



Long Term Care Workgroup

January 22, 2015

Purpose of Workgroup

- State law establishing RCOs in 2013 mandates:
 - The Agency conduct an evaluation of the existing long-term care system for Medicaid beneficiaries with input from long-term care providers
 - Report its findings to the Governor and Legislature on 10/1/15

Plan for Workgroup

- Review Medicaid Long Term Care Programs, Expenditures, and as a percentage of all Medicaid spending
- Review of how other states have incorporated LTC into Managed Care
- Openly Discuss Alabama's options for LTC in a Managed Care Model
- Meet Regularly for discussion and feedback
- Report to the Governor and Legislature on 10/1/2015

CMS Definition of Long Term Care

- Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living, like dressing or bathing.
- Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes.
- Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

Alabama Long Term Care Population

- In Alabama, individuals in need of long term care services include:
 - The elderly, young adults, and children with physical and cognitive impairment
 - Individuals of all ages with intellectual disabilities, developmental disabilities, debilitating conditions, TBI, HIV/AIDS
 - Individuals with functional limitations resulting from a physical condition, including stroke, dementia, and similar conditions associated with the aging process
 - Individuals who require assistance in performing activities of daily living (ADL) and independent activities of daily living (IADL).

Alabama Long Term Care Services

- **LTC Facilities**
 - Nursing Facilities
 - Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)
- **Community Long Term Care**
 - Seven HCBS Waivers
 - Hospice
 - Private Duty Nursing
 - PACE

LTC Spending

LTC Expenditures FY08-14 (mil)							
	2008	2009	2010	2011	2012	2013	2014
LTC Facilities	\$864	\$910	\$911	\$932	\$930	\$903	\$935
HCBS Waivers/PACE	\$350	\$370	\$373	\$390	\$370	\$368	\$393
Hospice/PDN	\$53	\$54	\$54	\$56	\$62	\$62	\$60
Total LTC Spending (bil)	1.268	1.336	1.330	1.379	1.363	1.334	1.389

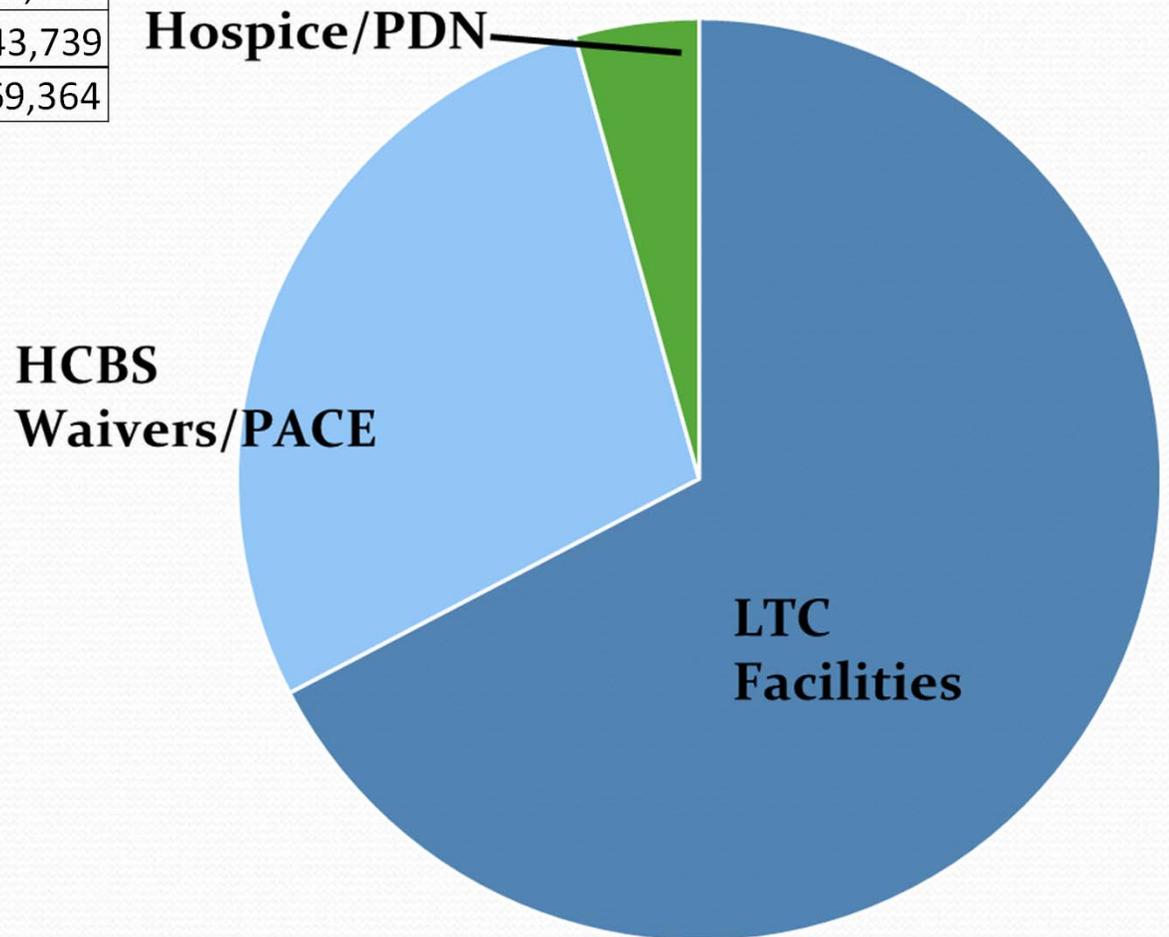
	2008	2009	2010	2011	2012	2013	2014
Total LTC Recipients Served	45,038	44,433	44,566	43,793	45,765	42,724	42,917

LTC Spending

	2008	2014	Percent Change FY08-14
Total LTC Recipients Served	45,038	42,917	-4.71%
Total LTC Spending	\$1,268,055,300	\$1,389,069,364	9.54%

LTC Expenditures 2014

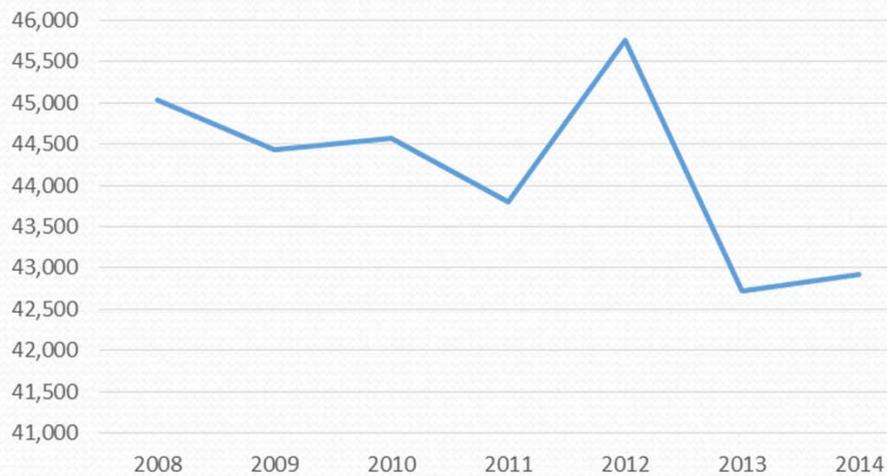
Fiscal Year	2014
LTC Facilities	\$ 935,537,528
HCBS Waivers/PACE	\$ 393,088,097
Hospice/PDN	\$ 60,443,739
Total	\$ 1,389,069,364



LTC Spending

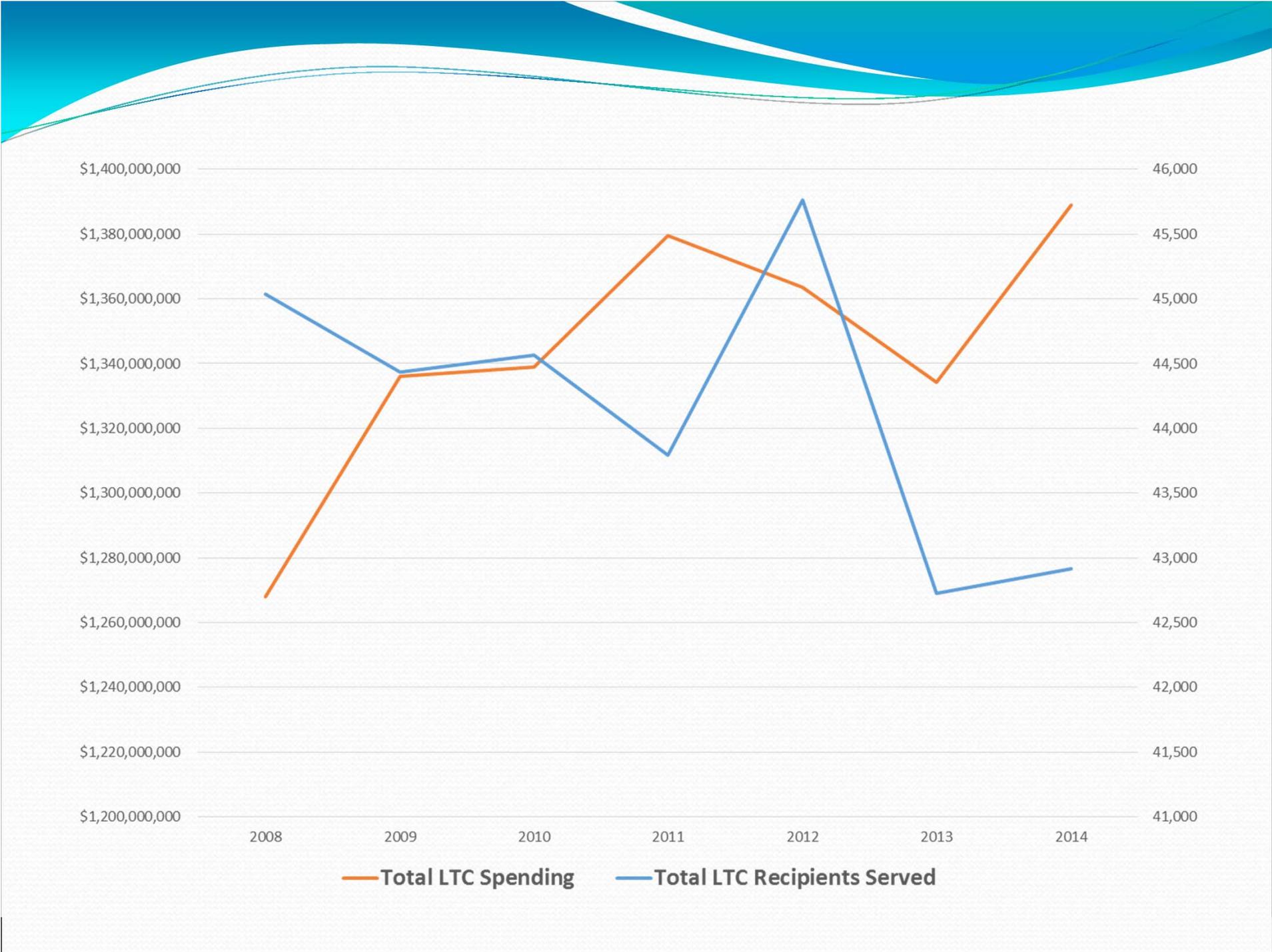
	2008	2009	2010	2011	2012	2013	2014
Total LTC Recipients Served	45,038	44,433	44,566	43,793	45,765	42,724	42,917
Total LTC Spending	\$1,268,055,300	\$1,336,154,395	\$1,339,024,399	\$1,379,422,503	\$1,363,606,777	\$1,334,142,756	\$1,389,069,364

Total LTC Recipients Served



Total LTC Spending

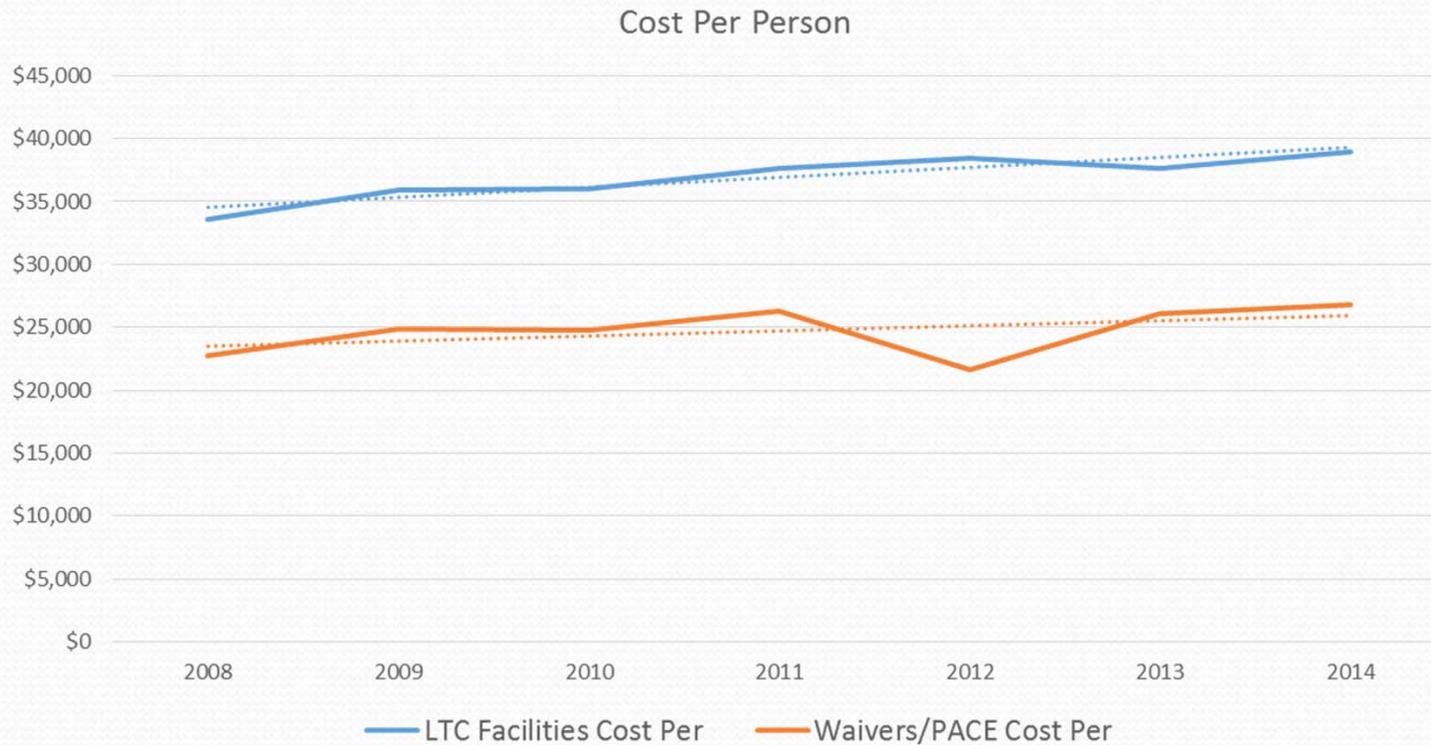




LTC Cost Per Person

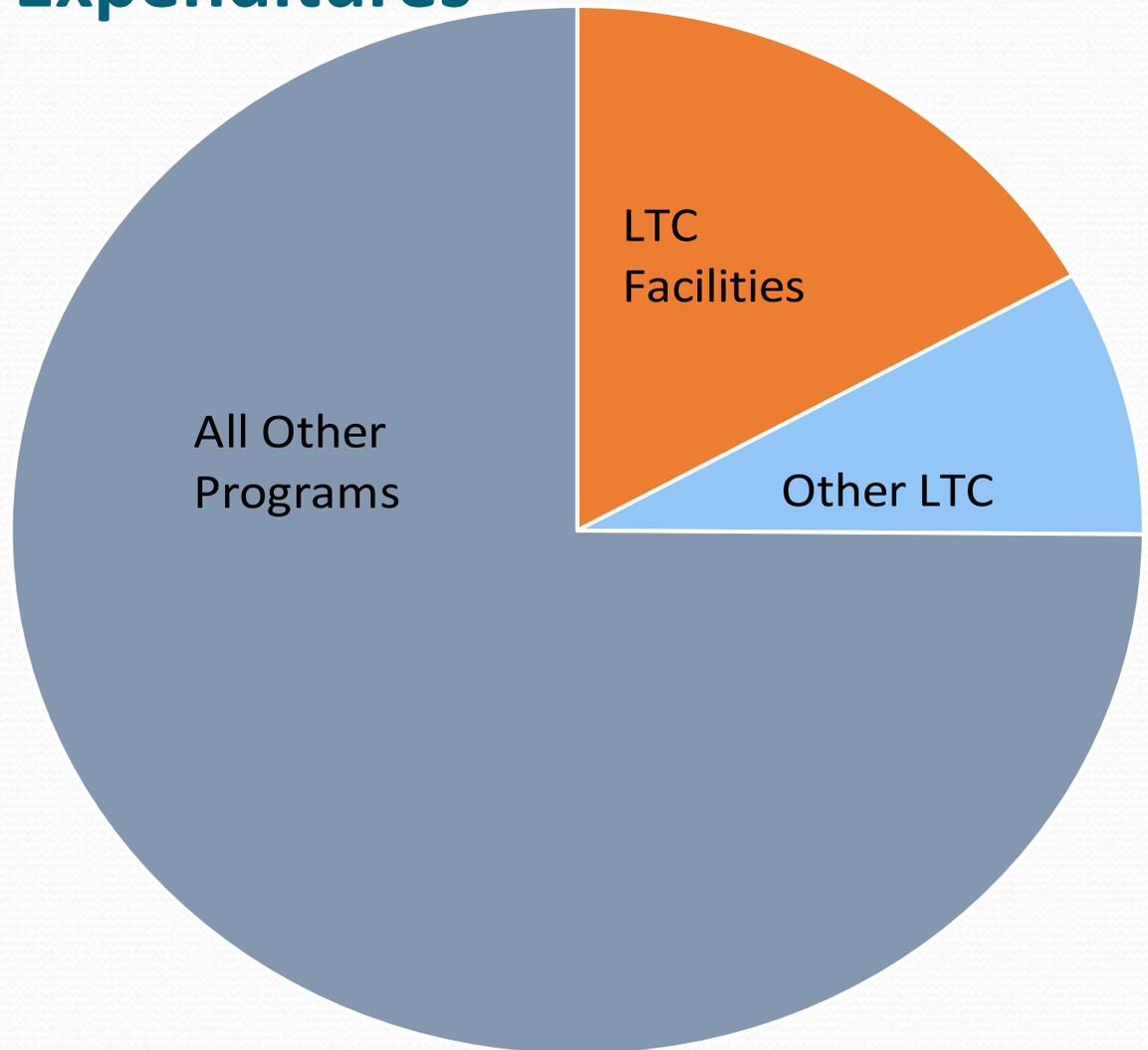
	2008	2009	2010	2011	2012	2013	2014
LTC Facilities Cost Per	\$33,603	\$35,864	\$36,053	\$37,626	\$38,467	\$37,647	\$38,971
Waivers/PACE Cost Per	\$22,772	\$24,893	\$24,792	\$26,243	\$21,589*	\$26,119	\$26,805

*ADPH E/D Waiver recipients moved to ADSS



LTC Expenditures compared to all Medicaid Expenditures

Fiscal Year	2014
LTC Facilities	935.5
Other LTC	453.5
All Other Programs	4.140
Total Program Expenditures	5.529



MLTSS Basics

- Managed Long Term Supports and Services (MLTSS) is defined as the delivery of LTSS through capitated managed care arrangements
- MLTSS Options:
 - Mandatory versus optional enrollment
 - Cover all or certain LTSS populations
 - Geographic area
 - Medicaid authority (§1915(b) or 1115 waivers)
 - Inclusion of dual-eligible members
- States are increasingly incorporating MLTSS programs for seniors and people with disabilities into Medicaid managed care as a way of better coordinating Medicaid and Medicare services and increasing beneficiary access to home and community-based services (HCBS)
 - In addition to expanding beneficiary access to HCBS, MLTSS can introduce new service delivery concepts (i.e., person-centered planning, self-planning and independent living)

States with MLTSS

- 21 states currently have MLTSS
- 18 states cover HCBS waiver populations

§1115 Waivers: 12 States	§1915(b)(c): 6 States	§1932 SPA: 3 states
Arizona	Florida	South Carolina
California	Illinois	Virginia
Delaware	Michigan*	Washington
Hawaii	Minnesota	
Kansas	Ohio	Note: these states do NOT include HCBS waiver populations in managed care
New Jersey	Wisconsin	
New Mexico		
New York	*MI has 2 (b)/(c) waivers	
Rhode Island		
Tennessee		
Texas		
Vermont		

MLTSS States

Of the 18 states that cover HCBS waiver populations by managed care, the following characteristics apply:

Number of States	Characteristic
11	Waivers have been approved since 2012
18	Include seniors and adults with physical disabilities, and dual-eligible members
5	Includes persons with ID/DD* (AZ, KS, MI, RI, WI)
14	Provide statewide MLTSS
16	Have mandatory enrollment
3	Do not cover institutional care (SNF) via managed care (MI, TX, WI, but TX will start in March)

Source: Musumeci, Marybeth. "Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers." Kaiser Family Foundation. November, 2014.

State Example: Texas

- Texas first created its MLTSS program in 1998 under a 1915(b)/(c) waiver, but transitioned to 1115 waiver authority in 2011
- Services are delivered through providers contracted with large, national MCOs
- While institutional services are currently carved out of the MCO benefit package, they will be carved in effective March 2015
- As of September 2011, Day Activity Health Services were added to the STAR+PLUS waiver; this amendment provided nursing and personal care, physical rehabilitation and HCBS services to individuals who are eligible for STAR+PLUS ,but exceed the financial requirements

Texas Summary

Program Name	STAR+PLUS
MLTSS Approval	1998 (1915(b)/(c) wavier); 2011 (1115 waiver)
Populations Included	Seniors, Individuals with Physical Disabilities (including duals)
Geographic Area	Statewide
Benefits Included	Institutional, HCBS, Acute/Primary, Behavioral Health

State Example: New York

- New York first launched its managed long term care program in 1998 in select counties, and is currently engaged in a phased-in implementation of mandatory managed long term care statewide
- The State is scheduled to transition nursing home populations into managed long term care in 2015
- The State is partnering with Maximus to implement a Conflict-Free Evaluation and Enrollment Center, which will provide initial evaluations to determine eligibility for community-based long-term care
- The State is developing a proposal to withhold a certain amount of money from premiums to create a quality incentive pool for managed long term care plans

New York Summary	
Program Name	Managed Long Term Care Program
MLTSS Approval	1998 (1115 waiver)
Populations Included	Disabled adults and children; dual eligibles (excludes partial duals)
Geographic Area	Select counties – expected to expand statewide by end of February 2015
Benefits Included	Primary care/outpatient services; institutional long term care; personal care; HCBS; dental; transportation

CMS MLTSS Guidance

CMS issued guidance in May 2013 that identified 10 “Best Practice” elements

1. Adequate planning and transition strategies for the design and implementation of MLTSS programs
2. Stakeholder engagement in the planning, implementation and oversight of MLTSS programs
3. Enhanced provision of HCBS that offer the “greatest opportunities for active community and workforce participation” and operate consistently with the ADA (American with Disabilities Act), the Olmstead decision (Supreme Court decision that rules that individuals with mental disabilities have the right to live in their communities rather than an institution) and CMS’s home and community-based setting requirements
4. Alignment of payment structures with MLTSS programmatic goals, such as community integration and the inclusion of performance-based incentives and/or penalties
5. Support for beneficiaries, including conflict-free choice counseling, independent advocacy or ombudsman services and enhanced opportunities for disenrollment

CMS MLTSS Guidance

CMS's MLTSS Best Practice Elements, continued:

6. Person-centered processes, including needs assessments, service planning and delivery as well as supports for self-direction
7. A comprehensive integrated service package, including physical health, behavioral health, institutional services and HCBS
8. Qualified providers, including adequate capacity and expertise to provide services that support community integration
9. Participant protections, including safeguards to prevent abuse, neglect and exploitation as well as fair hearings with continuation of services pending appeal
10. Quality, including quality of life measures



Next Steps