Supports (LTSS) for seniors and individuals with disabilities. Managed care programs with integrated LTSS are referred to as Managed Long Term Services and Supports (MLTSS). The majority of these programs serve persons with long-term functional and social needs receiving home and community-based services (HCBS) or nursing facility care. ***States have intentionally chosen this model because it offers comprehensive care coordination to members with chronic and complex needs that results in improved health and functional outcomes while preventing unnecessary costs by encouraging care in the most cost-effective and least restrictive setting.***

Today, Ohio's Medicaid managed care plans (MCPs) manage health care services for nearly 2.6 million Ohioans, representing 86 percent of Ohio Medicaid members, including women, children, and the aged, blind and disabled. Ohio moved to a mandatory managed care program in 1995 and has consistently expanded the platform statewide to include most Medicaid populations. In 2014, Ohio transitioned a large percentage of the aged, blind and disabled population into managed care, with the inclusion of additional populations in 2017. Ohio also participates in the managed care dual demonstration, which is a joint federal and Ohio initiative to integrate funding and services for dual eligible individuals. In 2014, Ohio was one of the first states to implement this program. Today, the MyCare Ohio demonstration serves over 108,000 dual eligible Ohioans. ***While the majority of populations and services are covered by managed care, Ohio continues to serve a small subset of populations and pay for LTSS in its single payer system, leaving out those who could benefit the most from the increased care coordination provided by MCPs.***

Today, Ohio pays for LTSS through a fee-for-service (FFS) system which is based on the volume of services provided rather than the value of services provided. FFS does not offer comprehensive care coordination, and unlike managed care, there are no financial incentives to improve quality outcomes, ensure access and control cost. LTSS services can be cumbersome to navigate. Ohio operates six distinct waiver programs and many individuals struggle to understand and access these programs. In many state-operated programs, there is a lack of awareness of the existing LTSS services among the community and a lack of care coordination. ***Unlike FFS, MCPs offer comprehensive care coordination and are financially incentivized to ensure high-quality care that improves outcomes.*** MCPs conduct a comprehensive assessment for all members to identify the member's needs, including LTSS, and coordinate care. MCPs actively assess and monitor members to identify ongoing or changing needs or members at risk of institutionalization and coordinate care to ensure services are being provided in the most clinically appropriate and least restrictive environment. ***In a managed care model, the state is able to shift the financial risk to private sector MCPs to provide health care coverage to Medicaid members and ensure budget predictability.*** The state pays MCPs a fixed capitated per member per month (PMPM) rate and they are at-risk for any costs that exceed the capitation rate.

Managed Long Term Service and Supports Overview

MLTSS continues to be a key strategy throughout the nation as states and policy makers look for progressive and effective ways to provide comprehensive, quality care to the most vulnerable populations, while at the same time slowing the growth in the cost of the program.

Over the past 20 years, policy makers, federal and state officials and stakeholders have worked collaboratively to develop innovations to MLTSS programs through the adoption of core principles and best practices. Several key pieces of federal legislation, coupled with state directives and stakeholder engagement have made these models highly successful in the delivery of care. Progression of these models continues through new innovations, such as the CMS Medicare-Medicaid dual eligible demonstration in which Ohio participates.

With nineteen states currently operating MLTSS programs, two states scheduled to begin operations in 2018, and four additional states in the process of implementation planning, it is likely that 50 percent or greater of the nation will operate an MLTSS model within the next 3-5 years.

Program Growth. The growth in states MLTSS is largely attributed to states' need to improve the quality of life and services provided to seniors and persons with disabilities while containing costs through better care coordination and improved health outcomes. States also face challenges to ensure access to LTSS services for the growing number of aging individuals. ***The need to have a stable, tested and proven model of care to support the growing needs of the population has resulted in an increase in the number of MLTSS programs across the country.*** Care coordination, coupled with financial incentives, help individuals receive the care they need to keep them healthier and living at home longer. This reduces the need for more costly institutional care.

The number of states that have implemented MLTSS has increased in the last 20 years (see chart on page 7).

- ✓ *The Centers for Medicare and Medicaid Services (CMS) reported an increase from 8 states utilizing waivers to provide MLTSS in 2004 to 16 in 2012.*
- ✓ *Currently, 19 states operate an MLTSS program, and two more states will begin operations in 2018.*
- ✓ *Four additional states are currently at various stages of implementation planning, ranging from conceptual design and outreach to procurement and evaluation.*

Program Expenditures. Medicaid is the single largest payer of LTSS in the nation. National data shows that Medicaid accounted for 61 percent of all LTSS spending in calendar year 2012, representing roughly one-third of the federal Medicaid budget. While these services encompass a large portion of the Medicaid budget both at the state and federal level, approximately only 15 percent of the total Medicaid population utilizes these services. This includes individuals with disabilities and members who are dual enrolled in Medicare and Medicaid. Individuals with disabilities have unique care needs that are high-touch and comprehensive in nature. ***In Ohio, four percent of the Medicaid population consumes 53 percent of the total Medicaid spending.***

Home and Community Based Care. ***One of the key goals of MLTSS is to incentivize the use of home and community-based services (HCBS) thereby reducing the need for institutional care, enhancing coordination across the full care continuum of acute and LTSS, improving health outcomes and managing cost.*** MLTSS programs vary in populations and services. For many states, like Ohio, the path to MLTSS has been an iterative one, decades in the making.

Dual Demonstration. The Medicare-Medicaid demonstration was enabled by the CMS Innovations (CMMI) initiative and integrates Medicare and Medicaid services, including acute, behavioral and LTSS services, through a single comprehensive model. These two highlight complex programs have historically operated under bifurcated and disparate systems. Today, eleven states participate in the demonstration, including Ohio, and may take either a managed care or FFS approach to coordinating Medicare and Medicaid services. Ohio opted for the managed care model of coordination and became just the third state to receive CMS approval to participate in the demonstration in 2012 and was the first state to receive approval to continue the program until the end of 2019. ***Despite being a voluntary program, the MyCare Ohio dual demonstration project has the second largest enrollment of the 11 dual demonstration projects in the country and the highest opt-in rate of all participating.***

MLTSS Program Benefits

In MLTSS, the MCP bears full responsibility for both the acute and LTSS outcomes and cost. The MCP can review all of the member's services and needs and coordinate care across the full continuum to ensure all necessary care is in place. Managed care offers services that are not covered by traditional FFS, but are cost effective and needed by the member and offer alternative services when appropriate. MLTSS also provides financial incentives to ensure effective hospital discharge planning to reduce the incidences of institutional care.

MLTSS enhances the delivery of LTSS through comprehensive care coordination that integrates acute, behavioral health, and LTSS services, the addition of value-added service offerings and accountability for member outcomes.

Comprehensive Service Coordination. The single greatest value of MLTSS comes from comprehensive service coordination for the member. Service coordination is facilitated by trained professionals providing ongoing support to members and their families with care planning and ensures they have access to appropriate services. MCPs begin with a comprehensive person-centered assessment of a member's health and functional needs to identify any unmet needs and an evaluation of member preferences, strengths and weaknesses. The goal of the assessment is to work with the member to establish an individualized plan of care that integrates all their physical, behavioral and LTSS services, encourages positive health outcomes and supports independence in the community. Most importantly these care plans are built around the member's desired outcomes. It has long been recognized that members who receive care in the community and direct their care through the planning process have greater satisfaction and often better health outcomes.

Service planning and care coordination in FFS is limited and often does not account for contributing factors or care needs that are outside of the scope of the FFS benefit. These programs are also limited by the services available through the program. While FFS is often required to coordinate with other care models, including managed care, because the care is outside of the scope of the program benefit offerings, coordination is limited. In Ohio, with the exception of the MyCare demonstration, LTSS is provided through six independent waivers, three that serve members with physical disabilities at varying ages and three that provide services to individuals with intellectual and developmental disabilities.

This results in six unique programs responsible for the delivery of LTSS services and does not include coverage for acute or behavioral health services that also require coordination to ensure all the member's needs are met.

Quality and Outcomes. MCPs are held to specific metrics and program requirements, not historically required in FFS. For example, unlike FFS, MCPs are:

- ✓ required to ensure an adequate network of providers,
- ✓ held to quality metrics to ensure positive health outcomes,
- ✓ have financial incentives to encourage HCBS, and
- ✓ must ensure a seamless transition of care for members who transition from a FFS model and those transferring from another health plan.

MCPs are required to operate member and provider stakeholder groups, monitor and report complaints and are subject to active and ongoing state monitoring. **When these programs fail to perform they may be held financially responsible by their state partners. Managed care lends itself to a higher level of accountability for services and outcomes.**

Community Care. ***MLTSS promotes the use of community care through a blended institution and HCBS capitation rate and implements financial incentives for MCPs to increase the use of HCBS.[i] Studies have found that the cost of HCBS is much lower when compared to the cost of institutional care and HCBS contain cost and result in a slower rate of spending growth.***[ii] MCPs have helped states further achieve their goal of ensuring comprehensive LTSS is provided to

members in the most clinically appropriate, cost-effective and least restrictive environment. Community care reduces the incidence of institutionalization. Through the assessment and service planning process, MCPs play a critical role in the early detection and identification of members in need of LTSS or at risk for institutionalization. MCPs also deploy a number of data mining processes to identify members at risk or in need of LTSS care. Furthermore, MCPs offer comprehensive hospital discharge planning to their members to ensure community supports are available upon discharge. This serves to reduce the rate of hospital readmission and decrement of health. All of these systemic processes enable the MCPs to better manage the member, keep them in their home longer, increase independence, improve outcomes and reduce cost. ***Because MCPs receive a blended rate for LTSS and are subject to quality metrics, they are both financially and clinically incentivized to manage care in the most efficient way that is beneficial to the member's overall health and lowers the cost of care.***

Value-Added Services. States also leverage enhancements available in MLTSS that are unavailable in single payer FFS. MCPs are required to cover all Medicaid benefits required by the state and in addition to those required services each MCP offers a selection of value-added services (VAS) to enhance the member's experience. MCPs provide AS at no cost to the state and are an avenue by which MCPs compete for membership. VAS can serve to reduce the need for institutional care and can also take the form of employment supports that enable members to gain meaningful employment and increase their independence. MCPs also work with community partners to identify housing opportunities for members and may offer an array of housing assistance VAS to help members transition from institutional settings into the community. In states that operate MLTSS, many plans offer enhancements to the LTSS covered services to provide additional services not covered by the traditional FFS model.

Strategic Partnerships. Implementation of successful MLTSS programs requires states, MCPs, and key providers to collaborate to ensure a seamless transition for Medicaid members. Programs across the country recognize that traditional LTSS providers play an essential role in the implementation of MLTSS. Successful programs highlight the importance of detailed planning to ensure historical processes, and providers of program and service assessments are thoughtfully integrated into the MLTSS system in a manner that enables conflict free case management and is supported by trusted providers who understand the enrollees' needs, and community and provider dynamics.

Best Practices, Considerations and Adopted State Processes

Collaboration with traditional providers and thoughtful integration of key functions are essential for the successful implementation of MLTSS.

Comprehensive Stakeholder Collaboration. Collaboration among providers, stakeholders, advocates and MCPs is a critical element to ensure success. As partners in the care continuum, focusing on effective communication with one another to achieve program goals, preserve critical infrastructure and streamline program transition is key. This is largely achieved by ensuring that all parties are engaged and have a comprehensive understanding of one another's perspective, role and concerns. MCPs can serve as great partners in the delivery of care when they are well informed of the issues and work collaboratively with the state and stakeholders to achieve program goals that ensure members have access to high-quality care that meets their needs. Many states operate state led forums that enable this collaboration. They also facilitate targeted workgroups to assist in the identification of programmatic, operational and policy needs to shape MLTSS to meet the program goals. These workgroups are long-standing and often continue well beyond implementation to allow providers, stakeholders, members and advocates with a forum for open discussion on issues post implementation to ensure active and effective resolution.

Industry providers and community supports are essential to the members served through MLTSS programs. These providers have a direct connection with the members that is rooted in the community in which they live. It is imperative to cultivate effective relationships that focus on ensuring member access and safety, and education and supports for providers and because MLTSS has a significant impact on traditional providers of HCBS and institutional services, prudent planning must be a goal established at the outset of the program design. ***In successfully implemented MLTSS programs, the state has played an active role in bringing providers, advocates and MCPs together. Only when all parties are***

working together and communicating in an open environment can issues and concerns be addressed and resolved.

Best Practices Include:

- State led forums: this includes providers, advocates, stakeholders, community partners and health plans.
- Proactive provider engagement: this may require health plans to employ dedicated provider relations staff responsible for supporting LTSS providers and cultivating effective relationships.
- Enhancements to provider contracting: this may require unique approaches to provider contracting that clearly delineates provider, agency and MPCs roles in the delivery of case management, assessment and services planning and services delivery as well as enable quality incentives.
- Provider education: MCPs provide on the ground training and technical training to providers to support them with understanding the plan's claim processing, prior authorization requirements, and other administrative processes to ensure a seamless transition. Providers must work to modify internal processes to ensure the submission of clean claims and gain an understanding of health plan specific requirements.

Value-based purchasing and incentive programs. The implementation of MLTSS affords new opportunities for many traditional providers. Through state, MCP and provider collaborations some states have implemented innovative models that enable value-based purchasing agreements and incentive programs that provide additional funding to providers, such as nursing facilities, for achievements in quality that result in savings to the overall program. Pursuant to federal law, states are required to implement a rating system for plans. Nursing facilities are also subject to a rating system at the federal level for services delivered under the Medicare program. Some states have established quality rating and incentive payments for facilities that are able to achieve increases in their quality rates.

Streamlining Administrative Processes. Another area of consideration is the transition of administrative processes. Both institutional and HCBS LTSS providers grapple with the transition from a single state payer to multiple payers involved in the enrollment, claims processing and authorization process. While this change may be complex, many states and MCPs have adopted policies to streamline the transition and ensure active support for the providers. Perhaps the most important process adopted is the dedicated staff that many plans deploy to serve as LTSS experts and work hand-in-hand with providers to support them through the enrollment and implementation process. These MCP representatives are specifically assigned to actively engage with the providers and become the point of contact for the plan to provide the support needed to assist them with the transition. MCPs also actively monitor data post implementation to identify opportunities for re-education and additional provider support.

National MLTSS Models

As stated above, nineteen states currently operate MLTSS programs with two additional states implementing in 2018. While these programs vary in population and services, the majority of these programs include aging adults and adults with physical disabilities. A growing number of programs also include coverage of individuals with intellectual and developmental disabilities and children with disabilities. Most of these programs operate statewide, require mandatory enrollment, and offer a comprehensive array of LTSS to include: nursing facility, personal attendant care, in-home nursing, habilitation, specialized therapies, and acute and behavioral health services.

Due to the growth in MLTSS, federal policy makers have adopted several key pieces of legislation that serve to ensure these programs are thoroughly developed, held to a high-level of accountability and meet specific quality benchmarks. In particular new Medicaid Managed Care Rules, commonly referred to as "the Mega Rule" were adopted in 2015 and require in part that the MCPs:

- Offer adequate beneficiary protections and comprehensive access to covered services,
- Are subject to program standards that are supported by quality measures,
- Ensure adequate planning and transition strategies for members who are transferring from a FFS to an MLTSS service delivery model are built into the design,

- Engage stakeholders and ensure active community and workforce participation,
- Include comprehensive care coordination, assessment and service planning that is person-centered, and
- Align payment structure with program goals to increase community integration and incentivize quality.

Review of MLTSS Models in Other States

The chart below shows states currently utilizing MLTSS for seniors, dual eligibles and persons with physical disabilities.

Summary of States' MLTSS Programs		
State	**Dual Eligibles**	**Physical Disabilities**
AZ	✓	✓
CA	✓	✓
DE	✓	✓
FL	✓	✓
HI	✓	✓
IA	✓	✓
IL	M/M Demo Only*	M/M Demo Only*
KS	✓	✓
MI	✓	✓
MN	✓	✓
NJ	✓	✓
NM	✓	✓
NY	✓	✓
OH	M/M Demo Only*	M/M Demo Only*
PA[1]	✓	✓
RI		✓
SC	M/M Demo Only*	M/M Demo Only*
TN	✓	✓
TX	✓	✓
VA[2]	✓	✓
WI	✓	✓

*M/M – Medicare/Medicaid Demonstration Only

1. Program is scheduled to implement on January 1, 2018.

2. Program is scheduled to implement on August 1, 2017.

In addition to the states noted in the table above, four other states are currently in the process of implementing MLTSS, including Oklahoma, Nevada, Nebraska and New Hampshire. ***With almost half of the nation implementing MLTSS, these programs are rapidly replacing single payer FFS to leverage managed care's ability to manage cost, improve care and measure outcomes.***

State Experience

Texas Experience

In 1997 Texas implemented its first MLTSS program, STAR+PLUS as a pilot program in Harris (Houston) County to manage the rising cost of health care and provide better management of services for individuals in need of LTSS services. The STAR+PLUS program included adults with disabilities and individuals who were dual-eligible for Medicare and Medicaid as well as voluntary enrollment for children with disabilities.

In 2000, Texas Medicaid worked collaboratively with advocates, providers, and managed care communities to conduct an analysis of the program which concluded that Texas achieved many of the goals set for the program. The review found that the program resulted in improved access to providers, savings to the state, allowed for greater accountability of the program and quality improvements that were not previously measured on FFS. While the program showed great promise and demonstrated member satisfaction, it also found the providers were generally more dissatisfied with the increased administrative complexity and oversight. To address these issues the state worked with the providers and MCPs to implement a number of changes to include, uniformed authorization forms for certain services, provider portals for claims submission and eligibility validation, uniformed billing and coding requirements and prompt payment provisions for specified services, and most recently, the adoption of a single vendor for provider credentialing.

Over the course of several years, Texas looked for new and improved ways to deliver LTSS and manage cost. In 2011, STAR+PLUS was expanded statewide. Since then, Texas expanded MLTSS to include individuals with intellectual and developmental disabilities, inclusion of inpatient hospital care and coverage of nursing facility services. Today five STAR+PLUS plans provide MLTSS across the state. These programs have proven both effective and efficient in transitioning members to community care and reducing overall program cost.

The state also operates a number of quality incentives programs aimed at improvements in LTSS care. In Texas, the Quality Incentive Payment Program (QIPP) was designed to encourage nursing facilities to improve quality and innovations in their services, using the CMS 5-star rating system to measure success. This model provides nursing facilities with additional funding to implement programs that enable these innovations as well as dollars for proven achievements through the rating system. MCPs are responsible for program oversight, review and approval of proposals, evaluation of quality and distribution of funds. This is done in collaboration with the state. The actual amounts to be paid to the nursing facilities varies and is dependent upon the amount of nonstate funds used as intergovernmental transfers and upon the number of entities that participate in the program. Texas is still in the process of finalizes payments for 2016. However, it is estimated that greater than $500 million will be paid out in the state fiscal year 2016.[iii]

In a report issued by Milliman, which evaluated the cost impact of managed care in Texas as compared to FFS, data showed that Texas' MLTSS program created cumulative savings of $172M from 2010-2015, an average annual savings of 3.7%.[iv] Furthermore, a report issued by Texas Association of Health plans found that Texas's MLTSS program reduced hospitalization and emergency room use by 28 and 40 percent respectively and resulted in a 70 percent increase in the use of community-based services.[v]

Texas is also among the 11 states that participate in the Medicare/Medicaid demonstration. Texas implemented its Medicare/Medicaid demonstration in March 2015. Texas leveraged its existing STAR+PLUS program in the six most populace counties in the state: Bexar, Dallas, El Paso, Harris, and Hidalgo.

While the implementation of MLTSS in Texas has been a long road, lessons learned throughout the many years of development have lent themselves to best practices in the state that enabled the quick expansion of populations and services over the course of the last three years. The program currently serves more than 500,000 members representing greater than 13 percent of the total Medicaid caseload in Texas.

Tennessee Experience

Since 2010, Tennessee has operated its fully integrated MLTSS program, TennCare CHOICES under the authority of an 1115 waiver. TennCare CHOICES includes services provided in nursing facilities and Intermediate Care Facilities for elderly

and physically disabled persons as well as HCBS for adults age 21 and older. Tennessee implemented TennCare CHOICES to expand HCBS options and improve access to HCBS and other LTSS services to individuals who qualified for coverage.

The Tennessee Division of Health Care Finance and Administration developed program options and worked with the Legislative Task Force to address the need to increase LTSS service capacity and supports for the aging population. At the time of development, it was noted that approximately eight out of ten members were receiving their LTSS in a nursing facility. With an aging population, limited nursing facility capacity and growing cost, Tennessee was forced to reevaluate its service delivery model and identify opportunities to enhance access to LTSS in an already strained system.

Over the course of a year, the state actively engaged advocates, industry providers, MCPs and federal partners to design and implement a program that increased use of HCBS and ensured the nursing facility level of care was prioritized to enable access to these services for the most medically needy. To effect this change the state retooled the nursing facility level of care model, which was previously set to allow nursing facility coverage for members with one identified need for assistance with activities of daily living (ADL), to be more in line with other states. They also implemented an at risk HCBS program that enabled access to LTSS for members with lower functional needs. This allowed Tennessee to increase capacity to provide LTSS in a manner that was medically appropriate and delivered care in the least restrictive and most cost-effective environment.

To effectively manage this model, enable accountability, streamline member access, simplify the complex LTSS system and align financial incentives the state implemented these changes through their existing managed care program, building upon the established infrastructure. State leadership worked hand-in-hand with all its stakeholders and most importantly, its federal partners to outline comprehensive contract requirements, including service coordination staff ratios to ensure that MCPs were sufficiently prepared to manage the new program and members. The care coordination model was designed with a single point of accountability across the full continuum of care. The state also implemented a blended LTSS capitation rate to align financial incentives for the MCPs. This ultimately resulted in the increased utilization of HCBS services, which grew from 15 percent to 35 percent in the first year and an increase in hospital discharge planning to ensure members were receiving adequate and medically appropriate home care following discharge to reduce readmission rates, keep the member healthy and in their community longer and reduce cost. ***Data from the Division of Health Care and Finance and Administration, 2014-2015 Annual TennCare report, show approximately 43 percent of individuals enrolled in the TennCare CHOICES receive their care in HCBS setting.***[vi] There has been a steady increase in the use of HCBS since the inception of the TennCare CHOICES program.

Tennessee also recognized the role of industry providers to ensure a dynamic and effective system moving forward. The state worked closely with the Area Agency on Aging and Disability (AAAD) to ensure their continued role in serving as the point of access for members not enrolled in Medicaid or LTSS who are in need of services. The AAAD continued to play a critical role in the identification and eligibility determination process for a variety of programs including non-Medicaid offering, working collaboratively with the state and MCPs. Tennessee continues to oversee the determination of nursing facility level of care to ensure individuals with the highest level of medical need are afforded access to it. The state also implemented a number of provider safeguards to include prompt payment requirements and established fee schedules for LTSS services. Finally, through the MLTSS program, the state implemented a number of provider value-based purchasing programs to provide quality-based financial incentives for LTSS providers.

Pennsylvania Experience

The Commonwealth of Pennsylvania is implementing a statewide MLTSS program called Community Health Choices (CHC) beginning in January 2017. The program will be rolled out by region and will provide services to more than 420,000 individuals who are dually eligible for Medicare and Medicaid and individuals with disabilities. Of that total, approximately 130,000 individuals are receiving either HCBS or nursing facility services.

Pennsylvania's CHC program was designed to reform the delivery of LTSS. The Commonwealth engaged in past efforts to reform LTSS; the most recent of these is the Pennsylvania Long-Term Care Commission, which released its report in 2014. The Commission found that the LTSS delivery system has many challenges that need to be addressed, particularly in light of changing demographics. Those demographics include a significant increase in the Commonwealth's older population

and the expectation that in the next decade the number of those aged 85 and over will grow faster than the total population. Additionally, there are over 1.7 million Pennsylvanians with physical disabilities.

Multiple commissions and workgroups studying the LTSS system in Pennsylvania identified:

- A lack of service coordination in the LTSS system resulting in consumers not having access to integrated supports and services throughout the continuum of care;
- Limited or no preventive care;
- Limited access to appropriately qualified providers of care, services and supports;
- Limited service design and lack of reliance on evidence-based practices that are based upon quality measures and outcomes; and
- Institutional bias and a lack of emphasis on transitions from more to less intensive settings to ensure continuity of care and prevent unnecessary readmissions.

During the development of CHC, the Commonwealth noted its commitment to improving the health and welfare of participants by enhancing and integrating health care and LTSS services while ensuring efficiency, transparency, accountability, and effectiveness. Enrollment for CHC is mandatory for adults receiving Medicaid LTSS and all dual eligibles over the age of 21, excluding individuals with intellectual disabilities.

The design of the CHC program included the following components:

- Person-centered program design and service plan development
- Services and supports coordination
- Access to qualified providers
- Emphasis on HCBS
- Performance-based payment incentives
- Participant education and enrollment supports
- Preventive services
- Participant protections
- Quality and outcomes-based focus

Pennsylvania implemented a broad-based stakeholder participation strategy that was applauded by CMS. They initially released a concept paper for CHC and received 2300 comments from stakeholders. These comments were used to inform the program design and the subsequent RFP. They also engaged the AAAs with the redesign of the participant assessment for LTSS and medical necessity. The AAAs formed a consortium called Aging Well who will hold the contract for completing medical necessity assessments using the Minimum Date Set assessment.

Pennsylvania did a new procurement for CHC and selected three MCPs. The MCP agreements include value-based purchasing concepts and continue the Departments' increased focus on greater coordination between the physical, behavioral health, and LTSS. The MCPs are currently engaged in readiness review activities with the Commonwealth.

For a minimum of the first six months of CHC implementation, the MCPs will be required to include all willing LTSS providers in their network to ensure continuity of care for participants. Prior to implementation and during the six-month period, MCPs must contract with willing and qualified providers of all types to make up their provider networks.

The University of Pittsburgh will conduct a comprehensive multi-year evaluation of CHC to provide an independent assessment of its implementation and outcomes to complement other oversight and quality assurance activities conducted by the Department of Human Services (DHS), Office of Long-Term Living.

Conclusion

The National Standard. Today, LTSS accounts for approximately one-third of the total Medicaid national budget. As a result, states have expanded MLTSS to improve care and contain cost in an effort to manage LTSS spending and reduce the incidence of institutionalization.

MLTSS programs are rapidly becoming an industry standard in the delivery of LTSS. With nineteen states currently operating MLTSS programs, two states scheduled to begin operations in 2018 and four additional states in the process of implementation planning, it is likely that 50 percent or greater of the nation will operate an MLTSS model within the next 3-5 years. With almost half of the nation implementing MLTSS, these programs are rapidly replacing the single payer FFS LTSS delivery models due to managed care's ability to manage cost, improve care and measure outcomes.

The cost of HCBS is much lower when compared to the cost of institutional care and HCBS contain cost and result in a slower rate of spending growth while improving outcomes and member satisfaction. MLTSS programs are used to promote the use of community care. Because MCPs receive a blended rate for LTSS and are subject to quality metrics, they are both financially and clinically incentivized to manage care in the most efficient way that is beneficial to the member's overall health and lowers the cost of care.

For years, MCPs have worked collaboratively with the state and stakeholders to achieve program goals that ensure members receive high-quality care that meets their needs. MCPs have profound expertise and the program flexibility to provide unique opportunities in the areas of care management, provider and member supports, value-based purchasing and value-added services. As a result of strict program oversight at both the state and federal levels and aseries of defined quality and accountability measures, it is in MCPs' best interest to provide high-quality care in the most appropriate and cost-effective settings. This results in increased budget stability for states and ensures that members have access to quality care that meets their unique needs.

Over the past 20 years, policy makers, federal and state officials and stakeholders have worked collaboratively to bring about a number of changes to MLTSS programs through the adoption of enhanced standards and best practices.

Moving Ohio Forward. The state of Ohio faces similar challenges to those noted by other states. Much like the state of Pennsylvania and Tennessee, there is a growing number of aging individuals. Data from the Ohio Department of Aging projects that the number of individuals 60 and older is projected to grow from 19.8 percent in 2017 to 29.3 percent by 2040. Furthermore, in Ohio data show four percent of the Medicaid population consumes 53 percent of the total Medicaid spending.[vii]

In a study conducted by the Kirwan Institute and the Ohio State University, it was noted that there is a lack of awareness of the existing LTSS services among the community and a lack of care coordination.[viii] LTSS services are cumbersome to navigate. There are six distinct waiver programs in Ohio and many individuals struggle to understand and access these programs. MLTSS ensures comprehensive care management and coordination is provided to members and ensures access to necessary and appropriate LTSS care while improving health outcomes and controlling cost. Service planning and care coordination through FFS is limited in scope and often does not account for contributing factors or care needs that are outside of the scope of the FFS benefit. Unlike FFS, MCPs offer comprehensive care coordination and are financially incentivized to ensure high-quality care that improves outcomes and actively connects members to services to avoid the decrement of health and maintain independents.

There is a wealth of knowledge and experience that can be leveraged in the implementation of and Ohio MLTSS program to ensure a thoughtful, efficient and seamless transition for members and providers while protecting critical infrastructure and managing cost.

End Notes

i. Rebalancing is a process by which states work to increase the use of HCBS and decrease the historical institutional bias by rebalancing LTSS spending, in compliance with federal regulations.

ii. http://www.mi-seniors.net/pdfs/publications/AARP%20hcbs%20research%20review%20cost-effectiveness%202013.pdf

iii. https://txhca.org/app/uploads/2014/10/84thSessionWrapUp_Final.pdf

iv. http://tahp.org/wp-content/uploads/2016/11/Milliman-Study-Medicaid-Managed-Care-Cost-Impact-Study-Feb-2015.pdf

v. http://tahp.org/wp-content/uploads/2016/08/TAHP-Resource-Guide-STARPLUS-May-2016.pdf

vi. https://www.tn.gov/assets/entities/tenncare/attachments/tenncareannual1415.pdf

vii. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=Nxq8VfG0HS8%3d&tabid=136

viii. http://kirwaninstitute.osu.edu/wp-content/uploads/2015/03/ki-tcf-senior-study.pdf

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