LTSS Rebalancing

AGING IN AMERICA

How Can States Improve Care for Older Adults with Complex Needs?

November 29, 2016

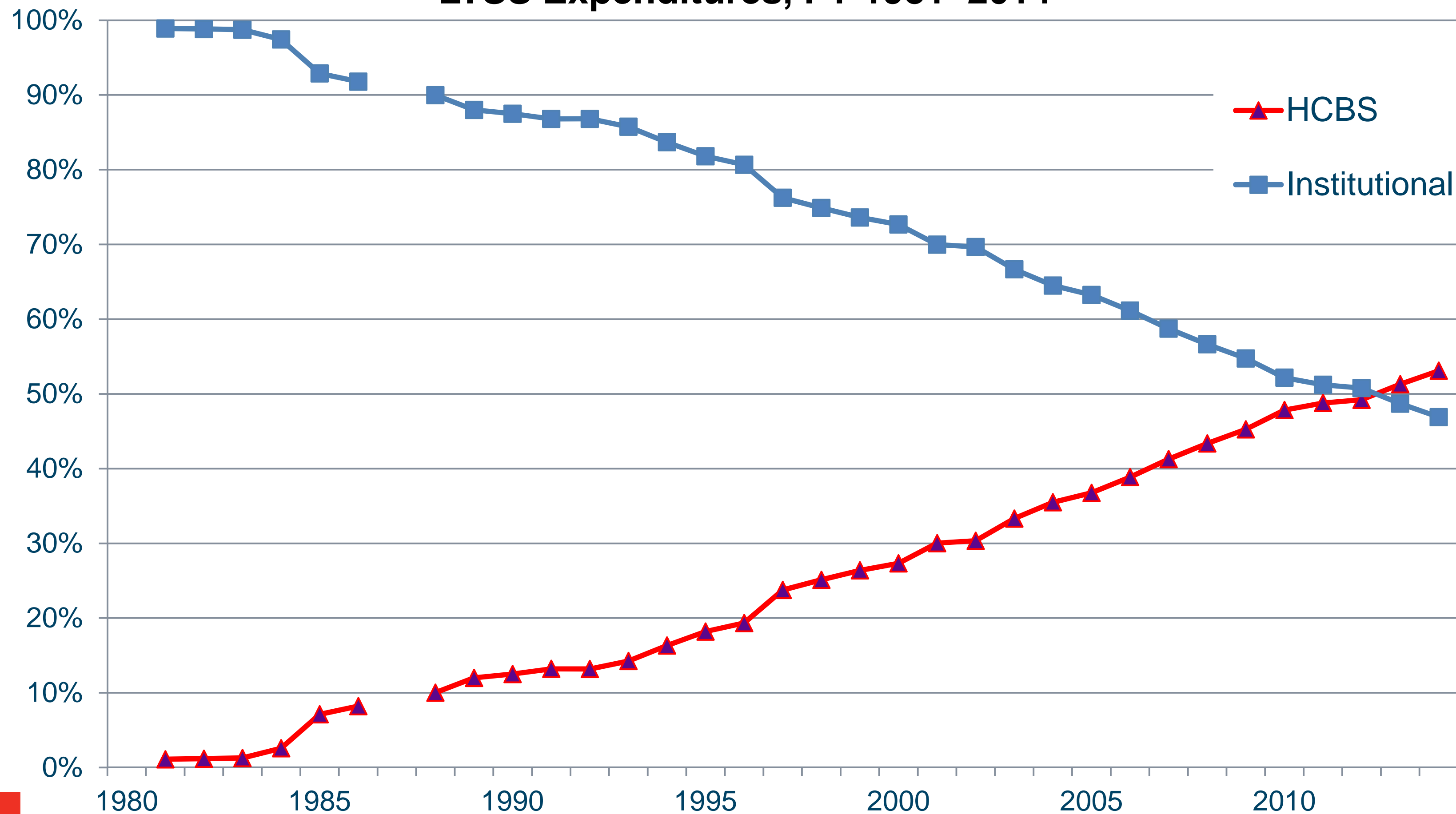
The Reforming States Group

with the Milbank Memorial Fund
and the Center for Health Care Strategies

Overview of
LTSS Rebalancing

TN Division of Health Care Finance & Administration

LTSS balance has shifted ***significantly*** since 1981



Source: Wenslow, Eiken and Sredl. *Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014.* Prepared by Truven Health Analytics for CMS, 2016.

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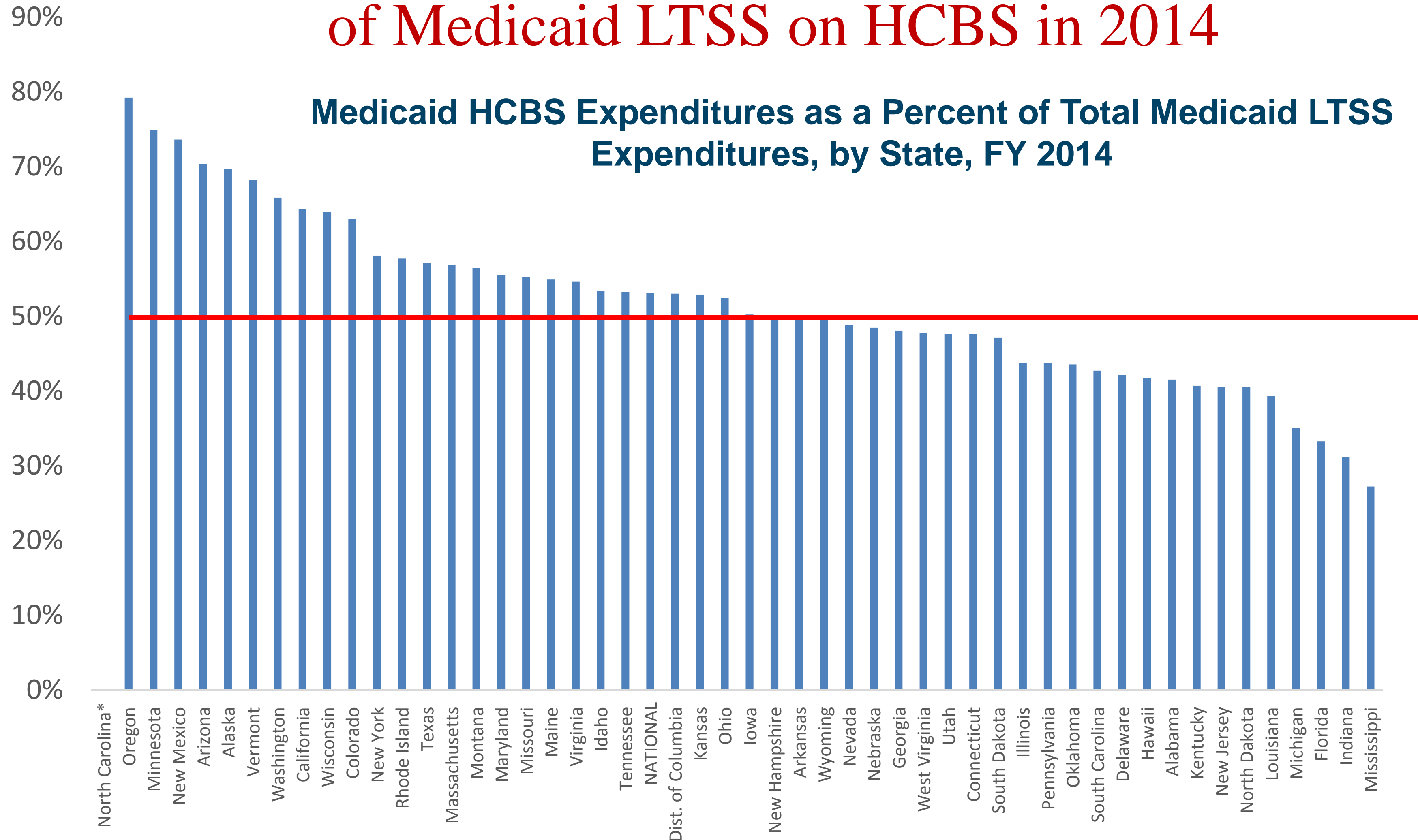
AMP1

About Half the States Spent More than 50 Percent of Medicaid LTSS on HCBS in 2014



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Source: Eiken et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014.* Prepared by Truven Health Analytics for CMS, 2016.

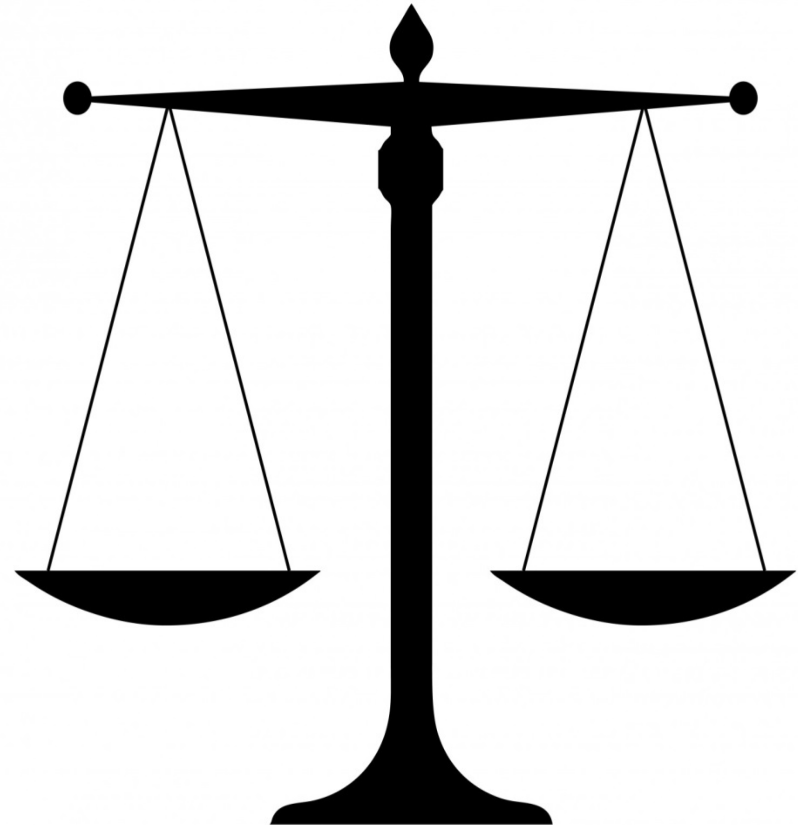
*North Carolina was excluded from the analysis because it has a high proportion of LTSS delivered through managed care and detailed information about the state's managed care expenditures was not available for FY 2014.

Slide 4

AMP1 Houston Meeting
States that should have red bars: AL, AR, ID, IN, IA, KS, ME, MN, ND, OH, TX, WI
Ann Mary Philip, 11/7/2016

What's shifting the balance?

- **Beneficiary Preference**
- **Cost and Financial Sustainability**
  (especially in light of aging demographic)
- **Americans with Disabilities Act**
  - Olmstead Ruling
  - DOJ Actions
- **Medicaid Authorities**
  - 1915(c) HCBS Waivers
  - 1915(i) State Plan HCBS
  - 1915(j) Self-Directed Personal Assistance Services (State Plan)
  - 1915(k) Community First Choice
  - MFP
  - BIPP
  - 1115
- **MLTSS**



LTSS Rebalancing in Tennessee

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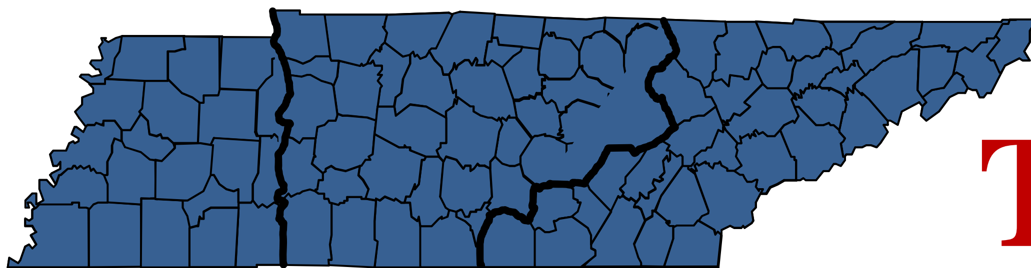

Tennessee

- Managed care demonstration implemented in 1994
- Operates under the authority of an 1115 waiver
- *Entire* Medicaid population (1.5 million) in managed care
  - 70,332 aged 65 and older
- 3 at-risk NCQA accredited MCOs (statewide in 2015)
- Physical/behavioral health integrated beginning in 2007
- Long Term Services and Supports (LTSS) for older adults and adults w/ physical disabilities in 2010
- MLTSS program is called *"CHOICES"*
- ICF/IID and 1915(c) HCBS waivers for individuals with intellectual disabilities carved out; populations carved in
- New MLTSS program component for I/DD as of July 2016: *Employment and Community First CHOICES*

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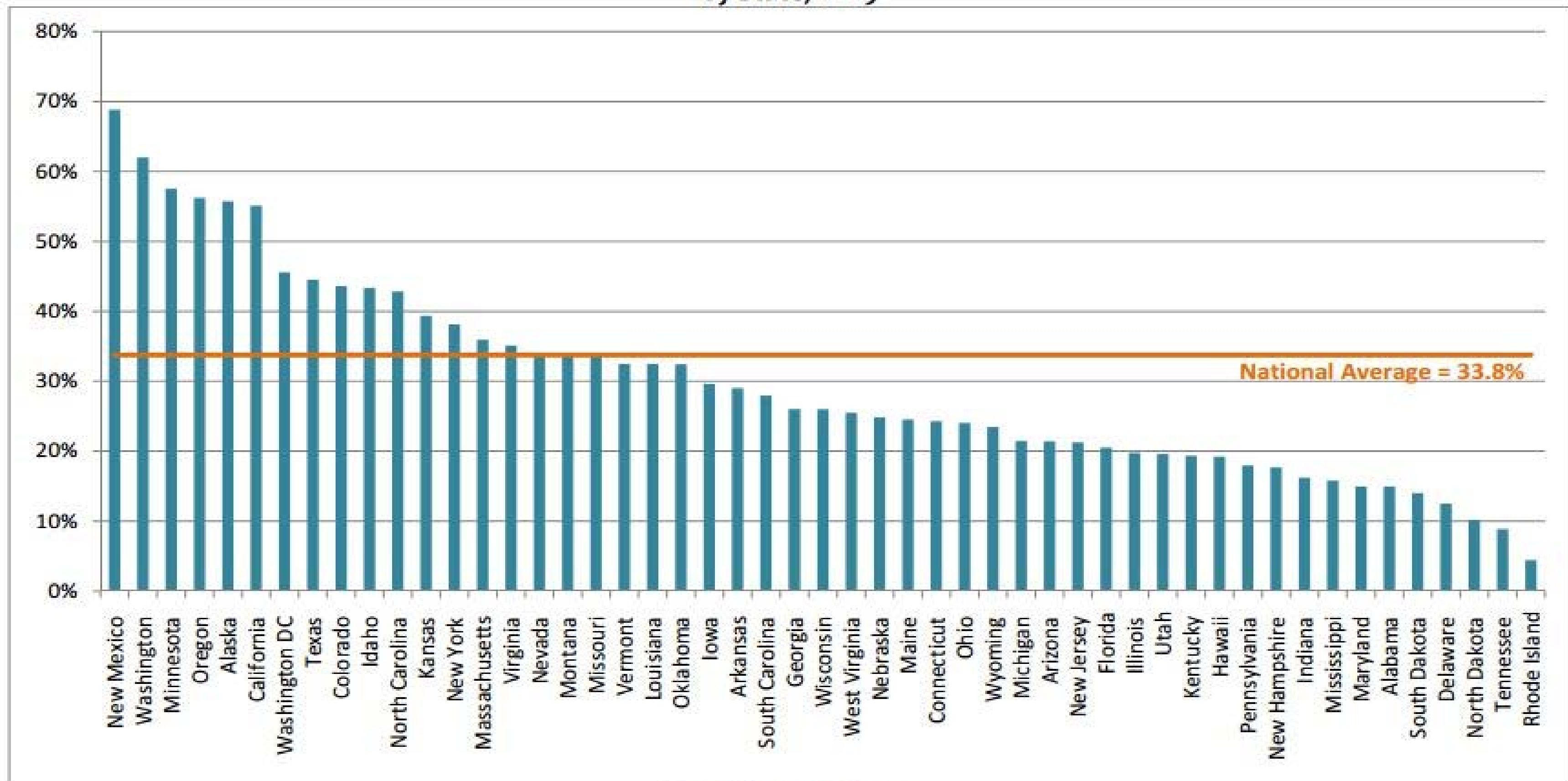
LTSS balance in Tennessee *before* CHOICES

Figure 4. Percentage of Medicaid LTSS Spending for HCBS for Adults Aged 65 and Older and Persons with Physical Disabilities, by State, 2009



Source: Thomson Reuters

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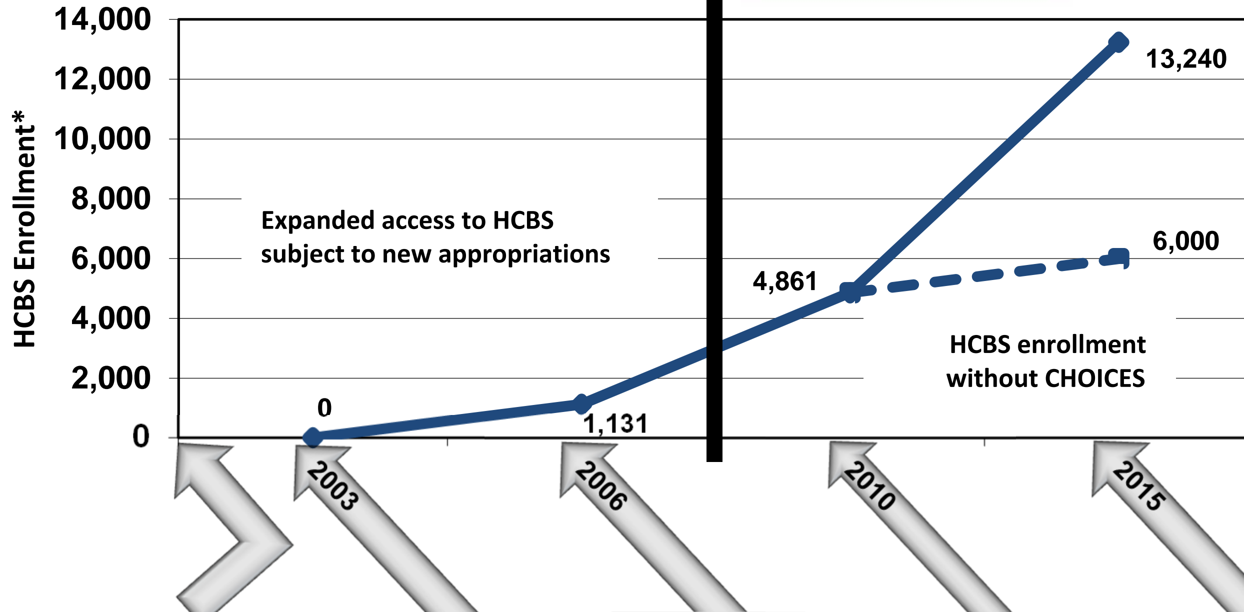
The Hilltop Institute

TennCare LTSS reforms began in 2010

- Improve quality/coordination of care
- Expand access to HCBS
- "Rebalance" LTSS expenditures

Access to HCBS before and after…



- **Global budget approach:**
  - Reinvest limited LTSS funding based on needs and preferences of those who need support
  - More cost-effective HCBS serves more people with existing LTSS funds
  - Sustainable model critical as population ages and demand for LTSS increases

No state-wide HCBS alternative to NFs available before 2003.

CMS approves HCBS waiver and enrollment begins in 2004.

Slow growth in HCBS – enrollment reaches 1,131 after two years.

HCBS enrollment at CHOICES implementation

Well over twice as many people receive cost-effective HCBS; additional cost of NF services if HCBS not available more than. $250 million (federal and state).

HCBS waiting list <u>eliminated</u> in CHOICES

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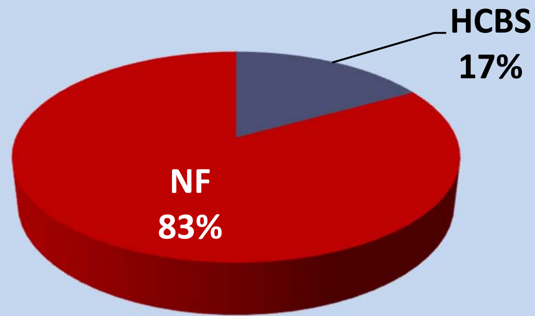
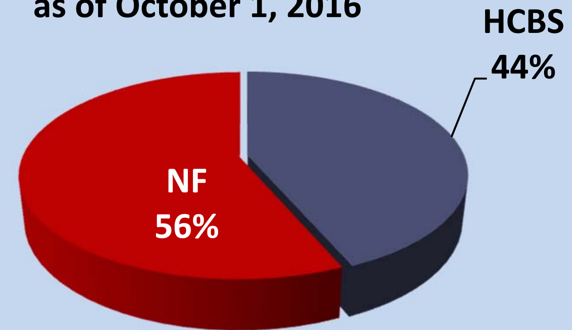
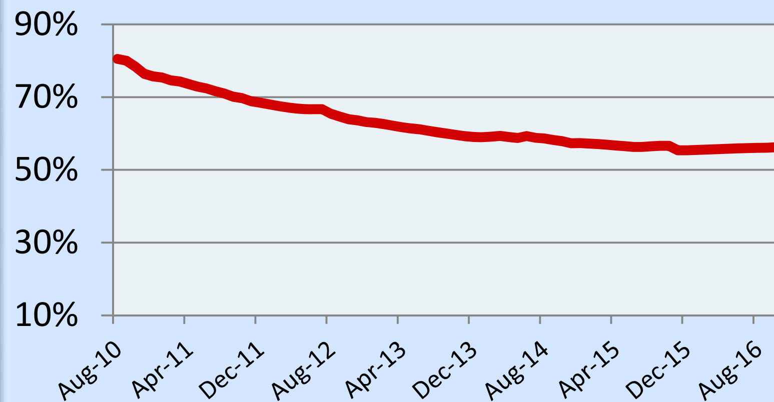
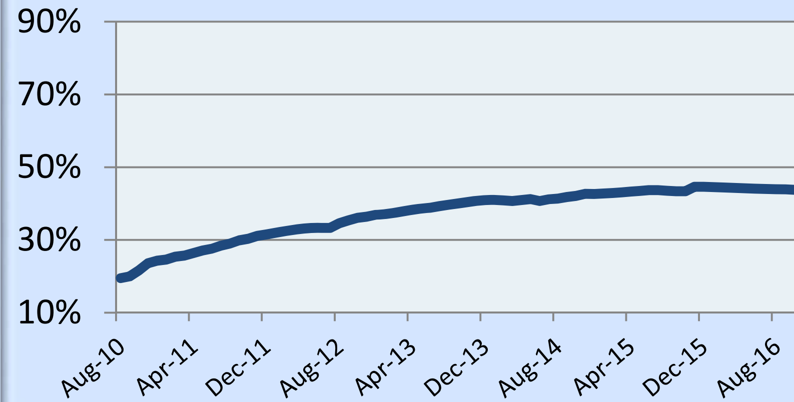
* Excludes the PACE program which served 325 people almost exclusively in HCBS, and other limited waiver programs no longer in operation.

Re-balancing LTSS Enrollment through the CHOICES Program









CHOICES Rebalancing Outcomes

- 170+% increase in # of persons receiving HCBS in CHOICES (from 4,861 to 13,240, as of 6/30/15)—12,654 as of 6/30/16
- 6,000+ decrease in # of persons receiving NF services in CHOICES (from 23,076 to 17,069, as of 6/30/15)—17,141 as of 6/30/16
- Overall program growth (across settings) was fairly minimal (roughly 2,400 members across the first 5 years of the program), and not simply the result of "woodwork" or growth in HCBS, but real changes in utilization of LTSS across settings (i.e., a reduction in utilization of NF services as well as increased utilization of HCBS)
- More than 3,000 individuals transitioned from NFs to HCBS as of 6/30/16, average of >600 per year, compared to 129 in the baseline year
- Average length of NF stay declined from 285 days to 245 days (as of 6/30/16)
- % of people coming into LTSS in a NF declined from 81.34% to 46.95% as of 6/30/14, with >50% of people choosing HCBS—49.47% as of 6/30/16

Policy Opportunities and Operational Challenges

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Levers on Both Sides of Balance Ratio

Expand HCBS	Reduce Institutional
• New or expanded HCBS • Community based residential alternatives • Housing and social supports • Technology • Consumer direction • Financial incentives	• Closures or reductions of state institutions • Diversion, including PASRR • Transition, including Money Follows the Person (MFP) • Level of Care • Financial (dis)incentives

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Source: Truven Health, *modified*

Operational Challenges

- State funding
- CMS approval; administrative requirements, complexity
- State capacity/infrastructure (development and oversight)
- Medicaid room and board policies; scarcity of subsidies
- Workforce
- Stakeholder resistance
- Opposition of nursing home industry/lobby
- Nursing facility payment methodologies
- Post-acute transition; relative speed/ease of NF admission v. HCBS; hospital pressures
- Eligibility policy/processes
- Institutional bias
- Misalignment of Medicare benefits

Future Direction (“Opportunities”):

At the Intersection of Rebalancing and Medicare-Medicaid Integration

Context

Majority of Medicaid Nursing Facility (NF) residents are:

- **Age 65+**
  (82% of TennCare CHOICES NF residents)
- **Medicare eligible**
  (92% of TennCare CHOICES NF residents)
- **Admitted to a Medicaid NF following a Medicare SNF stay**
- **In fee-for-service Medicare**

Recommendation:

Eliminate/reverse the institutional bias in the Medicaid program design

LTSS Benefits

- Change NF services to an optional (versus mandatory) benefit
- Allow states to limit the number of institutional "slots or placements," divert to HCBS, and maintain waiting lists for NF services, if applicable
- To ensure maintenance/expansion of LTSS *system* capacity, require that any reduction in institutional "slots" be paired with the addition of one or more community "slot(s)"
- Continue to offer flexible HCBS authorities which support the development of adequate community-based infrastructure and allow states to manage limited resources

LTSS Settings

- Modify freedom of choice requirements to default to HCBS rather than institutional care, i.e., a person cannot be placed in an institution (NF or ICF/IID) without being advised by a neutral entity of freedom of choice of available HCBS alternatives and affirmatively choosing institutional placement over available HCBS alternative
- Require enrollment in HCBS *first* (before permitting institutional placement) absent extenuating circumstances
- Allow FFP for limited room and board supplements in a community-based residential alternative setting (not just in an institution as currently permitted under the law), particularly for persons with income at or below the SSI FBR

LTSS Quality

- Encourage/require the development of value-based purchasing approaches for LTSS (NF and HCBS) in order to align payments with key measures of performance, including the member's experience of care and in NFs, transition to community

- Allow State exception to any willing qualified provider and freedom of choice of provider requirements for NFs with lower quality rankings (including all special focus facilities)

Recommendation:

Integrate funding, benefits, and coordination for Full Benefit Dual Eligible (FBDE) beneficiaries receiving LTSS

Integration/Coordination of Care

- Enroll all FBDE beneficiaries receiving LTSS in integrated and coordinated programs of care (e.g., D-SNPs, Financial Alignment Demonstrations) that include LTSS and coordinate services across the continuum
- Permanently reauthorize D-SNPs that are contracted with the SMA to deliver LTSS and to coordinate care across the continuum
- Clearly define the role of the SMA in the contracting and oversight of "integrated" D-SNPs
- Streamline administrative requirements for integrated D-SNPs

Recommendation:

Realign incentives in the Medicare program to support delivery of Medicare and Medicaid LTSS in the most integrated setting appropriate

Realign Medicare Incentives

- Implement prospective UR process (more than 3-day minimum hospital stay) for Medicare SNF benefits that includes consideration of HCBS options first
- Implement freedom of choice requirement for Medicare SNF benefits with default to HCBS rather than SNF, i.e., person cannot be placed in a SNF without being advised by a neutral entity of freedom of choice of available HCBS alternatives (Medicare HH and Medicaid options, if applicable) and affirmatively choosing SNF placement over HCBS alternatives
- Incentivize hospitals to discharge from Medicare inpatient to home with HCBS rather than SNF (and/or disincentivize hospital discharge to SNF)

Questions and Discussion