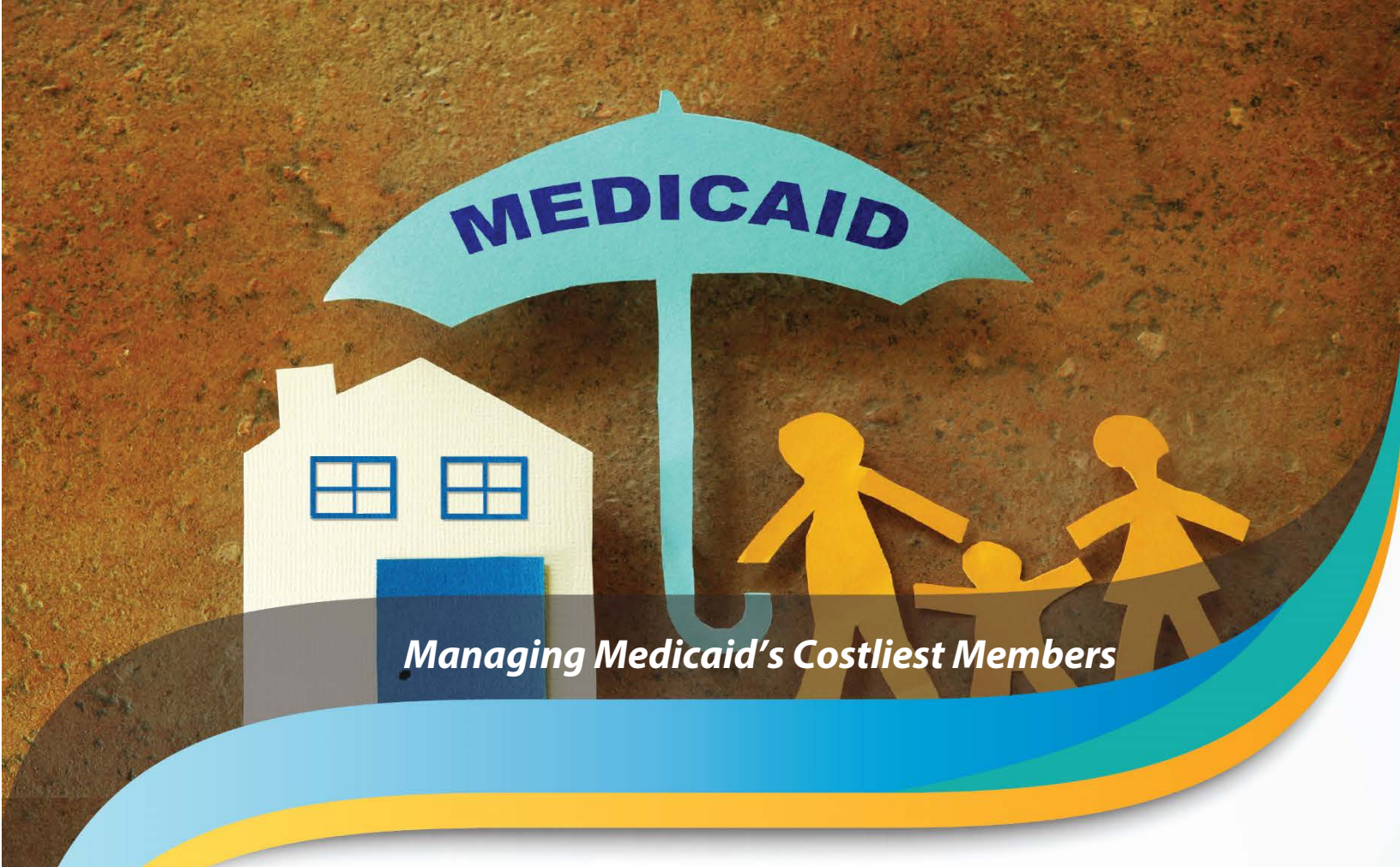

White Paper

January 2018

Telligen®

LTSS / MLTSS / HCBS:

Issues & Guiding Principles for State Medicaid Programs

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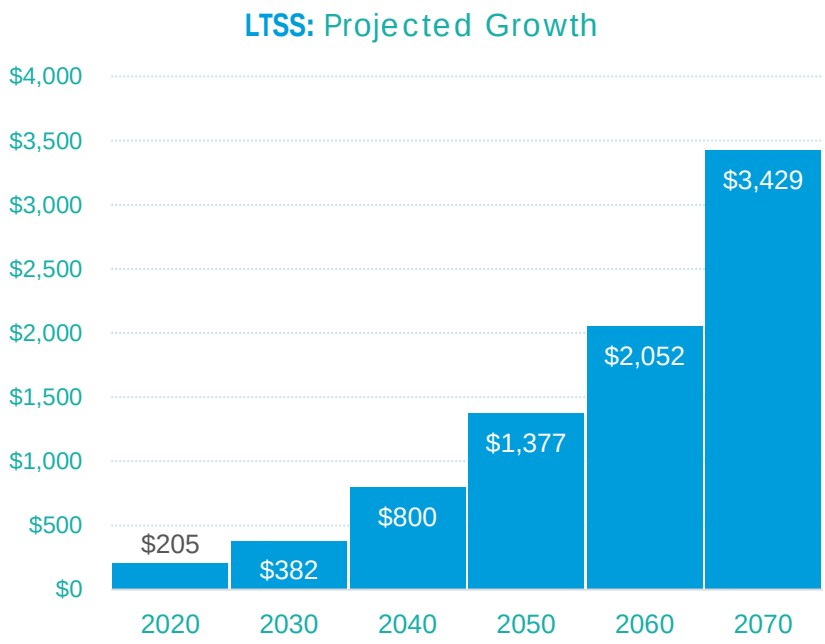
Executive Summary

Technological advances allowing people with disabilities to be more independent and live longer coupled with the aging Baby Boomer population is leading to an ever-growing demand for publicly funded Long-Term Services and Supports (LTSS). Created as a safety net healthcare program for the poor, the Medicaid program has become the default payer — spending more than $150 billion per year on LTSS.[1]



If We Do Nothing . . .

LTSS spending in the U.S. is projected to exceed $3T by 2070; more than a 10-fold increase.

- Urban Institute; *Financing Options for LTSS*; 2015

Individuals that utilize LTSS often represent approximately six percent of the Medicaid population in any state, yet account for more than forty percent of total costs. The increasing demand for LTSS and rising costs create serious budget pressures on state Medicaid programs. While finding efficient ways to provide long-term care presents a sizable challenge, it's critical for state Medicaid leadership to develop methods that provide high-quality, person-centered LTSS across service settings.

Telligen has developed this briefing to describe LTSS delivery and financing in the U.S., highlighting the transition away from institutional-based care, the emergence of managed LTSS, quality improvement efforts, and guiding principles for leaders in managing their LTSS programs.

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LTSS: The Basics

70 percent of people who reach the age of 65 will require some form of LTSS at some point in their lives.

- Bi-Partisan Center; *Challenges in the Financing & Delivery of LTC*; 4/2014

LTSS enables older adults and people with functional impairments to live with independence, participate in their communities, and increase their overall quality of life.

Beneficiaries include elderly and non-elderly people with intellectual and developmental disabilities, physical disabilities, behavioral health diagnoses, spinal cord or traumatic brain injuries, and/or disabling chronic conditions. Services and supports help those in need with daily living tasks such as getting dressed, taking medication, preparing meals, and arranging transportation. Services can be provided either in the individual's home, community, or long-term care facility.

The Increasing Demand for LTSS

As the Baby Boomer population continues to age, demand and expenditures for these services will increase. This increased demand is due to both an aging population — the over 65 population is projected to more than double by 2060 — and advances in medical research, treatments, and technologies helping the disabled and those with other chronic diseases live longer.[2]

The Financial Impact

The cost of obtaining LTSS often far exceeds individuals' financial resources; putting the fiscal burden directly on the Medicaid program.

- According to the Centers for Medicare & Medicaid Services, federal and state Medicaid spending in 2014 totaled $553.8 billion; with approximately $112 billion associated with long-term care services.[3]
- A 2016 report to Congress on Medicaid & CHIP shows 43 percent of Medicaid expenditures ($169.2 billion) were spent on LTSS users, even though LTSS users comprised only six percent (4.3 million) of Medicaid beneficiaries.[4]

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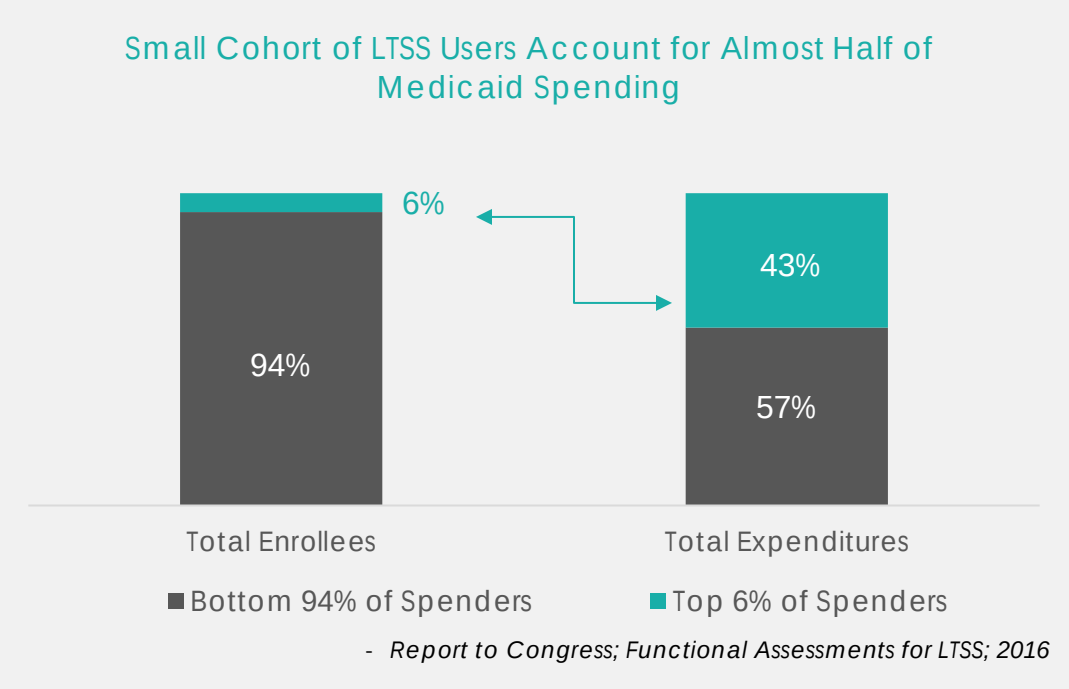

- *Report to Congress; Functional Assessments for LTSS; 2016*

State Approaches Vary Significantly

State Medicaid LTSS programs vary significantly in their approaches to eligibility, service delivery, and provider reimbursement. Factors describing a state's LTSS system include:[5]

- **Population and income** characteristics impacting state planning efforts to respond to current and future needs of its citizens.
- **Provider characteristics** considering the number and types of providers and the extent of financing available to support them.
- **Spending priorities** that vary widely with some states still spending far more on institutional care than home and community-based services.
- **Costs of services** and Medicaid reimbursement rates and methodologies used to determine them vary between states.
- **Quality oversight** and enforcement for both institutional and home- and community-based services also vary between states.
- **Unmet needs** will vary as states set the number of people who can be served.

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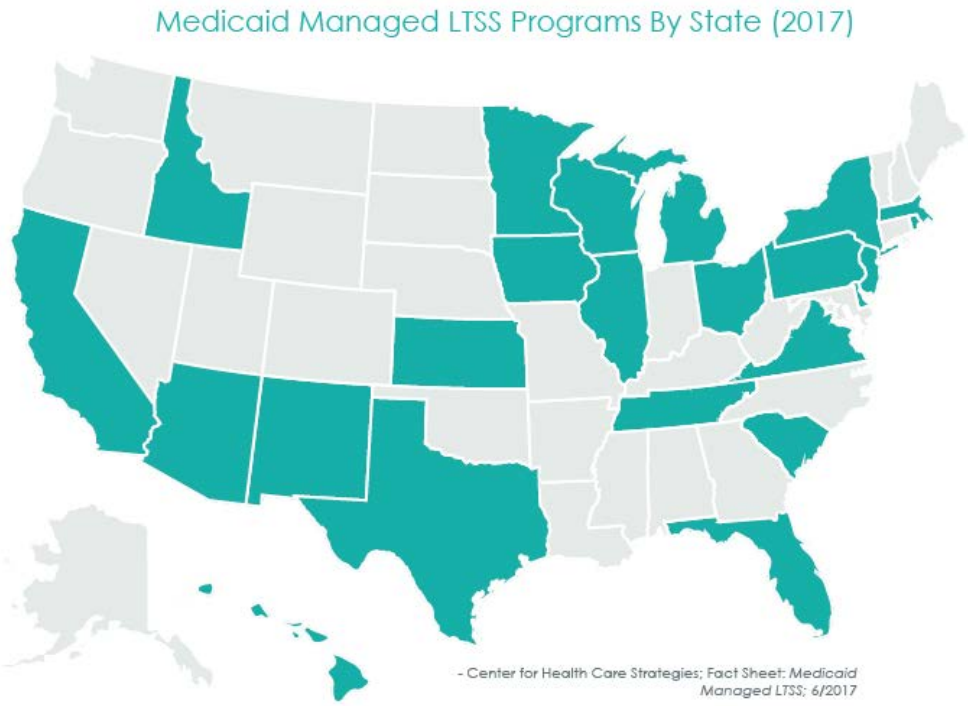
The Impact of Managed Medicaid

Many states have contracted with Managed Care Organizations (MCOs) to deliver Medicaid services to children, families, and pregnant women; while leaving beneficiaries with complex LTSS needs — such as the mentally ill, aged, and disabled — in traditional fee-for-service. Today, states are increasing their reliance on MCOs by shifting the LTSS population into managed care — this is referred to as Managed LTSS (MLTSS).

Issues like budget shortfalls, the need for predictable costs, and Medicaid expansion under the ACA have resulted in continued growth for managed Medicaid. By 2020, MCO enrollment is expected to account for nearly 85 percent of Medicaid beneficiaries.

- Vern. K Smith, PhD.; Presentation: Medicaid Health Plans of America Annual Conference; 10/13



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The Pros & Cons

Proponents associate MLTSS with cost savings for Medicaid and patient-centered care for beneficiaries. They argue that providing MLTSS in an integrated, coordinated fashion lowers the costs of services, supports integrated delivery, reduces hospitalizations and nursing home admissions, and extends the amount of time beneficiaries can live in their communities. Critics, on the other hand, argue that cost savings come at the expense of limiting care and denying services.

The Pros:

- **Reduced Administrative Burden** — MCOs assume full financial risk while receiving a fixed monthly per enrollee fee to deliver services through a network of participating providers.
- **Budget Predictability** — Offers the potential to manage costs and make state expenditures more predictable.
- **Care Coordination** — LTSS beneficiaries typically require more services from providers across more settings, thereby increasing the need for centralized care coordination.
- **Rebalancing the System** — Increases the opportunity to lower costs by avoiding delaying institutional care and enabling beneficiaries to remain at home or in the community.

The Cons:

- **Lack of Experience** — MCOs, traditionally geared toward providing only medical care, lack the skill set and/or experience in non-medical LTSS (e.g., bathing, cooking, and transportation); and issues related to participation, financing, contracting, and service integration.
- **Beneficiary Confusion** — Transitioning from fee-for-service to managed care can create uncertainty, confusion, and concern; especially for beneficiaries with low health literacy and/or cognitive impairments.
- **Conflicts of Interest** — Incentive to contain costs may lead to fewer and lower quality services over time.
- **Limited Accountability** — While MLTSS plans are required to report quality data; there are no agreed-upon quality measures to hold organizations accountable or evaluate performance.

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What the Research Says

According to the Robert Wood Johnson Foundation, there's an absence of unbiased, academic, and peer-reviewed research evaluating Medicaid managed care.[6] Research showing positive impacts are often cited, but are conducted by consulting firms on behalf of interested parties with a stake in the outcome of the findings. The research is further complicated by the fact that Medicaid is not a universal, nationwide program, but a collection of state-run programs with incredibly different policies and populations.

A Kaiser Foundation report[7] notes that in the absence of best practices, studying state-specific MLTSS programs can provide insights for successfully transitioning to MLTSS.

Summary of Insights from Successful Transitions[7]

Enrollment — Create Opportunities for Voluntary Enrollment & Plan Choice

- Provide sufficient time for beneficiaries to choose among plans.
- Conduct enrollment in a phased apporach.

Support — Deliver Information That's Easy to Understand & Accessible

- Use multiple communications methods to assist beneficiaries, including in-person counseling.
- Involve community-based organizations with existing beneficiary relationships.

Continuity — Include Current Providers in New Plan Networks

- Specify how and when needs assessments will occur.
- Ensure beneficiaries understand proposed service changes, their right to appeal, and how to access and navigate the appeals system.

Measurement — Plan Measurement Strategies Before Implementation

- Adapt measures of transition effectiveness from similar programs.
- Use external oversight to monitor program activity.

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Improving Access to HCBS

LTSS can be delivered in institutions (nursing facilities and intermediate care facilities for individuals with intellectual disabilities) or home and community-based settings. Federal regulations require the planning process for Medicaid LTSS to be person-centered, focusing on the individual's needs and preferences. Often this means providing services in the home or community — and away from an institutional setting — whenever possible.

States have responded by developing home- and community-based services (HCBS) to meet the needs of beneficiaries who prefer to receive services in their home or community. These services include residential services, adult daytime healthcare programs, home health aide services, personal care services, and case management services.

According to the Kaiser Family Foundation, these efforts are driven by beneficiary preferences for HCBS, the increased population of seniors and people with disabilities who need HCBS, and the fact that HCBS typically are less expensive than institutional care.[8]

- **Then**: In the past, Medicaid only paid for institutional LTC.
- **Now**: The waiver program "waives" the institutional admission requirement in favor of Medicaid-funded HCBS.

Growth in beneficiary preferences for HCBS and states' obligations coincides with the 1999 United States Supreme Court's Olmstead decision which found that the unjustified institutionalization of persons with disabilities violates the Americans with Disabilities Act.

-Olmstead v. L.C., 527 U.S. 581 (1999)

Although Less Expensive, HCBS Poses a Major Financial Burden

Setting	Service	Annual Per Person Cost* (2015)
Community	Adult Day Care	$18,000
	Home Health	$45,800
Institution	Assisted Living Facility	$43,200
	Nursing Facility *(semi-private room)*	$80,300
	Intermediate Care Facility Services	$123,053

** Genworth 2015 Cost of Care Survey.*

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Delivering Services

States deliver HCBS through either the Medicaid program or one or several HCBS waivers. This flexibility gives states substantial latitude in designing service and support options and managing the cost and availability of those services. The rapid expansion of HCBS waivers has introduced new challenges and risks for states, including:

- **Costly Implementation** — Applying for waivers involves a significant investment in resources to develop the waiver program and secure CMS approval.
- **Administrative Hassle** — Providing services to multiple waiver populations requires states to administer different sets of eligibility rules, which is often complex and time-consuming.
- **Scale and Accessibility** — Availability of providers and provider networks can be a major concern for rural and underserved areas.

Assessing Eligibility

Eligibility determinations for HCBS includes a variety of functional tools — screenings, assessments, evaluations, and reviews — that collect information on the applicant's health conditions and functional needs. Upon qualifying for coverage, these same tools may also assist in the development of patient-centered care plans.

The federal government does not mandate a standardized assessment tool(s) for evaluating eligibility or developing care plans. Instead, states have wide flexibility to select tools most appropriate for their needs and those of the population served.

Common Themes of Assessment Tools Used by States: [9]

- Using specialized tools for specific sub-populations; that is, a state might use one tool for individuals with physical disabilities and another for those with intellectual or developmental disabilities.
- Using state-specific (homegrown) tools as a supplement to or replacement for a third-party, independently developed assessment.
- Using assessment tools to both establish eligibility and develop care plans.
- Assessing functional limitations, including clinical needs and/or health status, and behavior and cognitive status.
- Capture information on additional factors including physical environment and psychosocial needs.
- Linking assessment results to resource allocation and payments for LTSS.

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Avoiding Conflicts of Interest

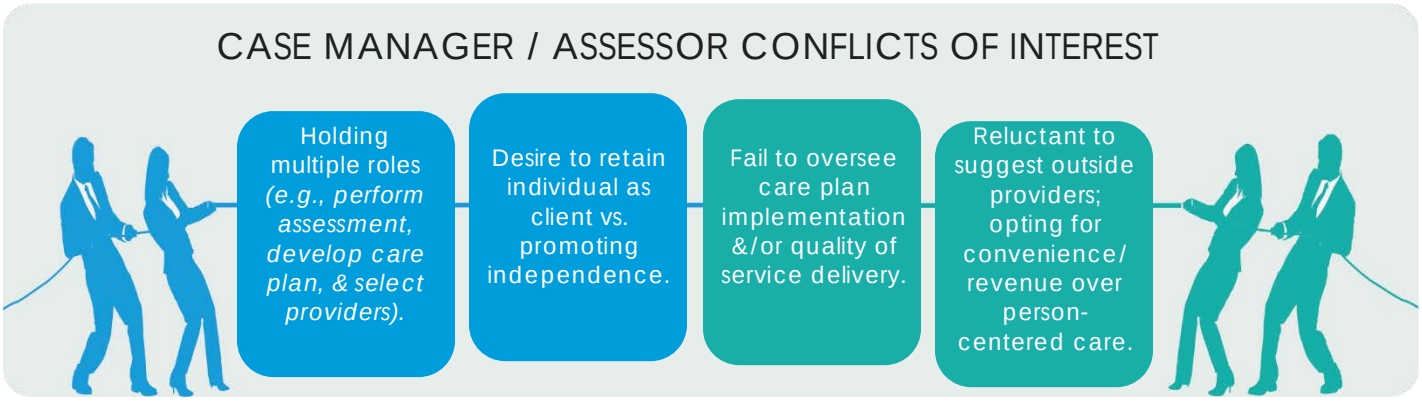
Since 2003, CMS has issued guidelines to help states mitigate conflicts of interest in the delivery of HCBS. A conflict of interest arises when the organization that conducts the functional assessment and/or develops the care plan is either responsible for payment or service delivery.

Holding multiple roles with the individual has the potential to incentivize inappropriate utilization of services. Service providers have an interest in retaining the individual as a client while also seeking to maximize the number of services delivered. In addition, payers have an incentive to limit the number of services delivered.

- ✓ **The Problem**: Interested parties performing assessments and/or developing the care plan may create over- or under-utilization of services.
- ✓ **The Solution**: An independent third-party — one that is not involved in either payment or service delivery — can mitigate this issue.

Although guidelines are in place, there can be significant variance in how states choose to interpret and implement strategies for achieving compliance. For example, many states structure their plans to address conflicts of interest by constructing an administrative firewall separating the operational unit performing assessments from the unit conducting care management.

Recognizing Conflicts of Interest



HCBS: How States are Coping

States are continuing to evolve the organization of their LTSS programs, including increasing the use of HCBS, modifying or consolidating HCBS waivers, and implementing MLTSS programs. State-operation of LTSS programs, via fee-for-service or MLTSS, often benefit from turning over plan administration and/or assessments and individualized care planning to a trusted third-party with specific expertise in LTSS care delivery arrangements.

A trusted third-party partner could assist the state and/or MCO in the following areas:

- **Eligibility Assessment**: Ensuring a timely, independent, federally compliant process for accurately determining beneficiary care and service needs.

- **Person-Centered Care Planning:** Developing a person-centered care plan that promotes the least restrictive setting possible, while factoring in the beneficiaries' goals, preferences, strengths, and functional needs.
- **Provider Quality Oversight:** Conducting ongoing monitoring of: 1) provider services in comparison with accepted treatment practices; and 2) adherence to the state's provider credentialing process.
- **External Quality Review:** Improving plan and processes by aggregating information on the timeliness, access, and quality of services furnished to beneficiaries.
- **Stakeholder Engagement:** Engaging as many stakeholders as possible to build relationships, improve processes, and leverage the expertise of community-based organizations.

Conflict-Free Case Management: What to Look For[11]

Category	Guideline
Eligibility & Assessment	Assessor/Evaluator is not: related to beneficiary by blood or marriage, financially responsible for beneficiary, tied to any paid service provider for beneficiary, able to make financial or health-related decisions on behalf of beneficiary, and hold financial interest in any paid entity to provide "care" to beneficiary.
	The entity determining clinical eligibility is separate from providing direct service.
	The MCO is separated from the initial eligibility determination and enrollment counseling.
Case Management /Care Planning	Care planning cannot be performed by HCBS provider.
	Case manager/care plan developer is not: related to beneficiary by blood or marriage, developing the service plan, is financially responsible for beneficiary, tied to any paid service provider for beneficiary, able to make financial or health-related decisions on behalf of beneficiary, and hold financial interest in any paid entity to provide "care" to beneficiary.
Firewalls & Standards	Appropriate firewalls and safeguards exist to mitigate conflicts of interest
State Oversight	State conducts robust monitoring and oversight.
Quality Management	State's quality management staff oversees clinical or non-financial program eligibility determinations and service provision practices.

Category	Guideline
	The case management agency tracks and documents consumer experience with measures that capture quality of care coordination.
Stakeholder Engagement	The state implements meaningful stakeholder engagement strategies.
Grievance & Appeals	The state and/or MCO have established clear, accessible pathways for submission of grievances and appeals.
	The beneficiary has the right to appeal a person-centered care plan.
	Case manager must explain enrollee's rights, including procedures for filing a grievance, appeal, and fair hearing.
	If beneficiary disagrees with finding, the case manager provides clearly written notice of right to appeal.
	The beneficiary has access to alternative dispute resolution process.

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Plan Oversight and Quality Measures

The increased demand for LTSS requires greater focus on outcomes, quality, and performance. States need a robust solution for monitoring access to care and measuring outcomes, while identifying areas of improvement. Quality measures for LTSS, however, are not as well-developed as those for care provided in other clinical settings.[14] LTSS performance measures vary by state, making it difficult to measure quality across states and identify opportunities to improve care for aged and disabled populations.

As more states move toward MLTSS structures, stakeholders are calling for a core set of nationally endorsed, LTSS-specific quality measures to evaluate structural elements (such as provider staffing capacity), service delivery processes (such as timeliness of assessment), or care and performance outcomes (such as an improved ability to complete a self-care task).[14]

> Medicaid stakeholders need uniform and validated measures that assess adequacy and impact of services, quality-of-life, extent of self-direction and self-determination; community integration and participation; health, functional and safety outcomes; and access to consumer rights and protections.
>
> - Disability Rights Education & Defense Fund: *Identifying & Selecting LTSS Outcome Measures*

The Role of Quality Measures: [15]

- Enable state and federal oversight of commitment and performance.
- Foster a person-centered focus for meeting beneficiaries' expressed needs.
- Encourage accountability by tracking outcomes over time, comparing results with other states plans, and identifying methods for improvement.
- Evaluate the effectiveness of integrated care coordination across both clinical and LTSS domains.
- Grant beneficiaries the necessary data to make choices about care options (e.g., choosing plans, providers, and service settings).
- Enable stakeholders, including patient advocates, providers, and policy makers, to identify programs with the best outcomes.

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Conclusion

As demands for HCBS continue to grow, state Medicaid programs are confronted with administrative and budgetary complexities. To strike the right balance between management, oversight, and care delivery; states and MCOs can enlist partners offering LTSS-specific knowledge and experience in the areas outlined below.

- **Engaging stakeholders** including LTSS beneficiaries, patient advocates, community organizations, state agencies, and state government representatives.
- **External quality review** to evaluate the quality of care provided to beneficiaries and help MCOs monitor and improve their quality.
- **Hiring and training** of qualified staff in health, aging, or disability departments charged with monitoring LTSS provider networks and quality.
- **Service monitoring** to ensure development, planning, and delivery of patient-centered, integrated services delivered by qualified providers.
- **Beneficiary protection** to identify, address, and prevent instances of abuse, neglect, and exploitation; promoting the least restrictive interventions possible.
- **Quality measurement** designed to track and compare outcomes over time, and identify opportunities for improvement.
- **Conflict-free case management** to reduce possibility the of assessments/care plans being driven by factors unrelated to the beneficiary's well-being.

For additional information about
Long-Term Services & Supports, please review our website at:

www.telligen.com/client-solutions/state

Or Contact:

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11) Based on list in CMS' Balancing Incentive Payment Guidance. Available online at: www.balancingincentiveprogram.org/resources/example-conflict-free-case-management-policies

12) The person-centered service planning rules for Medicaid HCBS programs are similar, but not identical. See 42 C.F.R. §441.301 for planning rules for 1915(c) HCBS waivers, §441.540 for planning rules for Community First Choice, and §441.725 and §441.730 for 1915(i) State plan HCBSLTSS

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