MANAGED LONG-TERM SERVICES & SUPPORTS (MLTSS) MANAGED CARE BASICS
WHO IS GORMAN HEALTH GROUP?

*Gorman Health Group* is the leading solutions and consulting firm for government-sponsored health programs.

**Government Programs**
Leading enterprise of national consulting services and software solutions for payers and providers.

**Our Mission**
Our mission, as the industry's most active professional services consultancy and provider of technology-based solutions, is to empower health plans and providers to deliver higher quality care to beneficiaries at lower costs, while serving as valued, trusted partners to government health agencies.

**Washington, DC**
Headquartered in Washington, DC with more than 200 staff and contractors nationwide with over 2,000 combined years of Government Programs experience.

**Leadership**
Deep payer and provider knowledge coupled with Centers for Medicare & Medicaid Services (CMS) regulatory expertise.

**Privately Owned**
Founded in 1996
Our clients have one-stop access to expert advice, guidance, and support, in every strategic and operational area for government-sponsored programs, across seven verticals.

**CLINICAL**
Changing how you approach Medical Management, Quality and Stars

**PHARMACY**
Leading experts in Part D, PBM, formulary and pharmacy programs

**HEALTHCARE ANALYTICS & RISK ADJUSTMENT SOLUTIONS**
Implementing cross-functional risk adjustment programs for medical trend management and quality improvement

**OPERATIONS**
Bringing excellence to every aspect of your implementation from enrollment to claims payment

**COMPLIANCE**
Offering guidance and support in every strategic and operational area to ensure alignment with CMS

**PROVIDER INNOVATIONS**
Supporting network design and medical cost control implementation

**STRATEGY & GROWTH**
Leading experts in Marketing, Sales and Strategy development that create short and long-term profitable growth
MEDICAID SERVICES

Dedicated to assisting Medicaid Managed Care Organizations achieve **strategic, operational and quality** goals across five verticals.

**CLINICAL**
Blending medical and pharmacy to improve care coordination, outreach and utilization management to meet the complex needs of your membership.

**FINANCIAL ALIGNMENT**
Providing health economic solutions for the needs of the Medicaid population including long-term care, behavioral health, and chronic condition management.

**STRATEGIC POSITIONING**
Analyzing and evaluating organizational adaptability, and readiness for change in new policy and population management environments.

**QUALITY PROGRAM OVERSIGHT**
Guidance and support to achieve the results your members and regulators expect while attaining compliance with State and Federal rules.

**OPERATIONS**
Creative solutions to maximize cost effectiveness, and deliver lasting results from eligibility to provider contract management, and claims.
THIS SESSION WILL DISCUSS

- Population and Cost Trends Driving States to Managed Care
- The Current Status of State Waivers for MLTSS
- MLTSS Best Practices in Model of Care (MOC)
- Quality Measures
- Staffing Needs Unique to LTSS
TRENDS DRIVING THE GROWTH OF MEDICAID MANAGED CARE FOR LTSS
LTSS IN THE U.S.

- An estimated 12 million people are currently in need of LTSS
  - Institutional or home-based assistance with activities of daily living (ADLs)
  - Persons with physical and/or cognitive limitations
- This number is expected to increase to 27 million by 2050
- Approximately half of users of LTSS are over 65
- Approximately half of the users of Medicaid-funded LTSS are dual-eligibles
MEDICAID IS THE PRIMARY PAYER FOR LTSS

NOTE: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, personal care services (government-owned and private home health agencies), and Section 1915(c) home and community-based waiver services (including home health). Expenditures also include spending on ambulance providers. All home and community-based waiver services are attributed to Medicaid. SOURCE: KCMU estimates based on 2012 Centers for Medicare and Medicaid Services National Health Expenditure Accounts data.
Medicaid LTSS Spending is Increasingly Devoted to HCBS as Opposed to Institutional Care

<table>
<thead>
<tr>
<th>Year</th>
<th>Home and Community-Based LTSS</th>
<th>Institution-Based LTSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>$54 (20%)</td>
<td>$80 (80%)</td>
</tr>
<tr>
<td>2000</td>
<td>$75 (30%)</td>
<td>$70 (70%)</td>
</tr>
<tr>
<td>2005</td>
<td>$104 (39%)</td>
<td>$61 (61%)</td>
</tr>
<tr>
<td>2010</td>
<td>$121 (45%)</td>
<td>$55 (55%)</td>
</tr>
<tr>
<td>2012</td>
<td>$123 (45%)</td>
<td>$55 (55%)</td>
</tr>
<tr>
<td>2013</td>
<td>$123 (46%)</td>
<td>$54 (54%)</td>
</tr>
</tbody>
</table>

NOTES: Home and community-based care includes state plan home health, state plan personal care services and § 1915(c) HCBS waivers. Institutional care includes intermediate care facilities for individuals with intellectual/developmental disabilities, nursing facilities, and mental health facilities.

SOURCE: KCMU and Urban Institute analysis of CMS-64 data.
THE COST OF LTSS

Average Annual Care Costs, by Type of Service

- Nursing Home: $90,520
- Assisted Living Facilities: $42,600
- Home Health Aide: $20,800
- Adult Day Care: $18,200

Annual Gross Income: $22,002

34% of seniors live below 200% of poverty

AGING POPULATION

Figure 1
The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050

CURRENT STATUS OF STATE WAIVERS FOR MLTSS
WHY MANAGED CARE FOR LTSS?

- LTSS are the largest category of services in the Medicaid Fee-for-Service (FFS) system – 34% of total expenditures, or approximately $140B (Source: Truven Health Analytics, 2014)
- Capitated managed care creates budget stability for states
- Managed Care Organizations (MCOs) have demonstrated expertise in effecting change through reimbursement and managed care practices
- Integration of LTSS supports the “whole person” through accountability for all services through a single entity
- Dual demonstrations create a system to combine services for a large percentage of LTSS beneficiaries
TYPES OF MLTSS WAIVERS

• Section 1115 Research Demonstration Projects: Flexibility to test new or existing approaches to financing and delivering Medicaid and Children’s Health Insurance Program (CHIP)

• Section 1915 (b) Managed Care Waivers: Services delivered through managed care delivery systems or limited choice of providers

• Section 1915 (c) Home and Community-Based Services Waivers: Long-term care services in home and community settings rather than institutional settings

• Concurrent Section 1915 (b) and (c) Waivers: Simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities
CAPITATED MEDICAID MLTSS WAIVERS STATUS – 2014

Map showing the status of 1115 Demo, 1915(b) Waiver, and combined 1115 & 1915(b) waivers across the United States.
CAPITATED MEDICAID MLTSS WAIVERS

• 11 of 19 waivers filed in 2012-14
  o Section 1115 demonstrations – 12 states
  o 1915 (b)/(c) – 6 states
• All 19 include seniors and non-elderly disabled persons
• All 19 include dual-eligible beneficiaries
• 5 of 19 include persons with intellectual and/or developmental disabilities
• 17 of 19 require beneficiaries to enroll in a managed care plan in order to receive services
MLTSS BEST PRACTICES: BUILDING THE MODEL OF CARE (MOC)
THE COORDINATION CHALLENGE

- Specialists
- Emergency Department
- Family Members
- Social Services Agencies
- PCPs
- CMHC/BH
- Home Health
- Facilities
MEMBER NEEDS ASSESSMENT

• Clinical Assessment
  o Clinical complexity, disease diagnosis/current condition
  o Level of care needs
  o Eligibility for services

• Psycho-Social Assessment
  o Family and community supports available
  o Cognitive, decision-making capability, memory, ability to make self understood
  o Behavior/Mood: Current, frequency, and easily altered

• ADLs
  o Eating, dressing, transferring, bathing, toileting, and grooming
  o Instrumental activities of daily living (IADLs): Medications, stair climbing, mobility indoors, mobility outdoors, housework, laundry, shopping and errands, meal preparation and clean-up, transportation, telephone, money management
MLTSS CARE PLANNING
BEST PRACTICES

- Patient-centered care plan
- Management of care transitions
- Multi-disciplinary care team
- Service continuity and provider network adequacy
- Collaboration with community and family supports
- Information sharing
PATIENT-CENTERED CARE PLAN

Examples of LTSS Services

- Adult Companion Care
- Adult Day Health Care
- Assisted Living
- Assistive Care Services
- Attendant Care
- Behavioral Management
- Care Coordination/Case Management
- Caregiver Training
- Home Accessibility/Safety Adaptation
- Minor Home Repairs
- Home-Delivered Meals
- Homemaker
- Hospice
- Housing Assistance
- Intermittent and Skilled Nursing
- Medical Equipment and Supplies
- Medication Administration
- Medication Management
- Nursing Facility
- Nutritional Assessment/Risk Reduction
- Personal Care
- Personal Emergency Response System (PERS)
- Respite Care
- Supported Employment
- Therapies, Occupational, Physical, Respiratory, and Speech
- Transportation
CARE TRANSITIONS

- Process to assess the treatment options needed once the transition occurs
- Adequate support during care transition decreases the likelihood of institutionalization
- Coordination may be challenging if other payers are involved
- Non-clinical support to ensure psychosocial and community-based services are coordinated
- Appropriate and thorough documentation and internal communication
UNIQUE “NETWORK” NEEDS

- Transportation
- Home modification and adaptive equipment
- Unlicensed home care providers
- Not-for-profit agencies
- Occupational therapy

- Adult foster care
- Expanded mental health access
- Nutrition, home-delivered meals
- Housing assistance
- Legal assistance
- Respite
WORKING WITH THE COMMUNITY

- A “boots on the ground” relationship with key community supports is essential
  - Faith organizations
  - Community centers
  - Unlicensed home care providers
  - Advocacy groups
  - Law enforcement
COMMUNITY AND FAMILY SUPPORTS

Estimated Economic Value of Formal and Informal Long-Term Services and Supports for Elderly People in the United States, 2011

- Institutional Care (31%) $134 Billion
- Informal Care (55%) $234 Billion
- Community-Based Care (14%) $58 Billion

Source: CBO based on other sources. See the supplemental material for this report.

CONGRESSIONAL BUDGET OFFICE
JUNE 2013
THE NEED FOR INFORMATION

• Frequent transitions can increase the risk of communication failures, inadequate coordination, and adverse drug events
• Other coverage for dual eligibles creates information gaps, the need to coordinate with other payers
• Multiple caregivers, facilities, physicians lack a common data platform, need to establish alternate communication strategies
  o Portal access
  o Case conferences
• Benefits of an Electronic Health Record (EHR) include:
  o Real-time storing and sharing clinical information
  o Enables physicians to better coordinate patient care across various delivery settings
  o Potential to prevent treatment delays, reduce hospital readmissions, and increase health care quality
IDENTIFYING AT-RISK MEMBERS

The Need for Respite Care

HCBS → Institutional
### PROVIDERS OF LTSS

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing home or specialty care nursing home services</td>
<td>• Transportation</td>
</tr>
<tr>
<td>Personal assistance services</td>
<td>• Occupational therapy</td>
</tr>
<tr>
<td>Homemaker/chore or meal preparation services</td>
<td>• Residential services</td>
</tr>
<tr>
<td>Family supports</td>
<td>• Home and vehicular modification</td>
</tr>
<tr>
<td>Social adult day care and respite care</td>
<td>• Community transitions</td>
</tr>
<tr>
<td></td>
<td>• Personal emergency response</td>
</tr>
</tbody>
</table>
WORKING WITH PROVIDERS

• Proactive provider engagement
  o Specialized provider relations staff
  o Field staff involvement
  o Case conferences

• Create provider partnerships
  o Emphasis on qualitative measures, outcomes
  o Participation in case conferences - payments

• Alternative contracts
  o Incentives for reporting and information sharing

• 2-way communication
  o Keep providers informed of case developments
PROVIDER EDUCATION

- Timely and clear information on processes, expectations
- Multiple delivery options – hard copy, webinar, in person
- Consider reward for participation – non-monetary incentives
- Directed education for office staff, non-clinical staff
- Onsite in provider locations
BRINGING IT ALL TOGETHER

• Coordinating with:
  o Medicare payer(s), and
  o Medicaid benefits, and
  o health care providers, and
  o non-clinical support providers, and
  o community support services, and
  o family members, and
  o other sources of financial assistance,
    • State ABD aid, food stamps, TANF, other state and local support
  o and patients??
QUALITY AND LTSS
QUALITY MEASURES FOR MLTSS ARE EVOLVING

• NCQA is studying integrated care measures; for now, existing accreditation standards apply to LTSS
• Dual demos include quality standards for LTSS
  o Assessment standards – timeliness and frequency
  o Individualized service plan standards
  o Generally based on nursing home standards at present
  o Consumer satisfaction (case manager, home workers, personal care)
FOR STATES:
10 KEYS TO MLTSS PROGRAMS

- Adequate Planning of Transition Strategies
- Stakeholder Engagement
- Enhanced Provision of Home and Community-Based Services
- Alignment of Payment Structures with MLTSS Programmatic Goals
- Support for Beneficiaries
- Person-centered Processes
- Comprehensive and Integrated Service Package
- Qualified Providers
- Participant Protections
- Quality Oversight

Source: CMS “Essential Elements of Managed Long Term Services and Supports Programs” (May 2013)
QUALITY PROCESS MEASURES – EXAMPLES

- Timely screenings, assessments, and reassessments.
- Service plans developed/initiated in a timely manner (state standard).
- Percent of members receiving participant-directed services within X days (state standard) from referral to the provider.
- Percent of members receiving timely care coordination contacts.
- Percent of complaints/grievances received and resolved.
- Percent of members diagnosed with diabetes who received diabetes management services.
- Percent of provider late/missed visits by service type.
- Increase in:
  - Annual dental exams,
  - Diabetes management,
  - Annual gynecological exams.
QUALITY OUTCOME MEASURES – EXAMPLES

- Reduction in member falls.
- Reduction in emergency room visits.
- Increase in number of persons transitioned from nursing facilities to the community.
- Decrease in number of members entering nursing facilities.
- Increase in community tenure of persons transitioned from nursing facilities.
- Decrease in hospital readmissions.
- Decrease in psychiatric hospitalizations.
- Number of potentially preventable hospital readmissions.
- Number of potentially preventable complications.
STAFFING THE MLTSS MOC
## MULTI-DISCIPLINARY CARE TEAM

<table>
<thead>
<tr>
<th>Role</th>
<th>Credential</th>
<th>Function(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTSS Specialist</td>
<td>RN</td>
<td>Assessment &amp; Care Planning</td>
</tr>
<tr>
<td>Clinical Case Manager</td>
<td>RN</td>
<td>Coordinate Acute Clinical Needs, UM</td>
</tr>
<tr>
<td>Behavioral Care Clinical</td>
<td>MSW</td>
<td>Coordinate Behavioral Clinical Needs</td>
</tr>
<tr>
<td>LTSS Coordinator</td>
<td>Non-clinical</td>
<td>Member support, Psychosocial resource coordination</td>
</tr>
</tbody>
</table>

- **Best practices**
  - 24/7 availability
  - Community-based staff
  - Dedicated Provider Relations
RECRUITING THE RIGHT TEAM

• Understanding of the community, especially non-clinical team
• Member engagement skills – ability to sell the program
• Listening skills, understanding the member doesn’t understand what’s going on
• All members of care team need to understand mental health issues
• Provide engagement skills – provider structure and workflow
• Care Management 101
• **Foundation** – A deep understanding of LTSS, including populations, providers, compliance.

• **Core Competencies** – Ability to engage members and providers, access resources, and collaborate with care team.

• **Toolkit** – Using all available tools within the plan and community to meet the needs of members and obtain cost and outcome objectives; documentation training.
Gorman Health Group, LLC (GHG) is a leading consulting and software solutions firm specializing in government health programs, including Medicare managed care, Medicaid and Health Insurance Exchange opportunities. For nearly 20 years, our unparalleled teams of subject-matter experts, former health plan executives and seasoned health care regulators have been providing strategic, operational, financial, and clinical services to the industry, across a full spectrum of business needs. Further, our software solutions have continued to place efficient and compliant operations within our client’s reach.

GHG offers software to solve problems not addressed by enterprise systems. Our Valencia™ software reconciles the capitation payment of more than six million Medicare beneficiaries and continues to support customers participating in the Health Insurance Exchanges. Nearly 3,000 compliance professionals use the Online Monitoring Tool™ (OMT), our complete Medicare Advantage and Part D compliance toolkit, while more than 45,000 brokers and sales agents are certified and credentialed using Sales Sentinel™. In addition, hundreds of health care professionals are trained each year using Gorman University™ training courses.

We are your partner in government-sponsored health programs

LESLIE MULLINS
Senior Consultant

T 301-275-3326

E lmullins@gormanhealthgroup.com