Arizona Long Term Care System (ALTCS) Overview
Arizona Managed Long Term Care

- Overview
- Principles
- Payment Structure
- Duals
- Results
Arizona Waiver History

- 1982 – Arizona last state to enter into Medicaid program. First state to establish mandatory Medicaid managed care premised on competition, choice and appropriate utilization management

- 1989 – Arizona expands Medicaid and establishes the Arizona Long Term Care Services (ALTCS) program including home and community based services
  - Elderly and Physically Disabled Population (EPD) managed through Managed Care Organizations
  - Developmentally Disabled (DD) contract with Department of Economic Security – state agency
Arizona Medicaid Program Today

- 1.3 million Medicaid enrollees
- 49,922 ALTCS enrollees (as of 06/01/12)
  - 24,481 individuals with developmental disabilities (DD)
  - 25,441 individuals who are elderly and/or have physical disabilities (E/PD)
- ALTCS accounts for 4% of the AHCCCS population and 25% of the spending
ALTCS Plans By Region

- Maricopa County/Phoenix – 60% of state population
  - 4 Plans
  - Bridgeway Health Solutions, Evercare Select, Mercy Care Plan,
  - Division of Developmental Disabilities*
- Pima County/Tucson – 20% of state population
  - 3 Plans
  - Evercare Select, Mercy Care Plan
  - Division of Developmental Disabilities*
- Greater Arizona
  - 2 Plans Per Region (1 plan to serve DD membership, 1 plan to serve E/PD membership)

*Coordinates care for individuals with developmental disabilities statewide
ALTCS Enrollment by County
As of June 1, 2012

Elderly and Physically Disabled (EPD) PCs = 25,441
BDWY = Bridgeway Health Solutions
EVRSLT = Evercare Select
MCP = Mercy Care Plan
DDD Division of Developmental Disabilities/DES = 24,481
ALTCS ENROLLMENT TOTAL = 49,922
ALTCS Population – April 1, 2012

- EPD: 25,441 (51%)
- DD: 24,481 (49%)

- NF: 27%
- Own Home: 49%
- Alt. Res.: 24%
- 99%+ HCBS
**ALTCS Model**

**Potential ALTCS Member**
- 2,750 Applications/Month

**Financial/Medical Eligibility**
1. Citizen/Qualified Alien
2. AZ Resident
3. $2,000/$3,000 Resources
4. $2,022 Income Maximum
5. Transfer of Resources
6. SSN
7. Medical Eligibility/PAS

**ALTCS Contractors**

**DES-DDD**

**EPD Contractors**
- Bridgeway Health Solutions
- Evercare Select
- Mercy Care
- ALTCS FFS – Tribal CM

**PCP/CASE MANAGER**

**Covered Services**
- Acute Care Services
- Nursing Facility
- ICF/MR
- Hospice
- Behavioral Health
- HCBS
  - Homemaker
  - Personal Care
  - Respite Care
  - Attendant Care
  - Home Health Nurse
  - Home Health Aide
  - Transportation
  - Adult Day Health
  - Home Delivered Meals
  - DD Day Care
  - Habilitation
  - Assisted Living Facilities
  - Community Transition Services

**KEY**
- EPD - Elderly & Physically Disabled (Age 65+, Blind or Disabled)
- ICF/MR - Intermediate Care Facility for Mental Retarded
- NF - Nursing Facility
- PAS - Pre Admission Screening

*Our first care is your health care*

Arizona Health Care Cost Containment System
Arizona Managed Care Principles

- Promote Competition and choice in marketplace
  - RFPs strong plan competition

- Establish proper infrastructure for oversight
  - Staff of 75 to oversee plans
  - Very good encounter data used for rate setting and quality measures

- Demand Improved member outcomes and Plan Performance
  - Track quality measures – sanctions for poor results

- Establish broad networks that ensure member access
  - Regular monitoring

- Be a competitive payer that attracts providers
  - Professional/OP rates typically at Medicare
Arizona Long Term Care System (ALTCS) Guiding Principles

- Member-centered case management
- Accessibility of network
- Service in the most appropriate setting
- Collaboration with stakeholders
- Integrate service model establishing accountability
- Leverage true potential of managed care with frail populations
Managed Care Competition

- EPD Procurement cycle – every 5 years
- DD – ongoing contract with DES
- Just awarded new EPD contracts – 10-1-11
- Competition statewide – 6 bid for 3 slots in Maricopa
- Procurement evaluated
- Program – Capitation Rate – Organization - Network
Setting Rates for E/PD Program

- Capitation is bid as component of Procurement
- Bid separately
  - All Medical Services – Case Management – Administrative
- Service Costs – weighted average of nursing facility and home and community setting costs – align incentives
- Data Sources for Rate Components
  - Enrollment history and projections
  - Reports on NF vs. HCBS placement by GSA and health plan
  - Databook for encounters approved and adjudicated
- AHCCCS currently has 3 actuaries on staff
- Agency makes annual adjustments based on trends and program changes
## ALTCS Capitation

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Gross CYE12 Rate</th>
<th>Mix</th>
<th>Net CYE12 Rate</th>
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</thead>
<tbody>
<tr>
<td>Nursing Facility</td>
<td>$5,242.23</td>
<td>28.56%</td>
<td>$1,497.18</td>
</tr>
<tr>
<td>Share of Cost</td>
<td></td>
<td></td>
<td>$ (224.60)</td>
</tr>
<tr>
<td>Net Nursing Facility</td>
<td></td>
<td></td>
<td>$1,272.59</td>
</tr>
<tr>
<td>Home and Community (HCBS)</td>
<td>$1,399.54</td>
<td>71.44%</td>
<td>$999.83</td>
</tr>
</tbody>
</table>

Our first care is your health care
Arizona Health Care Cost Containment System

13

“Reaching across Arizona to provide comprehensive quality health care for those in need”
ALTCS and Dual members

- 120,000 dual eligible members in Arizona
- In AZ 83% of the elderly and physically disabled members in long term care program are dual members
- 22% of developmentally disabled members are dual members
- Since 2006 Arizona strongly encourages plans to be Special Needs Plans
- Arizona has approximately 40,000 members or one-third of duals aligned and integrated into the same plan for Medicare and Medicaid – nationally less then 200,000
AHCCCS Oversight

- Strong system and staff infrastructure
- Strong contracts that allow for graduated compliance (corrective action plans-sanctions)
- Strong Quality Management measurement reporting
- Strong and frequent operational reporting (grievances – finances – utilization)
- Every 3 years full operational and financial reviews
- Quarterly staff meetings to review and compare plan performance

Our first care is your health care
Arizona Health Care Cost Containment System
Service Delivery Expectations

- Well documented case management policies
- Regular case management monitoring and training
- Established Network Standards
  - PCP and pharmacy within 5 mile radius (urban)
  - Requirements for MCO contracts with hospitals and SNFs and Assisted Living facilities by regions of metro area
  - Require appropriate specialists
  - Appointment standards – emergency/urgent/routine
Value of Managed Care

- Integration and alignment of all services for frail dual members provides opportunity to leverage full potential of MCOs -
- Leverage Data and turn to knowledge/information
- Seamless transition of care across settings
- Health Risk assessment tools
- Clinical support analytics, predictive modeling and care management staff to address
- Work with providers in getting them actionable data
- Serves as single entity accountable for outcomes of member
ALTCS Results
AHCCCS Results

- 97.3% - 30 day initiation of services (EPD)
- 87% 3-6 years olds PCP visit (DD)
- 87%-92.5% Diabetes HbA1c test (EPD)

Avalere Study of Mercy Care Plan Duals

- 31% lower rate hospitalization
- 21% lower readmissions
- 9% lower ED use
ALTCS E/PD Trend in HCBS Placement 1989 - 2011

Percentage %

'89  '91  '93  '95  '97  '99  '01  '03  '05  '07  '09  '11

Nursing Facility

Home and Community

‘Reaching across Arizona to provide comprehensive quality health care for those in need’
Reaching across Arizona to provide comprehensive quality health care for those in need

Our first care is your health care
Arizona Health Care Cost Containment System

ALTCS Program Savings

CY 98 CY 99 CY 00 CY 01 CY 02 CY 03 CY 04 CY 05 CY 06 CY 07 CY 08 CY 09 CY 10 CY 11 CY12

Increasing HCBS
40.2% HCBS
AHCCCS Results - Capitation

<table>
<thead>
<tr>
<th>Program</th>
<th>1-1-06</th>
<th>9-30-13</th>
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<tbody>
<tr>
<td>EPD</td>
<td>$2,976</td>
<td>$2,950</td>
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<tr>
<td>DD</td>
<td>$3,150</td>
<td>$3,223</td>
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Reaching across Arizona to provide comprehensive quality health care for those in need.
Trends in Medicaid Long Term Services and Supports

Presentation for the National Association of Medicaid Directors Fall 2012 Meeting
Cindi B. Jones, Director, DMAS and VHRI

October 2012
Navigating Long Term Services and Supports In Virginia
Composition of Virginia Medicaid Expenditures – SFY 2012

Notes:

- Long-Term Care Services
  - ID/DD: 26%
  - Other Waivers: 2%
- Medical Services
  - Long-Term Care Services: 43%
  - Behavioral Health Services: 34%
  - Indigent Care: 9%
  - Dental: 2%
  - Medicare Premiums: 7%
- Medical Services by Delivery Type
  - Managed Care: $1.7b
  - Fee-For-Service: $1.4b
Notes:
Average annual growth total Long Term Care services – 8%
Average annual growth Institutional services – 4%
Average annual growth Community-Based services – 14%
Proportion of Long Term Care services paid through Community-Based care has increased from 30% in FY02 to 51% in FY12
Key Components of a Managing Long Term Care

- Recognize the strength and need for informal supports

- Independent Gateway to LTC
  - Virginia has Pre-Admission Screening teams
  - Anyone who may become Medicaid eligible within 180 days of admission to LTC (300% SSI, spendown)

- Standardized and multidisciplinary assessment
  - SEMPA, Social, economic, mental health, physical health, and activities of daily living
  - Virginia uses same for all publicly funded services
Key Components of a Managing Long Term Care (continued)

- Standardized and defensible program criteria tied to assessment
  - 2-4 ADLs with medical and nursing needs
  - Virginia has high acuity
- Have viable community based alternatives/rebalancing
  - Virginia has 7 HCBC waivers
  - Money Follows the Person
- Case management/care coordination
- Monitor and measure outcomes
- Consumer directed alternatives
Implementing PACE is a Good Start for Integration

- The Program of All-inclusive Care for the Elderly (PACE) model is centered around the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.
- PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area.

- 10 Sites
  - Run by Health Systems
  - Area Agencies on Aging

- Perfect definition of Health Home
1996: began Mandatory MCO program that went statewide July 2012 for 625,000 TANF and ABD

December 2006: DMAS released the Blueprint for the Integration of Acute and Long Term Care Services that included community (PACE) and regional (VALTC) models. Community model: 10 PACE sites in Virginia; 6 additional sites planned

July 2009 (VALTC): DMAS planned to launch VALTC; however, due to budget constraints, provider resistance, and other limitations, did not move forward with initiative; 2000 with LTC in MCOs for acute care

December 2010: DMAS applied for CMS “State Demonstrations to Integrate Care for Dual Eligible Individuals” and was not one of the 15 states accepted

2011 & 2012: Appropriations Act language directed DMAS to develop and implement a care coordination model for individuals dually eligible for services under both Medicare and Medicaid

October 2011: DMAS sent Letter of Intent to participate in CMS’ Financial Alignment Demonstration and is currently pursuing model
Some Challenges

- High program criteria of 3-4 ADLs plus medical need
- No state plan personal care services
- No real care coordination
- Expectation that we will improve quality, outcomes and save money

- And the DUALS Demo has its own challenges
The Integrated Care Aligned
Medicaid Long Term Services & Supports
Recent Trends and New Directions

National Association of Medicaid Directors
2012 Fall Meeting, October 29, 2012

Debra J. Lipson, Senior Researcher
dlipson@mathematica-mpr.com
Overview

- Medicaid Long-Term Services and Supports (LTSS) cost trends

- Traditional and recent strategies to control LTSS costs and expand access to HCBS

- Managed LTSS (MLTSS)
  - Can it do better at controlling costs and improving quality? What will it take to succeed?
Growth in Medicaid LTSS Spending, FFY 1990-2009

In Billions

<table>
<thead>
<tr>
<th>Year</th>
<th>Institutional Care</th>
<th>Home and Community-Based Services</th>
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<tbody>
<tr>
<td>1990</td>
<td>$32</td>
<td>13%</td>
</tr>
<tr>
<td>1995</td>
<td>$54</td>
<td>20%</td>
</tr>
<tr>
<td>2000</td>
<td>$75</td>
<td>30%</td>
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<td>2002</td>
<td>$92</td>
<td>68%</td>
</tr>
<tr>
<td>2004</td>
<td>$100</td>
<td>63%</td>
</tr>
<tr>
<td>2006</td>
<td>$109</td>
<td>59%</td>
</tr>
<tr>
<td>2008</td>
<td>$115</td>
<td>58%</td>
</tr>
<tr>
<td>2009</td>
<td>$122</td>
<td>57%</td>
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</table>

SOURCE: KCMU and Urban Institute analysis of HCFA/CMS-64 data.
Medicaid LTSS Expenditure Growth

Average Annual Growth During 5-Year Period

1995-2000: 5.5%
2000-2005: 7%
2005-2009: 5.1%
But growth in Medicaid LTSS spending was less than other key benchmarks, *per capita*

Average Annual Growth, 2000-2009

- Medicaid LTC Per Capita: 3.0%
- Total Medicaid Per Capita: 4.6%
- Medicaid Acute Care Per Capita: 5.6%
- NHE Per Capita: 5.9%
- Monthly Premiums for Employer Sponsored Coverage: 7.7%

*SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis*
Traditional Strategies to Control LTC Costs

- Restraints on building new institutions (e.g. nursing home certificate of need moratoria)
- Closure of large ICF-MRs
- HCBS waivers – cost neutrality and enrollment caps
- Limits on amount, scope or duration of home health and personal care services
- Stricter standards for institutional admission
But strong incentives for institutional care remain

- Institutional care is a mandatory Medicaid benefit, HCBS are optional
- Interest groups favoring institutions are strong
Promote HCBS by shifting the paradigm

- Consumer-directed care

- Ask institutional residents if they want leave and help them if they wish
  - MDS 3.0 Sec. Q
  - Money Follows the Person and other types of transition assistance

- ACA federal flexibility and incentives (extra FMAP) to states adding HCBS

<table>
<thead>
<tr>
<th>Program</th>
<th># States Sept 2012</th>
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<tr>
<td>Balancing Incentive Program</td>
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<tr>
<td>Community First Choice</td>
<td>1 (2 more pending)</td>
</tr>
<tr>
<td>HCBS State Plan Option 1915(i)</td>
<td>12</td>
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Managed LTSS

- MCOs assume some, or all, of the financial risk, giving them an economic incentive to coordinate care and keep members independent and out of institutions.

- Capitated payments -- monthly payment per member (PMPM) paid to MCO to provide all covered LTSS services and supports.
Managed LTSS

- Same benefits of “regular” managed care
  - Potential to hold an entity accountable for access, quality and costs
  - Predictability of costs - PMPM set in advance

- Plus potential for improved LTSS outcomes
  - Shift the balance from institutional care to HCBS
  - Better LTSS quality
  - Integration of LTSS with acute, primary and specialty care, including behavioral services
Current Status of State MLTSS Programs

June 2012:
16 states had MLTSS programs in operation, twice as many as in 2004

By 2014:
26 states projected to have MLTSS programs

Source: Truven Health Analytics, July 2012
Challenges and Constraints to MLTSS

- MCOs have limited experience with LTSS and elderly/disabled populations with complex needs
- Transitioning beneficiaries and CBOs from fee-for-service to capitated systems
- Consumer direction vs. medicalization of disability services
- No national standards to assess HCBS quality
- State Medicaid agencies have limited experience with LTSS contract standards, rate setting, monitoring provider network adequacy in MCOs
State oversight of MLTSS

- Managed care program management plus LTSS expertise

- Staff and contractors with experience
  - IT, MCO licensing, LTSS delivery systems, quality of care, EQROs, data analytics

- Skills and Functions
  - Contract Negotiation
  - Contract Monitoring
  - Provider Network Adequacy
  - Quality Assurance and Performance Improvement
  - Member Education and Consumer Rights
  - Rate Setting
What can be learned from experienced States

- **Contract Monitoring**
  - Automated tools to ensure MCO reports are submitted, reviewed, and acted upon appropriately
  - Contract revisions to raise performance targets & incentives for exceeding quality standards

- **Provider Network Adequacy**
  - Mystery shoppers to verify that provider offices are open and accepting new patients

- **Quality Assurance & Improvement**
  - Electronic visit verification systems to monitor home care services in real time
  - Dashboard of performance indicators on many dimensions
  - Use of encounter data to construct quality measures
Cost savings? It depends.

- Accurate rate setting and risk adjustment
- Starting point in reliance on institutional care
- Coverage/risk for institutional services
- Integration with medical care & behavioral health
- Mandatory or voluntary enrollment
- Affordable, accessible housing
- Supply of direct care workers & caregivers
Cost savings are not guaranteed
- Depends on state starting point, program design & payment methodology

Improved quality and other outcomes not assured
- MLTSS requires a greater level of oversight than regular Medicaid managed care - will States invest in needed resources?

Next big challenge is Medicare integration for duals
- Full integration: same MCOs at risk for Medicaid and Medicare services and members must choose the same MCO
- Require MLTSS plans to coordinate with Medicare, MCOs must offer Medicare Advantage SNPs
- Further progress via dual demonstrations
Presentations from those were unable to Attend

Trends in Medicaid Long Term Services and Supports
October 29, 2012
Trends in Medicaid
Long Term Services and Supports
The LTSS System in Tennessee before…

- **Fragmented**—carved out of managed care program
- **Limited options and choices**
- **Heavily institutional**; dependent on new $ to expand HCBS

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Restructuring the LTSS System: Key Objectives

- **Reorganize** – Decrease fragmentation and improve coordination of care.
- **Refocus** – Increase options for those who need LTSS and their families, expanding access to HCBS so that more people can receive care in their homes and communities.
- **Rebalance** – Serve more people using existing LTSS funds.
Key Design of MMLTSS

• Began as a legislative initiative: *The Long-Term Care Community Choices Act of 2008*

• Integrates LTSS (NF and HCBS for E/D into existing managed care program via 1115 waiver and MCO contract amendments

• Enrollment target for HCBS supports controlled growth while developing sufficient community infrastructure to provide care (persons transitioning from a NF and certain persons at risk of NF placement are exempt)

• Cost and utilization managed via individual benefit limits and individual cost neutrality cap

• Blended capitation payment for physical, behavioral and LTSS (duals/non-duals; LOC)

• MCOs at full risk for all services, including NF (not time-limited)
  • Risk-adjustment for non-LTC rate component rate based on health plan risk assessment scores – John Hopkins ACG Case-Mix System – using MCO encounter data  
  • Risk-adjustment for LTC component of the rate based on mix by setting (NF vs. HCBS)

• Consumer directed options for core HCBS using an employer authority model

• Electronic Visit Verification system helps ensure fiscal accountability and provides immediate notification/resolution of potential gaps in care

• State leadership, collaboration, and strong contract requirements are key; CRA available at: [http://www.tn.gov/tenncare/forms/middletnmco.pdf](http://www.tn.gov/tenncare/forms/middletnmco.pdf)
Implemented in Tennessee’s Middle region
3/1/10 and East and West regions 8/1/10

- Transitioned 7,145 NF residents and 1,479 HCBS waiver participants on 3/1 (83%NF/17%HCBS)
- Transitioned 15,931 NF residents and 3,382 HCBS waiver participants on 8/1 (82.5%NF/17.5%HCBS)
- Existing TennCare recipients remained with their currently selected MCO which became responsible for LTC services upon CHOICES implementation
- Continuity of care provisions helped to ensure as seamless a transition as possible
- Freedom of choice of NF/HCBS – must be able to safely meet needs in the community

Ensuring the stability of the LTSS system
- MCOs contract with all certified NFs for first 3 years
- State sets MCO rates for NF and HCBS
- State determines medical necessity (level of care) for NF and HCBS
- Enhanced MCO training and technical assistance requirements for LTC providers
- Stringent LTC prompt pay requirements – 90% of clean claims w/in 14 days; 99.5% w/in 21 days
Ongoing Monitoring and Quality Oversight

• Uniform measures of system performance
• Detailed reporting requirements
• Ongoing audit and monitoring processes
  --Site inspections and inspections of work performed
• Measures to immediately detect and resolve problems, including gaps in care – Electronic Visit Verification
• Independent review (EQRO, TDCI)
• Key focus on member perceptions of quality
  --QOL/Member satisfaction survey
  --Consumer advisory groups
• Advocacy for members across MLTSS system
The LTC System in Tennessee *after...*

- Single Point of Entry for persons not on TennCare through Area Agencies on Aging and Disability; MCOs assist current members with accessing LTC

- Comprehensive Care Coordination provided by MCOs
  - Each member has an assigned Care Coordinator—nurses and social workers
  - Comprehensive ongoing needs assessment and person-centered care planning
  - Coordination of physical, behavioral, functional and social support needs
  - Management of chronic conditions and care transitions
  - On the ground and face-to-face with minimum contact requirements
  - Detailed contract requirements and protocols

- Consumer direction provides members (or qualified representative) with employer authority
  - MCO authorizes a fixed amount of services based on need
  - Member/rep, using fiscal/employer agent, is the employer of record
  - Member/rep sets the reimbursement rates for the worker from list of available rates set by the State and signs a Service Agreement with each qualified worker
  - Members may also “self-direct” certain health care tasks as part of consumer directed services
  - TennCare contracted with a single statewide fiscal employer agent to perform fiscal intermediary and supports brokerage functions
MLTSS “Enhancements”

MFP Demonstration

• $119,624,597 over 5 years to transition 2,225 individuals (primarily NFs); 50 from ICFs/IID

• “Layered onto” existing MLTSS 10/1/11

• MCO incentive payments focus on transition, sustained community living, rebalancing, consumer direction, and community-based residential alternatives

• Transitioned 300 people under MFP (166 Elderly, 120 PD, 14 ID; oldest - 98, youngest - 22 (PD); longest institutionalized - 50 years (ID), 20 years (Elderly)

Changing NF LOC and Implementing HCBS for persons “at-risk”

• Part of the original approved CHOICES program design; implementation initially prohibited by MOE eligibility provisions of ARRA/ACA

• 1115 amendment preserves eligibility pathways in order to comply with MOE

• Increased NF LOC targets NF services to persons with higher acuity of need

• HCBS provided to persons “at-risk” of institutional placement
Baseline Data Plan/Special Study

- **Objective #1: Expand access to HCBS**
  - # NF versus HCBS participants

- **Objective #2: Rebalance LTSS spending**
  - Total NF versus HCBS expenditures

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

- **Objective #4: Delay or prevent the need for institutional placement**
  - Average length of stay in HCBS
  - Percent of new LTSS members admitted to NFs

- **Objective #5: Facilitate transition from NF to HCBS**
  - Average length of stay in NF
  - # NF-to-community transitions
Access to Home and Community Based Services before and after

<table>
<thead>
<tr>
<th>Year</th>
<th>HCBS Enrollment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>0</td>
<td>No state-wide HCBS alternative to NFs available before 2003.</td>
</tr>
<tr>
<td>2004</td>
<td>1,131</td>
<td>CMS approves HCBS waiver and enrollment begins in 2004.</td>
</tr>
<tr>
<td>2006</td>
<td>4,861</td>
<td>Slow growth in HCBS – enrollment reaches 1,131 after two years.</td>
</tr>
<tr>
<td>2010</td>
<td>6,000</td>
<td>HCBS enrollment at CHOICES implementation.</td>
</tr>
<tr>
<td>2012</td>
<td>11,718</td>
<td>HCBS enrollment without CHOICES.</td>
</tr>
</tbody>
</table>

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

* Excludes the PACE program which serves 325 people almost exclusively in HCBS, and other limited waiver programs no longer in operation.
Re-Balancing LTSS Enrollment through the CHOICES Program

LTSS Enrollment before CHOICES Program (March/August 2010)

- NF 83%
- HCBS 17%

LTSS Enrollment as of October 1, 2012

- NF 63.9%
- HCBS 36.1%

Nursing Facility Enrollment

HCBS Enrollment
Other Successes

- 567 transitions during first year of the program (prior to implementation of MFP)
- % of NF eligible people entering LTSS choosing HCBS increased from 18.66% prior to CHOICES to 33.11% during the first year of the program
- 32-day reduction in average NF length of stay during first year of the program
- 8% of HCBS participants in Consumer Direction as of Aug 2012
- Length of time from referral for CD to implementation of CD services reduced from average of 122 days in Jun 2011 to average of 56 days in June 2012 (HCBS provided by contract providers in the interim)
- > 97% of all in-home services scheduled over the last year were provided; of those visits that did not occur as scheduled, the overwhelming majority (roughly 75%) were initiated by the member (not the provider); back-up plans required in either case
- > 99.75% of all scheduled in-home services provided over the last year were on time

Continued Challenges

- NF reimbursement methodology must reflect higher acuity of NF residents
- Easier to rebalance enrollment than expenditures, particularly if using cost-based NF reimbursement methodology
Lessons Learned

On Effective Contracting

1. New skill sets are required of staff as you shift from FFS to managed care.
2. Detailed program design and contract requirements, with aligned financial incentives, enforcement mechanisms, and appropriate reporting and monitoring processes are necessary to ensure compliance and improve quality.
3. Whenever possible, developing requirements in partnership with the MCOs helps to ensure they are understood and can be operationalized.
4. Contracts should be routinely reviewed and amended.
5. Thorough readiness review processes are critical prior to any program implementation.
6. Program leaders must be integrally involved in day-to-day program management and oversight/monitoring, and willing to hold MCOs accountable. There must be different types and levels of incentives and sanctions which are used when necessary to ensure compliance. Automated systems for tracking deliverables is recommended.

On Cost Containment

1. Aligning financial incentives is critical.
2. MCOs need multiple tools to manage benefits and cost.

On Quality

1. Quality of care is improved when coordination of care is enhanced.
2. High quality care is more cost-effective care.
3. Standardized outcome measures are needed for LTC.

On Integration of Care

1. All members should be enrolled in managed/coordinated systems of care.
2. NF services must remain carved in with the MCO at risk.
3. The MCO must be the entity responsible for needs assessment /care planning, and for ensuring timely access to quality services.
4. Integration of benefits results in improved coordination of care and reduces potential for duplicative services and/or cost shifting.

On Stakeholder Engagement

Communication/buy-in is key (in design and implementation).
What’s next?
Possible integration of other LTSS benefits
Integration/coordination of Medicare benefits

- Expanded PACE sites
- Dual demonstration under ACA authority
- Alignment of TennCare/Medicare MCOs under Part C authority
- Coordination of TennCare MCO and D-SNP using MIPPA agreement
  - Data interface, including eligibility/enrollment and encounters
  - Coordination of Medicaid benefits with a FBDE member’s TennCare MCO
- Quality monitoring
- Administrative requirements
- Provider networks
- Marketing