ALLIANCE FOR HEALTH REFORM

Medicaid Managed Long-Term Services and Supports: Are More Caution and Oversight Needed?
Alliance for Health Reform
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ED HOWARD: Welcome. My name is Ed Howard. I am with the Alliance for Health Reform. We have a program for you today that's going to examine how states are doing in making sure that the Medicaid managed-care companies delivering long term-term services and supports to older people, and to people with disabilities, are doing a good job.

Now, Medicaid is the center of a lot of attention these days, both here and in the States. One big reason, depending on how you calculate it, Medicaid accounts for anywhere between one-sixth to one-fourth of an average state's budget. In times when states' revenues have not really fully rebounded from the disaster of 2008, those are numbers that draw a fair amount of attention.

States have moved literally millions of Medicaid beneficiaries, into managed-care plans, and they started with moms and kids. But increasingly, the elderly and those with disabilities are finding themselves in managed-care plans – not just for acute care, but for what people my age used to call long-term care. It's now long-term services and supports.

Today, we're going to look at those long-term services and supports plans and how well states are doing with their responsibility to make sure that those vulnerable populations are dealt with safely, caringly and efficiently. Now, we are

very pleased to have as our partner in today's program, the AARP Public Policy Institute. For the last 25 years or so, PPI has been the focal point at AARP for health policy research, public policy research and analysis. And we are especially happy to have as our co-moderator today, the Director of PPI, Susan Reinhard, who is also a Senior Vice-President at AARP. Susan, thank you for being here.

SUSAN REINHARD: Thank you. Would you like to introduce everybody first, or no?

ED HOWARD: No, why don't you –

SUSAN REINHARD: Well, thank you, Ed. I was saying to Ed, they have this down. You and your folks really have this down. We did not – you did not send out the invitation until about two weeks ago, which was making me panicky. We have to get that out there. And I understand close to 300 people have responded and we're delighted you're here. We know a lot of you – some of you I don't know – but we're so glad you came to join us.

We're very happy that this report is being released. There's a lot of work that went into this. I, of course, want to acknowledge the authors from the Public Policy Institute – and you'll hear from her – Wendy Fox-Grage. Where is she? Wendy's in the audience. Waive your hands. There she is. And then, of course, from Mathematica, Debra Lipson, Jenna Libersky

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and Rachel Machta – I think I'm saying it correct – they have been really working hard for more than a year on this report, and I'll tell you a little more about that. So we're releasing it.

It is known as *Keeping Watch*. That is a very appropriate title. I want to commend anyone who figured that out. *Keeping Watch: Building State Capacity to Oversee Medicaid-Managed Long-term services and supports.* We wish we had something a little sexier than that, a little roll off your tongue better, but that's what it is.

We did this study for two reasons. The first was to really better understand what was happening at the state level, particularly state Medicaid agencies, the need to monitor performance of these programs which, as Ed said, are just blossoming, as you all know. And the second was to identify some promising practices that are going on in the field, so that states can learn from each other.

So, it's really a two-fold purpose, and you're going to hear about that in a few moments as we turn it over. I think you all know, but I've been encouraged to remind people what is Medicaid-Managed LTSS. It is a Capitated Risk-based Managed Care for Medicaid enrollees who have long-term services and supports needs.

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The Medicaid agencies pay a per-member, per-month rate, and the managed-care organizations bear the financial risk for delivering all of the covered services. I don't think that's news to any of you, but just for the record and for your archived program here. Older adults, and adults with physical disabilities, especially those with long-term services and supports needs, have typically been in the Medicaid fee-for-service world.

We know other populations in Medicaid have for many years now been in the managed-care world, but this is somewhat new. There are some states, as you will hear, that have some experience. But it's generally a new idea or a new movement in states. So that gave us particular reason to look at this. We think there are both opportunities and challenges here.

There are at least three opportunities with moving more of these populations into Medicaid-managed care, and the first is, hopefully, better care. That's the goal that we would like to see, that we can do better. Having these folks with pretty significant needs in a world where there isn't much care coordination going on, has not been the ideal situation to begin with.

So, the opportunity for better care coordination is what the hope, the promise-land is, so to speak. Having better care coordinators, having better outcomes of care across

settings, not just in one setting, reducing, avoidable hospital admissions, reducing unnecessary use of institutional care like nursing homes, for example.

And reducing medication mismanagement resulting from the multiple and parallel systems of financial and care. We know that many of these folks have three different cards, if you're in the duals world, also. You have a Medicare, Medicaid, you might have a pharmacy card, you might have a behavioral health card. So it's pretty confusing from a consumer perspective.

The second hope is better accountability, that states can hold managed-care organizations accountable instead of all of the different providers, all of the different agents who would be working with this population. That there would be sort of a one-stop shopping of accountability, is the promise for both controlling service use and providing quality care. However, they can't, in a fee-for-service system, do that kind of controlling service and quality care because there's so many different providers that they're trying to deal with and it's difficult.

The third promise is budget stability, and we know that is a big driver for why state governments are look at this, paying a single fixed fee that you can put in a budget. And that it's not going to change, is the ideal from their point of

view, that it makes spending, maybe not less, per se, but more predictable. So those are some of the promises, but of course, with all of these innovations, there are challenges, and I'll just list a few of them. Chief among them is the fact that this is not easy.

This is not an easy set of populations to do this, it's going to be tough for many states and the managed-care organizations because they don't have much experience, which is the second challenge, the limited experience. Many of them have not had experience with long-term services and supports for these populations. It's really very different – those of you in the audience – and I see many of you who do have a lot of experience in LTSS – know this is complicated. The people who have these needs have multiple issues they need to deal with, and it's not all medical.

It's not all medical needs. In fact, it's largely social needs. So, managed-care organizations, in general, have less experience in managing the need for social services, or support services. And finally, there is always the worry about the financial incentives, that plans may try to restrict access to services since they are at financial risk. That is always the – what is going to happen here when we change these incentives?

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So, let me just say a few words about why we conducted the study. You already heard that there was this tidal wave of innovation with many states moving to managed long-term services and supports, roughly half the states.

So that's the take-away, according to everything – we can take half the country and it's moving even more, either are, already have, or they're expanding, or they're going to be implementing this move towards Capitated-care for these populations. And also, many states are focusing on the dual-populations at the same time.

So, within one state, they're trying to do both things. We are focused on the importance of state-oversight for this Managed long-term services and supports. We believe that states have to have strong oversight and monitoring. I'm not going to get into the details because you will, I hope, Lynda. But I just want to say, that this need to look at oversight has been consistent with what many of our colleagues in the field have been saying.

So, for example, the Center for Healthcare Strategy cited robust contractor oversight and monitoring requirements as one of the top 10 milestones that states should strive for when they are moving in the direction of managed long-term services and supports. And, our wonderful colleagues at Kaiser, Commission on Medicaid and the Uninsured, called the

need for strong state oversight, such as measuring plan performance and involving consumers and providers in developing and monitoring the program, one of five key issues that we should be looking at as we shift into this new way of delivering services to people.

But, as all of this is going on, we also know that the budgets for states are so strained, just at a time when we would be expecting them to have more responsibilties and oversight, there is significant state staff downsizing. James was just telling me about 30-percent reduction in some states that he knows. So, it's very significant.

We do know the National Governors Association and the National Association of State Budget Officers just said that the numbers of FTE positions declined by 1.2-percent, as 31 states reduced their numbers. So, lots going on, more responsibility for states at a time that their capacity is declined.

I think we're going to turn it over to you. I just want to say that we did do a lot of work on this report. We had an innovation round-table in December. There's been an advisory committee on this. Some of you may be in the room. We want to thank you for your participation in this. You're going to learn a lot from our co-panelists. So, with that, I'm

going to turn it over to Ed, who will let you know who they are.

ED HOWARD: Great. Thank you, Susan. This is a really good opportunity for a conversation. A quick logistical review – you probably have heard much of this before – there's a lot of material in your packets, including biographical information about our speakers, and including, where we have them, the hard-copies of their Power Point slides. You can find all of those on-line at allhealth.org, which is our website.

You'll be able to view a webcast of this briefing on Monday, relive every thrilling moment, on the website of the Kaiser Family Foundation. Thanks to them for providing that service. You can access it through ours, as well. And you can find, in a week or so, you'll be able to find a transcript of the briefing on our website, too.

We'd appreciate you filling out the blue evaluation form at some point during the next hour and 40 minutes, or so. There is a green question card you can use for the Q&A period. There are also microphones – you may have to fight your way through the tight seating to get to them, but that's how you get the question asked in your own voice.

Now, we have a terrific panel with a variety of viewpoints and insights to present to you on the topic and we're going to start with James Toews, who is a Senior Policy

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Analyst at what is now the Administration for Community Living, in HHS.

He came to HHS from Oregon state government where, for years, he was part of the groundbreaking Oregon Initiative, that I know most of you are familiar with, to shift care for their vulnerable populations from institutions to home and community settings. James, thank you very much for being with us today.

JAMES TOEWS: Thank you. It's a pleasure to be here. So, Susan has covered this already, and most of you are familiar with managed care, but it is relatively new to the long-term Services and Support arena. And, particularly as we move towards capitation – we move large fee-for-service systems to capitation – we don't have a lot of actuarial experience in rate-setting and figuring out how we actually provide supports that people need.

In fact, we have a very long history of vast overspending on a lot of wrong things. So, recalibrating that into a capitation model that really is tailored to individual needs and is budget sensitive, is a relatively new task that we're learning from people like Patti, in Tennessee, and others that are well down that road already.

Right now, the map is changing rapidly. So this is probably way out of date already. And, as Susan said, about

half the states - and I think it's even more than half - are contemplating the move towards managed care on the long-term Services side. But these are the current states where some level of managed care for these populations already operates. But it still represents a very, very small percentage of the overall Medicaid expenditures for these populations.

Why now? I think the reasons are pretty obvious. The state budget deficits are still very much around. The growth of Medicaid spending, that we're all aware of, the current spending trends in long-term services and supports are completely unsustainable.

For the most part, despite progress made in the last 10, 15 years, most of our systems are still terribly out of balance. We overextend our budgets on the nursing home side in most parts of the country. You can see only about 36.8-percent from the score card that AARP has put together, is actually spend on community versus institutional services. Only seven states spend more than half of their current resources on the community versus the nursing home or institutional side.

Parenthetically, developmental disabilities is not included in this. That system rebalanced a long time ago. In fact, most states had rebalanced their systems in the early 90s already, and they currently spend about 80-percent of their resources on the community side. For the most part, they are

very much resisting the conversations in the states on the move to managed care, feeling they don't want to get trapped in a system that will not work.

But, I think they'll come around at some point, as well. In many DD systems across the country, they've built very expensive community systems and they have very large waiting lists of people living at home with aging parents. So, I think the model will expand to that population eventually, as well.

And then, of course, I think everyone has been enticed through the Affordable Care Act and the invitation to come up with new and innovative models of providing this kind of support. The potential benefits – Susan has already touched on that – are really, really huge.

The integration of acute and long term care – and, again, even if you have a managed care program that doesn't bundle acute and long-term services, but it's only bundling, or capitating, the long-term side, there's still an enormous opportunity to coordinate that at the MCO level with the health providers. Everybody talks about how costly the duals are, but really it's a subset of people that could be dual, could be Medicaid only, could be Medicare only – with functional limitations, and they're really the ones that drive the costs.

Their healthcare costs are two to three to four times more than their counterparts without functional limitations. So this is a real opportunity to link services for that group, as well. There are some recent studies, also, that show that the number of avoidable hospitalizations for people with functional limitations, already receiving home and community based services, is almost double that of their other Medicaid counterparts. So, again, there's a real opportunity to link those services and to improve the alignment there.

And I think there's a real opportunity for quality management. Many of us in this field have a poor track record of managing and monitoring quality in the fee-for-services system. You all know about that through the periodic press reports and exposes that occur around this. So this is an opportunity to change that paradigm, as well.

The challenges have been touched on already. The experience, for the most part, is pretty limited. It's driving the stakeholders crazy as they look at potential MCOs coming into their states that have virtually no track records in providing long-term services and supports. The whole state-readiness issue on this is a very, very big deal.

The fee-for-service world, which has been around forever in the provider community. You have many providers that are also sort of Ma and Pa providers, small community non-

profits, all that have a long history, in many cases, of providing good services. They have no idea how to interact with the managed care world, how to invoice, bill, they don't have a lot of the IT capacity to exchange information.

So, this is going to present a real challenge, and if a managed-care organization comes in and says, well we're going to develop a new network, here you're not simply talking about well, I may have to get a different doctor. You may lose your residential home, you may lose the personal supports that you have from home-care workers that have attended to your support for years. So, it's a very, very sensitive thing on how we bring in that far-flung network in the fee-for-service world under an umbrella that's capitated and under managed care.

A lot of the disability community is very concerned about re-medicalizing the long-term Services world. And quality is a huge issue, and that's, of course, in the paper that you're going to hear about.

The stakeholders concerns that are very pressing – we've been spending a lot of time with CMS developing guidance that, hopefully, will go to the states sometime this Fall. So it's real opportune that the document you have in front of you, which has really incredible suggestions about what needs to be done, but it's very, very opportune.

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CMS in most of the states have been very, very good about transparency and in really involving the stakeholder community in this huge shift because, again, the stakeholders are very concerned.

If MCOs are going to take over this body of work and they don't have experience, we're going to have to demand that they become literate and – in long-term Services – and that they employ staff and managers at their top leadership level that have experience.

We're hopeful that in most cases the systems will have a very, very strong bias towards the home and community based side and so, hopefully the guidance to the states will be don't carve out the institutional side.

And I think, for the most part, that's not going to happen. But, parts of the the industry, I think, will still try to carve themselves out. And obviously, if you carve out the institutional side, you have a real perverse incentive for the managed-care plan to simply shift people with complex needs over to the institutional side and it comes out of somebody else's budget.

And then there's real concerns, in person-centered planning that's reflected all over now in federal law and federal regulations really take root in a managed-care organization. I know that the paper you're going to hear about

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really talks about the need to monitor the quality. There's two major issues there. One, we don't have good quality measures – good evidence-based quality measures on the long-term Services side. For the most part, historically, it's been around process, not outcomes.

Secondly, the Medicaid agencies that will have the lead responsibility here, in many ways are very poorly positioned to do this work, for a couple of reasons. One, in most states, Medicaid agencies, themselves, don't have a lot of experience with long-term services and supports. That's been delegated to an operating agency that either runs a developmental disability or aging program. So they have to bring in those operating agencies in a very dynamic partnership to be part of that monitoring role.

And secondly, the staffing levels – I've mentioned, the state I came from, I think by the time I left, we were down nearly 30-percent of our staffing levels through repeated budget cuts, frozen positions, frozen vacancies. So that's going to be a very, very large challenge. And, of course, the Medicaid agencies are implementing everything around health reform that's already on their plate. So, now taking on this very, very vulnerable population, we really have to think about readiness and what it's going to take for them to do this work. So, with that, let me turn it over.

ED HOWARD: Great. Thank you very much, James. Now we turn to Lynda Flowers, who, as Susan noted, is a co-author of the report that is being released today from AARP's PPI. She's a Senior Policy Advisor at PPI, somebody with more than 20 years' experience dealing with Medicaid. She's a nurse and a lawyer, by training. She was one of the people who kept this project – that resulted in Keeping Watch, on track. We are very pleased to have her give us an overview of that report. Lynda.

LYNDA FLOWERS: Thank you, Ed, and good afternoon everyone. Thanks for being here. I just have two more thank yous. Susan covered most of them, but there are two other people that I'd like to thank. One is the Director of our health team, Lena Walker, who was instrumental in helping us flesh through the ideas and get our project underway and has been very supportive throughout. So, I'd like to thank you.

And I'd also like to thank my colleagues in federal and state affairs, AARP, who have been very supportive of our project and have lended useful comments along the way.

I'd like to just start out by saying, I'm going to be doing the overview, sort of setting the frame for the work that we've done, and my colleague, Debra, will be my bookend at the end and she will bring you some of the highlights of the findings of the promising practices.

So, my talk this afternoon will focus on the methodology that we use, the guiding principles that guided the work, as we move through and interviewed states.

The core monitoring functions that we identified that are critical for states to engage in as they oversee their Medicaid managed long-term services and supports contracts. Core oversight capacities, and then, finally, the components of what state capacity is, meaning who are the people that really have to be involved and engaged in this work.

For a methodology, we convened an advisory group. As Susan said, they were just tremendous. They were fully engaged and just rolled up their sleeves and really came through and helped us from the very beginning to think through the questions that we would want to bring to states, to think through our convening and who needed to be at the table to help us really flesh out this idea. And finally, at the end, when they reviewed the report and gave various comments for improvement, I want to just thank them again.

We conducted interviews with senior state Medicaid officials and often these were groups of people in the rooms. High-level people, people who were Medicaid Directors, maybe even, the managed-care Directors, all in the room sharing their experiences and thoughts on oversight. So we went into Arizona

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and Massachusetts and you can see the rest of the states that we interviewed.

We also talked to quality review contractors in some of the states, just to get their perspectives on what they bring to the table, in terms of oversight. And then we also – my colleague, Wendy, and I rolled up our sleeves and looked at all the contracts to try to figure out what key capacities we needed to bring forth, in terms of oversight.

The four guiding principles – we worked with the advisory group to try and identify some principles that would guide this work, and also that would guide our thinking as we developed the interview protocols and guides. The first guiding principle was that states and their local partners are first responders.

Even though the federal government does play a role and has a meaningful role in oversight of Medicaid managed long-term services and supports, it's the states and their on-the-ground partners that have the day-to-day oversight responsibility. They're the first responders, they're going to get those phone calls, they're going to be accountable to their communities and their legislatures. So they're really the touchstone for all of this work. And they are the people that form and solidify the relationships with the health plans. Those relationships are key to making these programs work.

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The second principle is that oversight capacity for Medicaid managed long-term services and supports differs from that required for younger people and people with disabilities. This is a different type of population. They're more vulnerable, they're people with multiple chronic conditions, often, or people living with disabilities.

They need a different service package, including very robust and high quality care coordination. They also often need attention to their family care-giving needs. All of that needs to be integrated into the way services are delivered. So it's not the same oversight that one would want to put together for a younger population of families and young children.

The third guiding principle is that states need adequate oversight capacity before they start enrolling these beneficiaries. These are very vulnerable people. We need to hit the ground running, in terms of our ability to make sure that they're getting high quality and safely delivered care.

We also need to have a staff with a different skill-set. They need to have some long-term Services and Support experience and knowledge, so that you really can tune into the needs of the population from the very beginning.

And the final guiding principle for this study was that building and maintaining state capacity should be viewed as a continuous improvement process. Things are rapidly changing in

this field and I imagine they will just - as more and more states get into this, it's going to just explode. So you have to think about staff turnover. How are you going to address that? That's going to be a continual problem.

New technologies are emerging and that may be useful for states and their oversights abilities. Better strategies for monitoring plan performance may emerge and new plans are coming on-line all the time. So, it's always moving and the states need to be thinking about this, in terms of a continuous improvement process.

So, what are the core monitoring functions that states need to pay attention to? What are the domains - the buckets of things that we need to focus on when we're thinking about state oversight? First is sort of the general oversight contractual monitoring. That's sort of the beginning phase where you're working with plans as you put out the RFPs, and as you let these contracts out, working with them to establish the accountability systems - how you're going to communicate with one another?

Who are the point people there, from the state agency side and from the plan side? What are the reporting systems going to be like? You have to work together because often these systems have to interface with each other, so it's the plan system and the state's. They have to come together and

put those systems together. There needs to be lots of dialog about what the contract requirements really are. What sometimes one reads on paper is not what translates into what the expectation is, so we need to have that relationship, that on-going dialog, and clear expectations on both sides.

The second core function would be ensuring high-quality plan performance. That's a core capacity that states need to have. They need to be – from our talks with them, they consider technical assistance high on the list of things that they provide to the plans. Remember, it's a partnership, not an adversarial relationship. States want these things to succeed, so they're rolling up their sleeves and providing lots of technical experience on things that they have more experience with, especially on the long-term services and supports side.

They also need to be able to use the tools that are available to them to leverage high-quality plan performance. Some of those are corrective action plans, financial incentives, penalties, sanctions, and sometimes suspend enrollment for really egregious behavior.

Another core oversight capacity, and critical, is that we need to ensure network adequacy. That's both if you have primary and acute services, but also long-term services and supports. Sometimes it can be very challenging to build those

networks because, particularly in rural states that have large rural areas and it's hard to get to. So states and plans have to work in partnership to be very creative to try to figure out how to develop robust – very creatively, develop robust networks.

Also, these networks need to make sure that beneficiaries have timely access. Often that will include rules about length of travel times, and times when providers need to be available. The services have to be cultural competent, linguistically appropriate, and physically accessible. All of these things go into what states are looking for when plans put these services together.

We also need to make sure that health plans are receiving adequate payment rates. This is key to making these programs work. These rates have to be actuarially sound. We have to make sure that these plans remain financially solvent because we don't want a situation where we're putting people into plans and then the plan can't afford to provide the service and it falls apart for these beneficiaries. So, making sure those rates are sound is a key thing.

A key component of that financial soundness is the risk –adjusting. Making sure that plans that have very low-cost users, more healthy people, aren't being overpaid. Also making sure that plans that have an inordinate amount of people that

have significant health problems are being paid adequately. It's a delicate balance that takes a lot of state involvement and oversight and working with plans. And that's a continual process, because people are often moving around in these plans.

Then, of course, it' important to pay enough to promote the network adequacy. That means, that when that capitation goes out to the plan, the states have to also make sure that the plan are paying their down-stream providers enough to make sure that we can have adequate networks all the way down the line.

The next core capacity is that we need to ensure member education and consumer rights. That involves timely education about a range of things that plans have to do including enrollment and disenrollment, treatment options and alternatives. We also need to make sure that states are ensuring that plans are ensuring the rights of the individual enrollees to do consumer direction, to be in charge of their own care.

We also need to make sure that plans are providing adequate grievance and appeal processes, making people aware of what those processes are. And on the state side, monitoring the nature and frequency of these appeals. Also often using hotlines. Either states operate or they contract for the

hotlines, so they can really get a handle on what those issues are.

Then, of course, as in all aspects of managed care interface with the beneficiary, they need to be culturally competent, language-accessible, attuned to the needs of vision and hearing impaired individuals, and be at the appropriate literacy levels.

So, the components of state capacity, this is sort of getting to, what are the tools, what are the things we need? We need adequate state agency staff, and then these are all the potential partners that states could work with. I think Derek came up with the three Bs – I like them. You buy it, you build it, or you borrow it. These are the key players that you could either work with. Buy, build or borrow to develop your capacity. I'm happy to take questions at the end.

ED HOWARD: Terrific. Thank you so much, Lynda. Lynda's told us what states should be doing and now we're going to take a look at what one state actually is doing and for that we turn to Patti Killingsworth, who is the Chief of long-term services and supports for Tennessee, and Assistant Commissioner of TennCare.

She's got over a decade of experience in state health policy, both in Tennessee and Missouri, much of it dealing directly with elderly, disability and other vulnerable

populations. We're glad to get the report from the front lines. Patti.

PATTI KILLINGSWORTH: Thank you. I appreciate very much the opportunity to be a part of this distinguished panel and in particular I appreciate the opportunity to be a part of this process. Hopefully, to contribute some things that will benefit others, but also to continue to learn as we all strive to do better with respect to delivery services and supports to folks who need them.

Just real quick, setting the stage for Tennessee – we are a managed-care state and we have been for nearly two decades. Unlike a lot of states, we've had the elderly and adults with disabilities, in our managed care program since 1994 for the physical and behavioral health services. We originally had long-term services and supports carved out, but our managed-care organizations are very familiar with the population.

We had an integrated program, with respect to physical and behavioral health, before adding in the Long-term services and supports component in 2010 for the elderly and adults with physical disabilities. Our individuals with intellectual disabilities continue to have their Long-term services and supports carved out – ICFIID – I'm getting use to the new

acronyms – are out, as well as home and community based waiver services for folks with intellectual disabilities.

We do have an integrated program for the elderly and adults with physical disabilities as it relates to long-term care. That's been in place since 2010. We do pay our managed-care organizations a risk payment, which encompasses all of their physical behavioral health and Long-term services and supports. That's risk-adjusted and we can talk more about that later.

We have a number of mechanisms that give our managed-care organizations tools to effectively manage care and to help the state manage its budget, even as we move into this new integrated program. And we have a consumer direction component, which I'm happy to talk more about, too, if folks are interested in that.

What I really want to focus on, though, are several things that we believe, from a state perspective, are really key with respect to overseeing managed Long-term services and supports. I will say that, even though we've been a managed-care state for two decades, we didn't always do managed-care well. We've learned, we think, to do it well, and we're still learning every day and, hopefully, we bring all of those lessons to bear every time we move forward with a new aspect of our program.

I want to talk about the role of the Medicaid agency and our partners, a little about some of the key design elements, readiness review, and then our ongoing monitoring and oversight.

Starting with the Medicaid agency, it takes a village to raise a child and it takes more than a village to run an MLTSS program. It is a collaborative partnership, make no mistake about it. Unlike a lot of Medicaid agencies, we have not had drastic staff reductions. We have some 500 positions – not all of them filled all of the time – but almost all of them are fully dedicated to various aspects of our managed-care program. We do very little fee-for-service.

Some of the divisions – and by the way, this is not all – are listed on the slide. But you can see that they're very much targeted to a managed-care delivery system. So, we have a managed-care operations division that's focused on our contract and compliance with the contract, all aspects of that contract.

We have units who work with providers and who monitor network adequacy, via information that's provided by the managed-care organizations. We have a quality oversight division that does all sorts of things including work with our external quality review organization, and that has a care coordination unit that has nothing but folks who monitor care coordination activities that are performed by our health plans.

In the Long-term services and supports division, we have completely reorganized in the last two years and look very little like what we did before, when we operated fee-for-service programs. So, I now have an audit compliance division that receives reports on a regular basis from managed-care organizations, that follows detailed protocols, in terms of reviewing and analyzing those reports, and that conducts on-site audits of our MCOs.

I also have a quality and administration unit that really is the face of our division, with respect to interfacing with the managed-care organization. It is that technical assistance arm, as it relates to LTSS.

We have spent the last two years, in addition to integrating LTSS into our delivery system – quite frankly, integrating the Long-term services and supports division into our bureau. For many years, long-term care was carved out and we operated sort of as an island unto ourselves, in large part. It has been a learning experience for everyone in the organization to understand and embrace their role in the delivery of these services as a part of our managed-care program.

We have a member services division, just as health plans do, and that member services division has a call center

which receives calls from members, 24 hours a day, seven days a week. We have really modified our structure in that regard.

Our finance budget division, in addition to doing all the things that Medicaid agencies typically do, work constantly with an actuary. We have our own health care informatics unit that does nothing but review, analyze and counter data and use that to help us, both from a care-management and also from a cost-management perspective.

In addition to that, we have a number of contractors, and that includes other state agencies. We have contracts primarily with the Department of Commerce and Insurance, who is our insurance regulator for the state. In addition to licensing all of our HMOs, they do things like making sure that our plans have adequate reserve requirements, they monitor prompt pay requirements under our contracts and claims payment accuracy for our managed-care organization. So they have an important regulatory role for our program.

We have contracts with other state agencies, as well, and a whole host of other kinds of providers who bring tremendous expertise and depth to the things that we do every day. I won't read through all of them, but they're there for you to look at. They are an integral part of how we manage and oversee the long-term care delivery system, as a part of our managed-care program, broadly.

I don't want to neglect to mention our other partners and our stakeholders that have been key to the design, to the implementation and to the ongoing monitoring of the program. In addition to our managed-care contractors, and our other contractors, we work very closely with our providers and provider organizations, members and member advocacy groups. We have ongoing communications with legislators and, of course, taxpayers are our partners, as well, and that's an important audience that we have to think about.

I do want to just mention that, I think there's a fear that when states move into managed-care that they're sort of giving away or delegating their responsibilities to other entities. Absolutely not. You have to be integrally involved in the day-to-day operations of the health plans. We don't meet with our health plans on a monthly basis. We talk with them probably on a daily basis, certainly multiple times each week, and are very much engaged in running the program with them, to ensure that it achieves the goals and the values and the principles that we expect it to achieve.

Moving on to the next key piece of this, it is important – and we've already talked about this, so I won't spend a lot of time on it – that states define very clearly exactly what they expect from their contractors, and that they have effective mechanisms in their contracts to both

incentivize and to hold accountable those organizations for doing those things that the contracts require.

There are lots of things that states have to think about as they design their contracts, things that are very, very important to members, like freedom of choice, like continuity of care. Will I get to use the same providers? Will I get to receive the same services? What do those transition processes look like? How will care coordination actually work? Our care coordination requirements are nearly 50 pages, I believe.

Very specific time frames, and requirements about how we expect that aspect of care to be delivered in a person-centered and holistic and integrated way so that it's not a medical model, it's not a social model. It's an integrated model. And then the education outreach component also needs to be spelled out in the contract. How will that occur so that you can ensure that members are getting accurate, consistent information in order to make informationed decisions?

Finally, there's lots of things that providers really care about. Will you require MCOs to contract with them? What role will the state play in setting rates that MCOs have pay to providers? How quickly will we require that MCOs have to pay providers? What kind of training and technical assistance will be provided?

This is a whole other discussion, so I'll highlight it very quickly, but states have to have a comprehensive readiness review strategy before an MLTSS program is brought up. And it includes more than just looking at paper. It includes looking at the actual operation of the health plan and ensuring that what the paper says is going to happen is, in fact, what happens.

So, end-to-end testing and ongoing review of everything that that managed-care organization will do, from the systems they will use to the people who will perform the various functions and the actual functions themselves. We ride along with care coordinators. We observe the work that they do with our members on a regular basis, in addition to reviewing plans of care, periodically, and all sorts of other kinds of activities that we do, from an audit perspective.

And then, finally, this ongoing monitoring and quality oversight component is never really finished and we're always learning how to do it better. It is important that states really are looking at quality and the success of their program at all levels.

So, everything from, what is it that you want to achieve with your program on a systems level? And we did define a baseline data plan. I highlighted a little bit of it on the next slide. We have five key objectives and 28 measures

that we look at to see if the system is really achieving the goals that we set out to achieve, as well as detailed reporting requirements, things that we do from an audit and monitoring perspective.

We do an electronic visit-verification system that gives us real-time access to information, to know whether or not people are getting the care that they're supposed to receive when they're supposed to receive. If not, allows a care coordinator to intervene immediately to fill those gaps in care, either using another provider or a backup plan – all sorts of things that we use to discover and correct issues and then to improve the program overall, which are key.

Finally, just wrapping up – quick takeaways. I don't think any of us have all of this figured out, right? We're trying to figure it out together. So, there's always opportunity for us to learn from one another. I will say that my greatest fear, as so many states move to managed-care, and they move quickly, is that we don't mistake a failed implementation for a failed model.

It's really, really important that we understand that coordinated care, integrated care, is a good thing for people. It will improve quality. And it is, by the way, more cost effective. But the implementation takes time and it takes planning in order to go well, and I hope that this information

will help states as they move toward that so that we can really see the success of the model.

ED HOWARD: That's great. Thank you very much. Finally, we're going to hear from Debra Lipson, who is a Senior Health Researcher at Mathematica Policy Research, and principal author of the Keeping Watch report that you've been hearing about. She's been a principal analyst – many of the signature initiatives involving vulnerable populations, the dual eligibles, the PACE program, the money follows the person demo, the workforce needs these populations, and many more.

And in the granularity that we heard from Patti that goes on in TennCare, we've asked Debra to describe, in the context of the Keeping Watch report, what kind of broad selection of states that were studied measure up to the kinds of standards that we've heard from Lynda and from Patti. Debra, thank you for being with us.

DEBRA LIPSON: Thank you, Ed, and thank you to Deanna for organizing this Alliance meeting. I also want to extend my thanks to Susan Reinhard and all the team at AARP that sponsored the study and provided guidance, and oversight, throughout the process. I also want to acknowledge my co-author in the room today, Jenna Libersky, who's at this table ahead, as well as Jim Verdier, also here, my colleague at

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Mathematica who provided very important input and feedback throughout the report.

My message today is mostly a good news story. Some pioneering state Medicaid agencies have shown that oversight of managed-care programs for older adults and people with disabilities can be done very well – and you've just heard from one of the newest stars – but like so many of the stories behind the Olympic medals that have been won this week, the path to success is often a rocky one, and the achievements are very hard won.

As Lynda previewed for you earlier, and Patti amply illustrated, state oversight capacity is indeed very multi-faceted. In addition to the staff, information technology, partnerships and other resources, and the ability to perform key oversight functions, the management and integration of oversight partners, information staff, is also part of the equation.

In our study we found that, over time, the states gain experience with oversight of these types of plans, they've come to realize the advantages of a more integrated management structure that merges all – or at least most, of the oversight functions, into one department. Because that kind of a model reduces barriers to communication and information sharing across all those units, and increases the potential to monitor

the delivery of the full spectrum of services covered under the contract, from acute, post-acute, primary care, behavioral services, as well as LTSS.

Our study closely examined the types of oversight practices in the eight states with varying lengths of experience and, after we compared their practices to what federal rules technically required and what they actually did in practice, we classified their approaches into three categories.

Norms were what was essentially consistent with federal rules and regulations, or used by most of the experienced states at this point in time. Promising practices tend to go beyond those federal regulations, have a greater chance of improving plan performance, we think, or beneficiary outcomes, because they typically involve more frequent review, or require greater investments in oversight.

We also found, at least in a few cases, what we call caution flags, where they may pose a risk to beneficiaries, or have a lower likelihood of achieving overall protocols because they really involve much more sporadic or cursory oversight, or don't really apply consistently the incentives or penalties that can be so important to motivating success.

We discussed the norms and the promising practices, caution flags extensively in our report, so I won't, and I

don't have time, to go into detail now. But, I just want to give you a preview, and a few examples of some promising practices in four of the oversight capacity areas.

First, contract monitoring and performance. I have to say, before I go into this, that even the best and most intensive contract monitoring can only be as good as the requirements and specifications that are contained in the contract, itself, regarding managed-care performance.

But if we assume that the state Medicaid agency has done its homework and has clearly described its expectations for performance in the request for proposals and has chosen managed-care plans that can demonstrate their ability to meet those expectations, it is the norm for states to develop partnerships with the MCOs that they choose to promote open and honest communication about what's going well and what may not be going so well, and what to do about it.

We have found that some states, however, go further, because they very carefully and closely track the submission of all the reports that are required in the contract. They evaluate plan performance against clearly defined quality or other performance measures, and they provide feedback to those plans on what they are doing well or could be doing better.

A few states, we've also found, really make a conscious effort to raise the performance bar, over time, by providing

payment incentives and bonuses to plans that exceed the minimum performance targets.

On member education and consumer rights, at least for those plans that are serving duals, some states go beyond the norm in making integrated and coherent member education materials available to those duals. In addition to reviewing the reports that MCOs are required to submit on any grievances that they may receive from members. Some states supplement this by operating very dedicated ombudsmen staff who investigate all complaints, whether they rise to the level of a formal grievance, or not. And in some cases, that really can help to prevent problems from becoming serious risks to access or quality.

In provider network adequacy and access to services, states operating these programs can do a number of things to ensure the plans have adequate provider networks and assure access to care. For example, contracts with plans usually specify the number of providers per enrollees, or the maximum distance from a member home to provider offices, and they use HEDIS and caps, experience of care measures to monitor plan performance and quality standards.

All of that works pretty well for what I would call the regular managed-care plans that cover acute and primary care. But it's a very different thing when you're dealing with plans

that cover LTSS. Indeed, we found that some states go further on both the acute and primary care providers, as well as LTSS, by using mystery shoppers, and other ways to really get the beneficiary perspective into the equation, to make sure that the providers who are listed in those networks are actually there and accepting new patients that are members of these plans.

I can't stress this enough, for plans that do cover LTSS, standard approaches to monitoring quality are really not adequate. Remember that the people who are served by these plans often depend on someone coming to provide hands-on assistance to perform activities of daily living - eating, bathing, dressing, toileting.

Indeed, the most common long-term care service used by these individuals is personal care assistance, and to assure that that assistance is indeed provided, when it's supposed to be provided, states may use things like electronic visitation verification systems.

Patti didn't mention that, but that is one of the things that we've found extremely interesting and it's used by just a couple of states, that require home-care workers to electronically check in when they arrive and when they leave a member's home. That information feeds in, not only to the plan, but to the Medicaid agency.

We also found that some states make better use of encounter data than others. Plans are required to submit encounter data. These are service records of the actual units of service they're providing to members. They're required to submit them to state Medicaid agencies. But some states do a much better job of really maximizing that data to construct their own measures of access and quality. In the long-term care area, that would mean, for example, determining whether new members are receiving personal care assistance and other critical long-term care services, within a certain period of time after enrollment.

To say that these are promising practices sort of begs the question, so what? Do these extra efforts really make a difference? Is it worthwhile to devote more resources to building and strengthening state oversight capacity? Is there any evidence of a link between strong state oversight and good outcomes for enrollees and for changing the long-term care system toward greater use of home and community based care.

I think the honest answer we have after doing the study is, maybe. It's hard to know for sure, because state oversight is only one of many factors that influence these outcomes. Others being such things are provider care quality, health status and behaviors of the beneficiaries, and the marketplace incentives that influence plan behavior.

At the same time, we did find some encouraging indications that state oversight can improve beneficiary outcomes. We found it very interesting to look at one special study in Arizona that has been looking at care processes for diabetics over time. Remember that in many of these contracts now, they're not just covering long-term care, but they're covering the full spectrum of services and diabetes is a condition that affects many of these people.

In the Arizona program, they have found that the care processes for these folks have really improved over time due both to increasing their performance expectations of these plans on those measures, as well as targeted corrective action plans in some cases. We also found that both in Arizona and in Tennessee, there are measurable increases in the use of home and community based services among the entire population using long-term care.

And while this outcome may be due in part to the way these states set their capitation rates, we haven't dealt with that very much. It's a very technical area, but we have to at least acknowledge that. It also appears to be due to the expectations that stay set regarding care coordination and ensuring plans give beneficiaries a real choice of where they want to live and receive services.

In terms of implications for all of those states out there you heard in the beginning that are thinking of moving in this direction, clearly this is an area where the states are going to require a whole new set of skills, knowledge, resources, to do the whole spectrum of things, from developing those well-crafted RFPs, selecting qualified plans, writing specific contract requirements, and we list in the report some of the things that, from the veterans we talk to, really have to be in place on day one, when managed-care programs begin enrolling members, including the ability to monitor provider networks, determining whether personal care services are really going to be provided in a short window time after enrollment, knowing how to use the information that are in the reports that they expect from plans.

These are the issues at CMS, state policy makers, consumer advocates, all stakeholders really must assure are ready to go through thorough readiness reviews for state Medicaid agencies.

In conclusion, I just want to echo and emphasize many of the points already made. This is a whole different ballgame than traditional Medicaid managed care, and the skills and approaches used must be tailored to the needs of the population using LTSS. Fortunately, we do have some valuable experience

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to draw on from a group of states that have been doing this for many years, and learning how to do it better over time.

Even the states with experience, however, do exhibit a range of practices that suggest even they can improve in some areas. Patti was very honest in admitting that. But they also – the kinds of things that we discuss in the report, give every state a way to figure out what they are doing well and how they could, perhaps, do things better.

Finally, we need to really make sure that states who are doing this for the first time are given adequate training and technical assistance and, at a minimum, make sure that they can fulfill the federal requirements and be confident that they have the resources to prevent any harm to beneficiaries.

I'm a researcher, so I have to make a few final little caveats. First – and Patti, again, emphasized this – the practices that we describe in the report are what states were doing in the Fall of 2011, and state practices do change, sometimes very quickly. And also, for states that have been operating these programs for many years, we really didn't examine their early experience to go into the gory details and what they did wrong and how they learned from it.

And finally, until we have stronger evidence showing a link between these promising practices and improved outcomes, it's best not to regard them as best practices, but their

adoption by some of the leading states means we should pay close attention to them.

And in conclusion, I just want to express my deep appreciation to the two dozen state officials who shared their time and insights and lessons with us. They are the pioneers who had the courage to venture into a new frontier in managed-care, and their successes are an inspiration to all of those who follow in their path. Thank you.

ED HOWARD: Terrific. Thanks very much, Debra. I remind you the microphones are on either side here. You can go to those and ask your questions. Please identify yourself, if you would, and keep your question as brief as you can, so we can get to as many as we can. As you can see, members of our staff are going among you and will take the green cards on which you write your questions and bring them forward.

Let me just ask a clarifying, stupid question, and that is, is it true, in all of the states that you looked at, that the Long-term services and supports contracts were integrated with the acute care and primary care contractors that were already operating managed care?

DEBRA LIPSON: No, there were at least two, maybe three states, where the institutional and community based services are their own contract, very much separated from what's going

on on the acute care side. But in the other, I think it was five states, they were integrated.

ED HOWARD: And that presents the problem that I think both Lynda and Patti alluded to, which is making sure that you don't make sure it's somebody else's expense and the care doesn't get delivered.

DEBRA LIPSON: Yes, that's right.

ED HOWARD: Okay, very good. Yes, ma'am.

BRENDA SULICK: Hi, I'm Brenda Sulick with the National Committee to Preserve Social Security and Medicare, and our organization is working with a number of other consumer advocates from the disability and the aging community, on these issues to make sure that consumer advocate positions are represented, and I've been meeting with the duals office.

Some of the things that aren't clear to me is, as we know, states don't have a lot of experience in working with the LTSS population, so how are we going to be able to compare? I haven't seen a lot in the proposals about control groups. What if things don't work? We have these really big systems in place and how will they get dismantled once you have a big system? And how can we even compare to know if it's working?

ED HOWARD: You want to take that?

DEBRA LIPSON: Sure. Excellent question. You know, the comparisons that are made, typically are between – in all

of the evaluations of managed-care, in the past anyway, between fee-for-service beneficiaries and those in managed-care. The problem in Long-term Service and Supports, as I think just about most everybody in this room knows, is there really are no good quality or access measures on the fee-for-service side. We have a set of things in the 1915C waiver assurances that look at structure and process, but very few things that relate to outcomes.

I sometimes wonder whether we even – and again, in a state like Tennessee or Arizona or increasingly Texas and some other states that are moving this direction – there will be no fee-for-service groups to even compare this to, even if we did have appropriate measures. So there's some really big very difficult issues involved in conducting a rigorous comparison or evaluation.

That being said, I just have to say, for my part, and this comes from my experience with the Money Follows the Person program for the last five years, I've come to feel that some of the most important outcomes for those folks who are receiving Long-term Service and Supports, are not the traditional quality of care measures like HEDIS that we have typically seen, but really quality of life. And I think we've made some advances in that area and maybe that's what really we should be investing a lot more efforts in as we go ahead.

SUSAN REINHARD: There's a question that came up that came up that is related to that, if you'll just bear me, and I think it goes to Peggy. Do accreditation organizations, such as yours, accredit LTSS services and programs?

ED HOWARD: It's nice to have a qualified audience.

PEGGY O'KANE: Susan, as you know, we're working on this and we agree with the point that HEDIS measures are fine for commercially insured and for Medicare – you know we have Medicare, HEDIS measures, Medicaid – but they were never designed for these populations and that's what we're working on right now, and we agree with your point about quality of life and self-determination, I think, to a large extent being some key things to pay attention to. Thanks.

ED HOWARD: Thank you, Peggy O'Kane, from NCQA.

CAROLINE POPLIN: I'm Dr. Caroline Poplin. I'm a primary care physician. Most of my patients are older and some are disabled. This is all a very complicated, technical process of designing a managed-care program. What I don't hear is how the beneficiaries get involved in the design stage.

Now, in some cases there'll be organized groups, consumer advocates representing this particular community, Michael Lehy who just spoke. But in other states, there may not be. I wonder if there is a plan to go out an engage the beneficiaries before the managed-care plan is in place, just

because they may not understand all about the contracting, but they may know what the problems have been and they may have suggestions about where you should be looking for trouble. So that's the question.

SUSAN REINHARD: We're going to ask James.

JAMES TOEWS: It's a very good question. As we've looked at most of the states where this planning is going on, the stakeholders or the consumer groups are at the table but, as you say, this gets to be highly technical in nature and often that sort of gets lots on even some of the pretty sophisticated consumer groups.

There are a couple of federal contracts that are being let to provide direct monetary assistance to consumer groups in states to help them get organized around this. We have been working with a couple of organizations to develop consumer toolkits that really drill down in details and sort of translate managed-care language into real language so people can ask their questions and get their issues brought to that table.

We're also looking – CMS is planning to put together a website to go live that will have best practices on terms and conditions so that every consumer could go to that and say, are these reflected in the plans that my state is developing?

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So, I think there is a growing awareness that we really have to, not only bring people to the table in the design stage, but also use them effectively in the monitoring and the post implementation, as well, both at the client level and at the state level.

CAROLINE POPLIN: And at the community level?

JAMES TOEWS: Correct. I meant by the plan level, yes, at the community level.

CAROLINE POPLIN: Okay. Thank you.

LYNDA FLOWERS: Can I just add to that? One of the things that we reported in the study was that some of the best practices are where you have consumers engaged at every step of the process. And they actually then become part of the oversight team. So, they're considered vital to the oversight.

ED HOWARD: And Patti:

PATTI KILLINGSWORTH: I will just say that even though these programs are very complicated, at its core, the things that members really want are fairly simple and straight-forward. What we found to be very important was to engage them, in particular, on the topics that matter most to them. So, when we were designing requirements for care coordination or around quality or around consumer direction, we found it particularly important to convene groups that included members and representatives, as well as our managed-care organizations

and providers to really look holistically at what mattered to people as we were putting those requirements together.

ED HOWARD: Yes, Tony?

TONY HOUSNER: Hi, Tony Housner, I'm an independent consultant, formerly with CMS, and also a volunteer with the Obama campaign. I'd like to direct my question to Debra and Patti. I'd like to have you tell us more about the quality measures that you've seen out there, some of the best kind of quality measures. You've talked about quality and life and activities of daily living, but if you could give us a broader perspective? What are some of the more important quality measures that plans should be looking at and states should be looking at?

DEBRA LIPSON: We actually have an entire appendix that just lists for the eight states the kinds of quality, the reports and quality measures that they're beginning to use that specifically address these plans and the outcomes they expect for the long-term care services. I'll just highlight a couple, because there's a whole section you can dig in and click on the on-line version. I assume you can click on the websites for these states and find out what they are.

Some of the state's sort of add on a whole section of questions to either caps, experience of care, questionnaires, or other kinds of beneficiary surveys to really get at – did

they meet with a care coordinator within a certain period of time? Did they feel like their care was more coordinated? Were they asked about their wishes and desires with regard to where they wanted to live and receive services, or from whom, in a consumer directed program, or through a regular kind of case-managed system?

I guess I would say that some of those are ways of getting feedback and also constructing measures at the same time, because it sets benchmarks, in terms of the percentage of beneficiaries that are satisfied. Satisfaction is one of those measures that some people regard as very important, others diminish the importance of it, but I think, in this context, it's a very important one.

Some of the other – I'm trying to think very quickly of some of the other measures that have been developed – again, they pretty much relate to the initiation of services after a member has been referred or enrolled in a plan, again, because of the critical nature of these services to these beneficiaries. There are some others, though, that I encourage you to look at.

TONY HOUSNER: Do you look at things like whether you avoid hospitalization or a nursing home?

DEBRA LIPSON: Oh, yes, oh yes, absolutely. Those are more typical measures that would be –

TONY HOUSNER: What are some of the quality of life measures that you mentioned?

LYNDA FLOWERS: I think a lot of the measures that we identified in the report are process measures. As Debra alluded to, and Peggy as well, we're still in the process of developing outcome measures. So states are looking at things like number of home safely evaluations, shared plans that even enquire about care practices among beneficiaries, patients receiving comprehensive assessments within a certain period of time. So, it's still heavily tilted toward the process side of things. We're trying to get more toward the outcome measures.

PATTI KILLINGSWORTH: I'm excited about the work that NCQA is doing, because we really are looking forward to something that looks at structure and process and then also moves beyond that to look at member perceptions of quality, which are critical. I would add to all of those which are critically important, sort of that systems level of performance, what is it that you're trying to achieve with your overall program?

If it's rebalancing, how are you going to balance that? If it's nursing home diversion, how are you going to measure that? So you want to look both at the systems level, at the plan level, in terms of how they operationalize the program and particularly at the member level.

TONY HOUSNER: Okay, thank you.

CAROL REAGAN: Hi. My name's Carol Reagan. I work with Paraprofessional Healthcare Institute, PHI, and we advocate on behalf of quality jobs through quality care. We also run a – we have an affiliate that runs a managed long-term care plan for people with physical disabilities, in New York City. I want to ask a question about network adequacy. Thank you all for the presentation. The timing is great, information we're all eager to pore over.

My question is to you, Patti. One of the things that I think you all have done in your managed long-term care plan, that I recently learned about, which is, I think, a promising practice, is around workforce development. I saw you have contract language in there, very specific contract language around workforce capacity and identifying workforce needs and including training.

So, I have a two part question for you. One, what have you learned from the plans on that over the past couple of years? And then secondly, very specifically because I'm very interested in this, how can we, as consumers of this information, get access to those annual reports so we could read and understand a little bit more about the workforce development you're doing?

PATTI KILLINGSWORTH: We're fortunate, I think, in Tennessee in that, to date we've not faced shortages, really, with respect to having adequate capacity to serve people in the community who need services. But we did recognize early on, and quite frankly it was our partnership with AARP that helped bring it to our attention very early on, that we needed to focus on workforce development and really get ahead of that curve, which is why those requirements are in the managed-care contracts.

They are required to have and to implement workforce development strategies. One of the nice things is that this is an area where, although they've all done some of their own things, we've also come together with all three of the plans, with ourselves and with some additional partnership with non-profit entities, with the local university, and are looking at some creative strategies that will really transform the system, we believe.

In terms of developing certification training programs and bedding that with local community colleges, even trying to create a high school track that will begin to make people more aware of this as a career opportunity, doing some technology development that we can leverage to really engage people who are providing support as paid workers, in the overall quality process, as a part of the care team, if you will, and that will

also give people more choice and control with respect to the people who are directly delivery their care services. So those are things that are in development, but that we're very excited about.

In terms of what we've learned, I think we've learned that one of the great things about our health plans is that they do have tremendous resources and lots of creativity that they can bring to bear in those kinds of challenges that I think states have been grappling with for years. If you're interested in those reports, please let me know.

CAROL REAGAN: Great. Thank you so much.

PATTI KILLINGSWORTH: Sure.

ED HOWARD: Great. Now the queue is shorter here, but the queue stand longer there.

JOSH WIENER: Thank you. Josh Wiener, RTI International. Help me understand the money, because money drives it all. So, managed-care plans typically take 10-percent, 15-percent, off the top for administration. This is a complicated population, so maybe they need another 5-percent more for administration for care management and assessments and so on.

And then maybe the state is taking another couple percent off the top, cause they're supposed to be getting savings out of this. So, the plan has maybe 80 to 85-percent

of the fee-for-service expenditures to spend on care. How are they providing an adequate level of care if what they're spending is so much less for the population? Or, do I not have that correct?

PATTI KILLINGSWORTH: It's one of the primary concerns that we hear a lot from people, when you talk about moving services into managed-care. First of all, there's always a cost of administering a program. In our HCVS waivers that existed prior to our managed Long-term services and supports program, we actually paid a significant higher percentage for administrative costs than we did in our current managed-care program.

So, our administrative costs are closer to 9-percent. They're not in the double digits and, by the way, that's offset by a premium tax that covers about 5.5-percent of that 9-percent. We get a significant reduction off the cost of the administrative services.

I will say this, we expect an awful lot from our plans and they have the capacity to do things that we, as a state, could never do, from a fee-for-service perspective. The level of sophistication – all of our plans are NCQA accredited. They follow guidelines and requirements that we, as a Medicaid agency, were never required to follow and, quite frankly, could not have achieved, with respect to the way care coordination is

done. The structures and processes are in place. And the way that claims are processed. They pay much more timely than we were able to pay providers.

I understand the concerns, but truthfully, the savings is not necessarily in paying providers less, nor is it not in giving people what they need. It is in providing the right care, in the right place, at the right time. More cost efficient care tends, by the way – higher quality care tends to be more cost efficient care, as well.

So we find that when care is better coordinated, and people are receiving the right care when they needed, that the overall cost of providing care is lower. By the way, our managed-care program – again, two decades old – but our Medicaid trend rates are about half of the national Medicaid trend rates. And our average per person expenditures are about half of the U.S. average, per person expenditures. Our satisfaction rates, on the other hand, are 95-percent, an all-time high for the program. And we've seen continuous improvement in our quality measures over time.

So, is it possible to deliver quality services and also manage costs? Yes, it absolutely is possible.

JOSH WIENER: If I could ask one follow-up. Lynda, are the contracts taking a certain percentage off the top compared to the fee-for-service?

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LYNDA FLOWERS: The contracts taking off the top? I'm not sure I understand.

PATTI KILLINGSWORTH: I'm sorry, I'm not sure I understood.

JOSH WIENER: I'm asking Lynda if the capitation rates in the contract take the fee-for-service rate and then lop off a couple of percentage points? Cause otherwise it's hard to see how the states are going to get any savings from this, since otherwise the managed-care plan gets the savings.

SUSAN REINHARD: In other words, when you look at your costs, have they cut off 5 or 10-percent and then given the rest to managed care plans? Is that right, Josh?

PATTI KILLINGSWORTH: I'm going to come back to the importance of actuarially sound rates. It's very, very important that what you pay a health plan is sufficient for that health plan to be able to do the things that you expect them to do and to deliver quality services, and to pay providers a sufficient rate so that they network is fair and people get the care that they need.

First of all, we didn't implement a managed Long-term services and supports program to save money. We did it to improve quality and coordination of care. We believed that we could spend our money more cost effectively and serve more people, which we've demonstrated. We also believed that we

could rebalance our system, which we've demonstrated remarkable progress in that regard, as well.

The savings are there, but I do believe that it's perhaps penny wise and pound foolish to be overambitious in the beginning, about projecting too much savings. It takes time to implement the program, to stabilize the program, and then as you do that, and you can really dig in and begin to better coordinate care, and to see the kinds of quality improvements that are possible, the savings will come over time.

SUSAN REINHARD: I'm going to pause. We gave a question to James, so we can move on.

JAMES TOEWS: The question is regarding participant directed care. How do states maintain the integrity of this approach in managed-care? This is a really, really good question and I would say a smart state that is moving into managed-care that is, at this point, badly out of balance and over-reliant on institutional services and lacks a community infrastructure.

One of the first things you can do in terms of building a network, or network adequacy, is building a consumer directed, or participant directed, system of supporting people in their own homes, and allowing – if you look at the big states that run – not the big states, but the states that run big consumer directed programs, and offer ample hours, as well,

and allow family members and friends and neighbors to also be hired - they tend to have much lower institutional rates, they tend to support people with pretty complex, not pretty but real complex needs, in their own homes, and they don't have a labor shortage because they are drawing from natural support systems.

So this is one of the quick wins that even a state that's way behind the eight-ball can move toward, but it is a dicey thing. The consumers who have championed consumer directed care, when they start talking to some of the MCOs who say, these people are hiring their own staff. Their hiring and firing and what's the liability? It is a complex issue.

But, again, some of the states that have built these programs well, have built support systems around participant directed care that provides payroll and monitoring and training and other kind of support functions.

The other advantage of, if you really make this a key part of your managed-care program, is you also deal with the private pay issue. You create a marketplace and registries and trained workers that can also support people on the private pay side.

Again, if you're smart, in a Medicaid agency, you're thinking almost as much about the pre-spend-down group, and having a marketplace where they can buy their services and not spend down so quickly, as they do in an institutional state,

where you go into a nursing home spend-down within a matter of months.

SUSAN REINHARD: Patti, can you just say a word about Tennessee, and then we'll get to our questions?

PATTI KILLINGSWORTH: Sure. And I will say this, one of the things that we believed in implementing consumer direction in a managed-care delivery system, with all of the concerns that you just spoke about from our managed-care organizations, is that we wanted a consistent program across the state.

So, we elected, as a Medicaid agency, to hold to the contract with the fiscal employer agent, and to really specifically define exactly how we wanted consumer direction to work, right down to the HERA, the member materials that you will review with every member. And here's the piece of paper that you will have every member sign, as to whether or not they do wish to direct their services, so that we can ensure that people were getting their choice of whether to participate in that model.

We're a new program, we hadn't had consumer direction before, but just in two short years, we're a little bit shy of 10-percent of our population electing to participate in consumer direction and we're really pleased with that progress.

SUSAN REINHARD: You've been very patient.

BOB GRISSS: I didn't know I had a choice [laughter], in spite of the theme of the conference. Bob Griss, with the Institute of Social Medicine and Community Health. I have a follow-up to Josh's question about payment. Some of these presentations listed risk adjustment as one of the things that's essential. But I didn't hear any examples of how you do risk adjustment, what variables you build into that.

I'm particularly interested in whether you feel there are any implications from this work that you're reporting on, for the way bundling of payments would take place in the larger health care delivery system, where these are - where many of the patients are also people with disabilities, having range of needs that may go beyond acute care. So, I think this is - and I haven't heard anything about non-profit versus for-profit plans, as whether that makes a difference or not?

SUSAN REINHARD: Thank you, because that was one of the cards. That would be good. Deb?

DEBRA LIPSON: I just wanted to make sure that you understood that, while we looked very briefly at the rate setting approaches that were used in these states, we really didn't go into all of the nuances and details of rate setting methods. It's a very technical issue. Risk adjustment is critical. We do identify that.

There are some states that are, essentially, doing uniform standardized risk assessments, or – assessments on everybody that feed into the risk adjustment process. But, again, it's a whole separate issue and we really didn't have the time or resources to delve into that in this particular study. We don't mean to diminish the importance of that, just it's not this time. Any other comments about that one? We didn't look at the for-profit, non-profit, issue.

PATTI KILLINGSWORTH: Just one state's perspective, because I think you will find 50 different ways of doing it, and truthfully it depends on your program design, significantly. We adjust the non-LTSS component of the rate separately from the LTSS component of the rate. We adjust the non-LTSS component of the rate, as you would expect, based on the health conditions that people have and the degree of risk associated with that. We actually use Hopkins ACG.

But for the LTSS component of the rate, and it's a full-blended rate, we actually risk adjust based on service delivery setting. That's part of the way that we've purposefully aligned or developed our capitation payment to put all of the benefits in one place, and to really align the financial incentives.

So it matters if you have a higher mix of people in the nursing facility setting versus in the home and community based

setting, because you get the same payment for both. So that's how we do the non-LTSS component of the rate. We've found that to be very successful for us. I can't tell you that that's the way that other states do it, but it's working.

And with respect to profit, non-profit, we have both. And, by the way, I think both do a very good job. They obviously – pros and cons on either side, but we have both in our system.

LYNDA FLOWERS: And, I'll just speak to the non-profit, for-profit. When you talk to Pam Parker from Minnesota, she'll tell you that when they first started out with Medicaid-managed Long-term services and supports, it did rely heavily on their not-for-profit, homegrown sort of plans. As that program has developed, they've had some of the bigger plans come and play and I think there's been a lot of synergy. They've learned from each other, they have bought into the mission, and it's worked very well. I don't think she's seeing a tremendous amount of difference between quality or access or issues among those types of plans, at least in Minnesota.

CHRIS ANDERSON: Chris Anderson, I'm an independent journalist, a freelancer, and also the mother to a DD child. One of the areas that we have experienced a persistent difficulty over quite a while, with consumer directed as well

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as other based services, are in the compensation side, for providers, for individuals who come to work with the children.

It tends to be a very low rate. So what you find is that, once someone comes and works with the child, and gets used to working with a child, or a group of children, and then decides that the pay rate is so low, they go off and working someplace else. So we have this constant sort of traffic through the – and I'm wondering if there's any thought to how that could be addressed in designing, or changing, as we go forward?

PATTI KILLINGSWORTH: I think in any health care delivery system, you're always trying to balance the need for balancing services in the most cost-efficient manner that you can, while also ensuring that the rate that you're paying for services is sufficient to maintain an adequate – whether it's network of providers, or whether it's network of directly-employed workers who are delivering care. It's just one of the things that states have to continue to evaluate, and that managed-care organizations have to continue to evaluate.

If you are monitoring the adequacy of the network, if you are making sure that people are accessing care in a timely manner, that helps you to ensure that the rates are sufficient to be sure that people have access to care. I think that one of the things that all states are looking at over time, with

respect to workforce development, though, is really how to incentivize things that we know are directly related to quality, like turnover. It's one of the most important factors.

So, maybe there will be opportunities in the future to really sort of reward longevity and build some of those things in for providers who try to help ensure that people have the same staff providing their support over time.

ED HOWARD: Either Patti or Debra, or Lynda, is the wage level that's being paid by your plans part of what you get back from each of these plans, in your data requirements?

PATTI KILLINGSWORTH: We may be a little bit unique in this regard, too, and this is the only aspect of our program where we actually set all of the rates that are paid. In every other aspect of our managed-care program, the managed-care organizations negotiate the rates with providers. In our LTSS component of the program, we set the nursing facility rates.

We also set the home and community based services rates, and we have a range of rates for consumer direction from which members can choose. We provide some guidance, in terms of things they need to think about – weekends versus weekdays, nights versus daytime, the degree of physical assistance that's required – those kinds of things. But they do have flexibility and we continue to monitor, again, those rates with respect to

all the kinds of things that I've already talked about, to ensure that they're adequate.

DEBRA LIPSON: And I know of at least one of the states that we examined was sort of forced into doing something like that as a result of a lawsuit [laughter].

EILEEN CARLSON: Good afternoon, my name is Eileen Carlson. I'm with the American Nurses Association and, first of all, I just want to applaud AARP for what seems like an absolutely fabulous report, and for looking at this crucial, crucial issue. And also, as a nurse with significant experience with dual-eligible's, I have a question that I think this panel could really shed some light on.

I was having a conversation with a state Medicaid official who pointed out, as has been pointed out here, there are 50 different types of Medicaid systems across the country. I know – I believe CMS has done some efforts in quality issues in Medicaid that would apply across the board. I think the rule I believe that was recently released, is very limited in scope.

My concern is that we're creating and incentive for 50 different quality entities to be duplicating the same thing in every state. I'd like you all to address the issues between what the federal government can and should be doing? And what should be left to each state? I understand that each state has

a distinct population and its own distinct program, but Medicaid is also funded, to a great degree, by the federal government, and it just seem that there would be greater efficiency in establishing quality requirements across the board.

DEBRA LIPSON: We heard very loud and clear, in our interviews with the state Medicaid officials, that they would love to have some standardized, national quality measures that were appropriate for this population, and the services that we're talking about here. If even a handful are just crying for that – because they want to be able to benchmark their own plans with those national standards. They don't want to have to create the measures themselves each time. It's an absolutely essential need.

I think CMS heard that. There have been some efforts over the last several years. They have not, necessarily, come to a lot of fruition, but I know that many, many people in the long-term care quality arena are actively working to develop some of those measures.

LOUISE RYAN: Good afternoon. My name is Louis Ryan. I'm with the Administration for Community Living. I wonder if Debra could give a little more insight into the ombudsman best practice? And in particular, are those ombudsmen independent

of the managed-care organizations? Or a part of? Or, if you could just talk more about that.

DEBRA LIPSON: Real quickly, at least in a couple of states, I believe it's a unit within state government – I'm not sure which department it is – it may be something that is more relevant for states that have more and more of their total enrollee population who are enrolled in these plans. So it may be an issue of economies of scale. So it really makes sense to have a dedicated ombudsman program, when you're reaching a certain percentage of the population who are in these plans. So there may be that element involved.

But, it's really – they operate 24-hour call lines, that are not the plan's calls line, and not the state Medicaid agency – but people who are prepared to address a full range of problems that may come up.

ED HOWARD: We have time for just a couple more questions that have come up on cards and I would ask that, as you listen to those questions and the responses, that you pull out those blue evaluation forms and fill them out.

SUSAN REINHARD: So you have to do two things at once. You can do it. This is a question that is certainly very near and dear to my heart, and conversations that we've had within AARP, just today I think we were talking about it. That is, what are some specific benefits for family caregivers? And how

do you see this population as a growing trend in providing services.

I think James talked about family members being able to be part of consumer direction, self-direction, and so I trust that was – but we are also concerned, or want to explore more about, family caregivers as they are now going to interact more and more with managed-care organizations.

AARP, and many others in this audience – I know some have left already – have been for years trying to get attention to the needs of family caregivers. We say it, address and assess, the needs of family caregivers. Particularly, those that are already directly involved in helping people stay home, for example. I think James point earlier was really critical.

If you have carved out nursing home care – although Minnesota seems to have done that pretty well with a 180-day kind of cap – but if you carve it out, we are concerned that managed-care companies or organizations may not feel the same need to support family caregivers, because you might as well just go right into the nursing home, and then you're not part of my capitation anymore. That's just a worry. We don't know that, we've had one roundtable on it. We continue to explore that.

So, we just want to let you know that we want the family care organizations to start thinking about this with us,

and we will continue doing work with it. But we think that they're essential, obviously, in Long-term services and supports.

We also have time for one more question, I hope, for Patti. How has TennCare tackled the challenges posted by the restrictions of Long-term services and supports, managed-care implementation in rural communities, such as transportation time, lack of high-speed internet, etc.? I thought that might interest the audience.

PATTI KILLINGSWORTH: In terms of rural areas, it is one of the areas where, quite frankly, where probably that natural support network and some of the non-traditional caregiving opportunities becomes really, really important. So, having consumer direction as an option is certainly very important in rural areas.

By the way, we do require that managed-care organizations have providers available in all rural areas of the state, in every county, they have to have providers available, so that people always have the choice of contractor providers to deliver any service, even in rural areas of the state. The nice thing about so many Long-term services and supports, is that they are delivered in the person's home.

So, it matters less where the provider is located, than it does whether than provider is really willing to travel, or

to have staff who are available to travel, to wherever a member is located in order to deliver services.

For services that are facility based, like adult daycare, we do have time and distance standards for our managed-care organizations, and if they can't meet that time and distance standard – maybe there isn't an adult daycare program located within that area – then we require them to provide transportation if people want to participate in that, or obviously to offer an alternative benefit that would meet the needs of someone who's family caregiver may work during the day.

And that sort of ties back to the first question, too, about caregiver supports. One of the things that we require, is that our managed-care organizations, when they do a comprehensive assessment, a piece of what they asses is the natural support network.

They're obligated to do that. They're obligated to look at what our family caregiver's doing. What's their capacity to continue doing that? Do they need respite care? Do they need adult daycare services? Do they need things to help sustain that network over time?

SUSAN REINHARD: I don't think we'll have time to answer this. Is Sarah Lass still here, from the National

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Quality Forum? This is a fabulous question. I just want to at least share it with the audience, because it's very insightful.

The question is, which entity should monitor or measure which entities? So, for example, do plans measure their networks? Do states measure their plans? Does a national organization measure all or most of the states? And, given the diversity of state experiences and lack of measures, is there any hope for standardization [laughter]? That's like a whole panel! If there's anyone that wants to say anything, please do.

ED HOWARD: We'll have a panel on that next year.

LYNDA FLOWERS: The only thing I would say is, it sort of raises the question of should there be a mandatory expanded role for the EQRO, or the external review process? Right now, federal law only requires three domains where you have to have validations. So, it sort of raises a question in mind whether or not that should be broadened, and, we could talk about that more?

ED HOWARD: I think we have squeezed an awful lot out of this time period on a very important topic. I want to thank you all for staying with it. It got pretty granular and I saw a lot of nodding heads at times when some audiences would have been nodding off.

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I want to thank our friends at AARP's Public Policy Institute and their outstanding director, for her co-moderation. And, I'd like to ask you to join me in thanking our panel for a wonderful presentation.

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