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Trends in Reforming Medicaid's Long-Term Services and Supports (LTSS) System

July 27, 2016

Agenda

The Role of LTSS in the Care Continuum

The Imperative for LTSS Reform

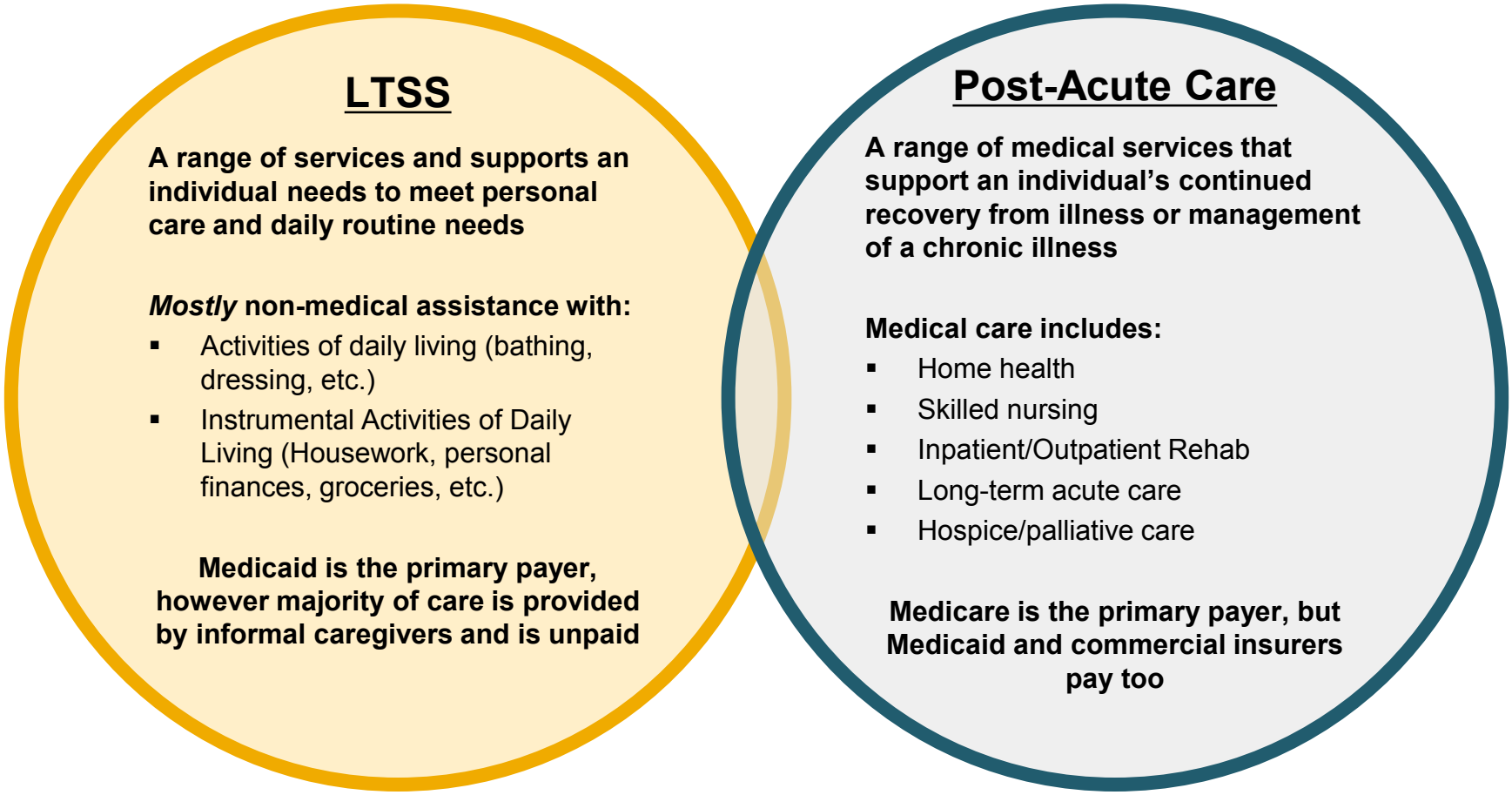
Moving Toward a New Vision for LTSS

Foundational Reforms: Challenges and State Strategies

Conclusion and Q&A

Defining Long-Term Services and Supports (LTSS)

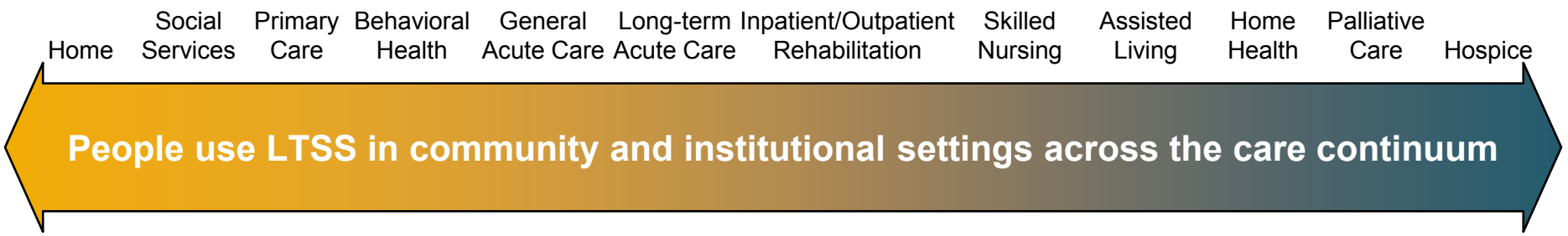
LTSS are provided on an ongoing basis and help people with disabilities, disease, and chronic conditions live independently and participate in their communities, to the extent possible



LTSS Are A Vital Part of the Care Continuum

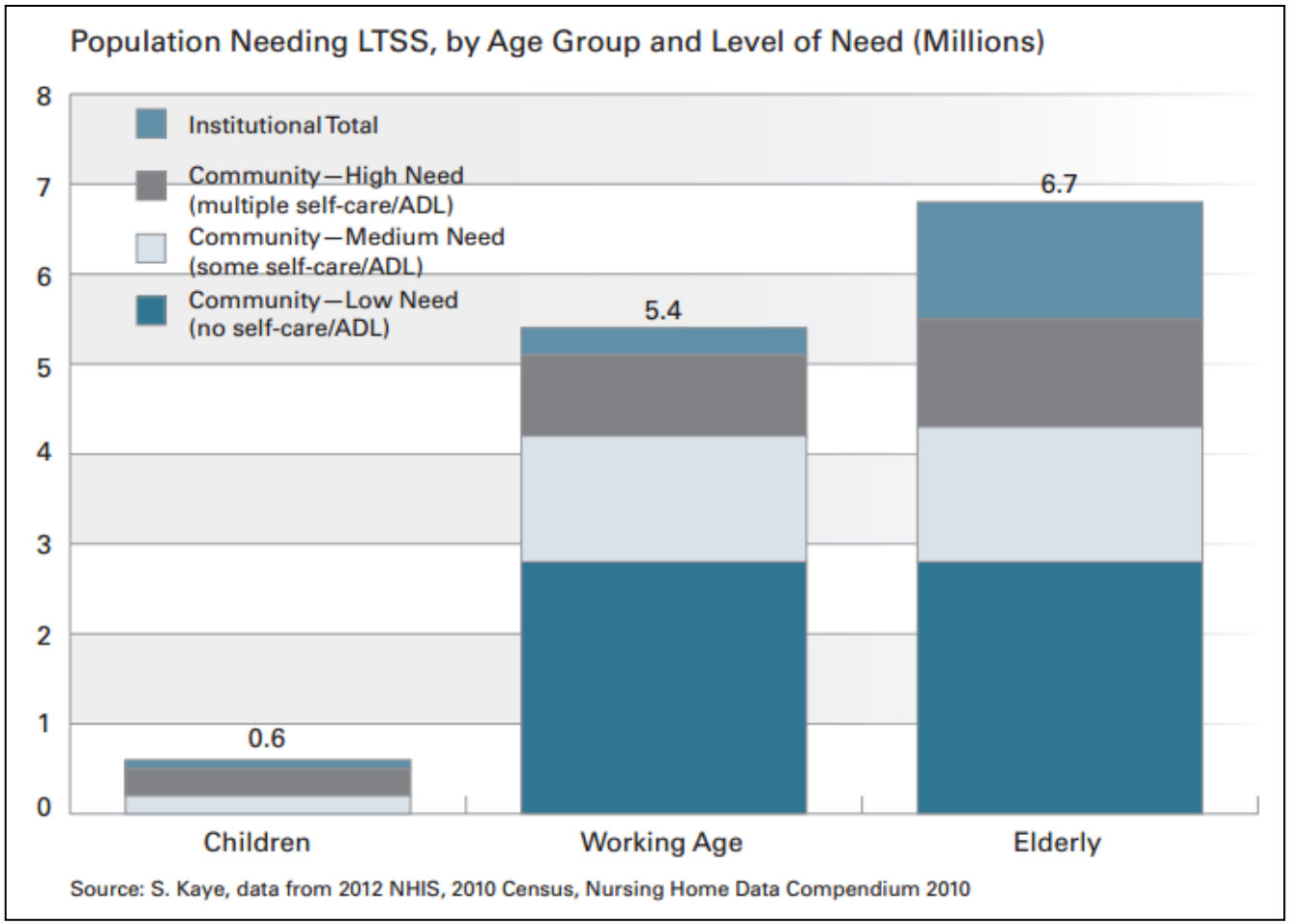
Long-term services and supports (LTSS) include a range of services that people with disabilities and chronic conditions use to meet their personal care and daily needs in order to promote independence, support their ability to participate in the community, and increase overall quality of life, to the extent possible, such as:

- *Care coordination*
- *Homemaking services*
- *Medication management*
- *Laundry / chore*
- *Meal preparation*
- *Day habilitation*
- *Adult day health*
- *Personal care services*
- *Home health care*
- *Private duty nurse*
- *Physical therapy*
- *Skilled nursing care*



People of All Ages Use LTSS, But Needs Vary Significantly

Nearly half of the over 12 million people needing LTSS are under age 65 and many have medium to high needs



Source: *Report to the Congress,* Commission on Long-Term Care, September 2013.

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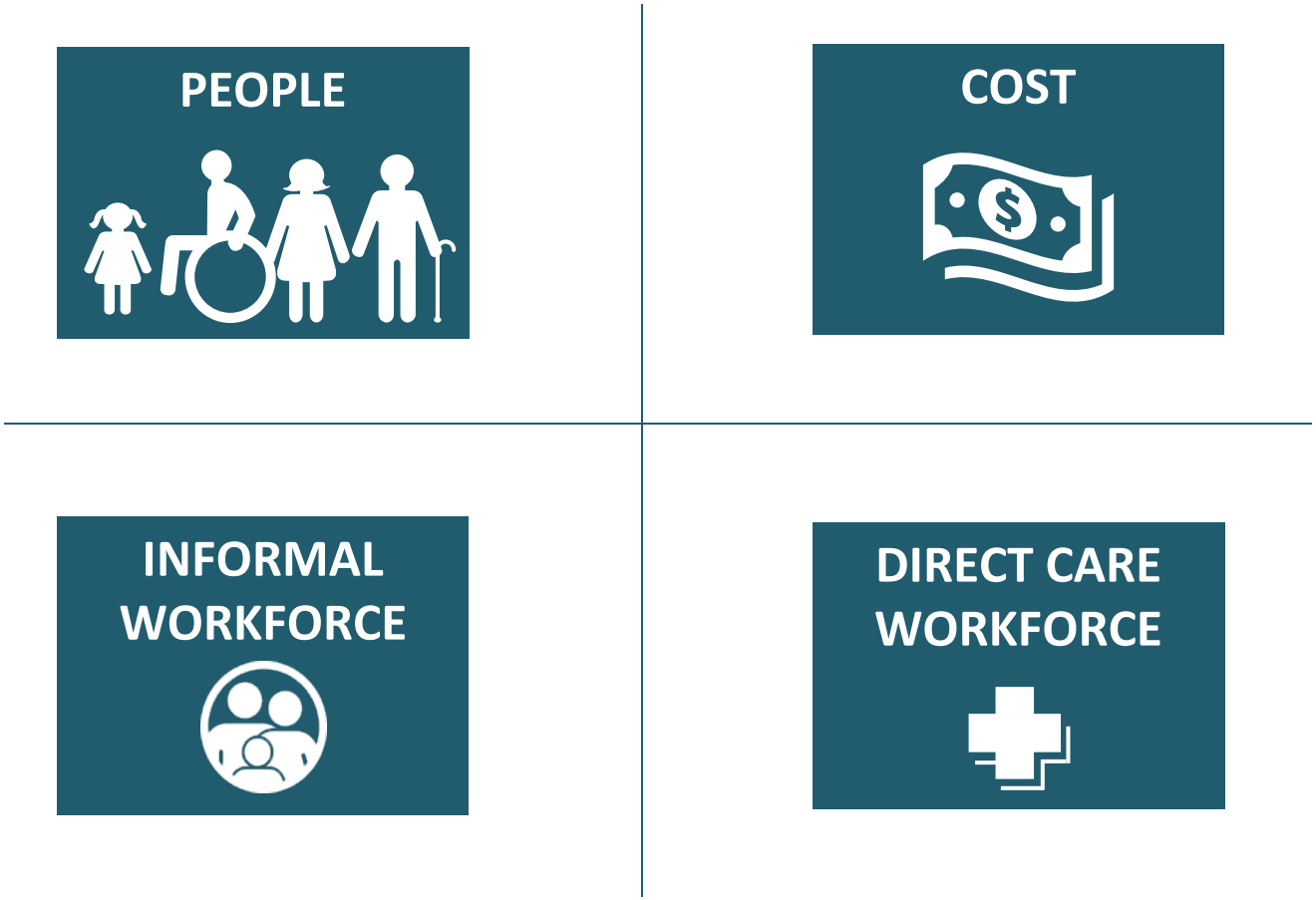
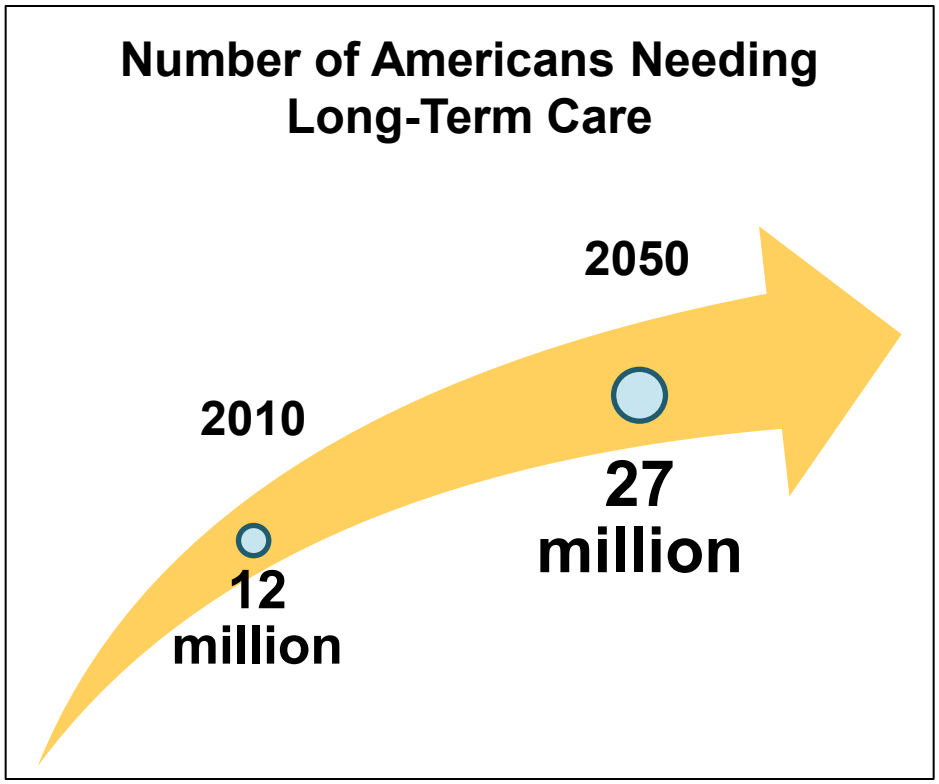
Imperative for Reform

Many states face persistent challenges in their LTSS systems that inhibit access to person-centered, high-quality LTSS and threaten Medicaid's long-term sustainability



Imperative for Reform

Demographic changes and medical advances are increasing the demand for LTSS



Estimated Population Growth of those aged 65+	
2014	46.2 million
2060	98 million
% Change	**112%**

Estimated Population Growth of those aged 85+	
2014	6.2 million
2040	14.6 million
% Change	**135%**

Sources: *Report to the Congress,* Commission on Long-Term Care, September 2013; *A Profile of Older Americans: 2015*, Administration on Aging, 2015.

Imperative for Reform

Few people adequately plan for, or even think about, LTSS until they need it

Over 5 in 10 Americans 40+ report having done little to no planning for their long-term care needs

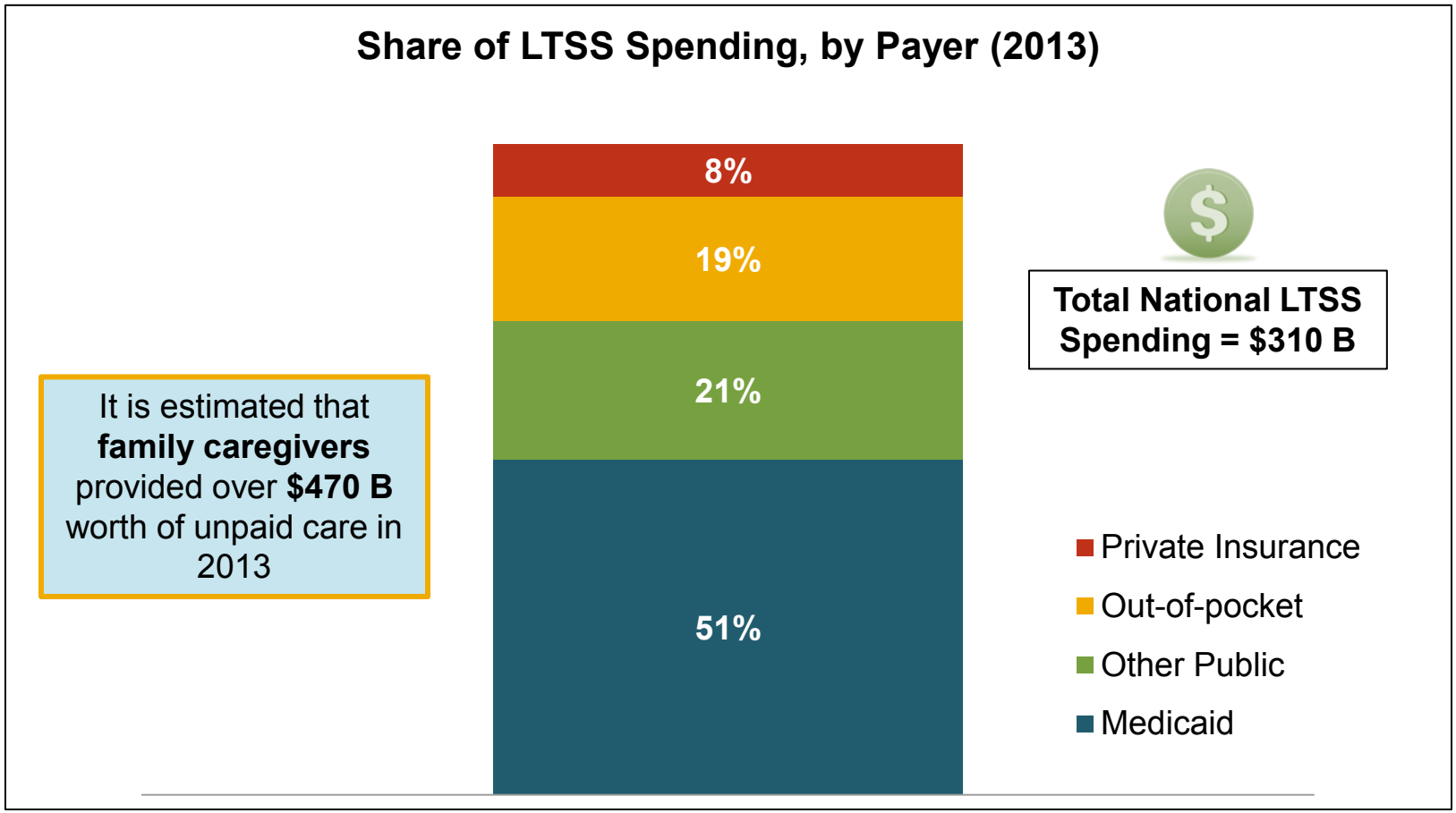
Nearly 4 in 10 Americans 40+ mistakenly believe they will rely on Medicare to cover long-term care costs

Only 2 in 10 Americans 40+ report having long-term care insurance from a private company

Sources: *Long-Term Care in America: Expectations and Preferences for Care and Caregiv*ing, The Associated Press and NORC, May 2016; *Pathways to Progress in Planning for Long-Term Care*, Langer Research Associates, August 2013.

Imperative for Reform

Medicaid is the primary payer for LTSS, covering over half of all LTSS expenditures in 2013



Sources: *Medicaid and Long-Term Services and Supports: A Primer*, Kaiser Family Foundation, December 2015; *Valuing the Invaluable: 2015 Update*, AARP Public Policy Institute, July 2015.

Imperative for Reform

Spending on LTSS is reaching unsustainable levels, with LTSS accounting for nearly a third of all Medicaid spending

National estimates project the rate of spending growth for Medicaid LTSS to be more than 3 times that of Medicaid overall

National Spending

Total federal and state Medicaid LTSS spending was $152 billion in FY 2014 and accounted for a third of total Medicaid spending

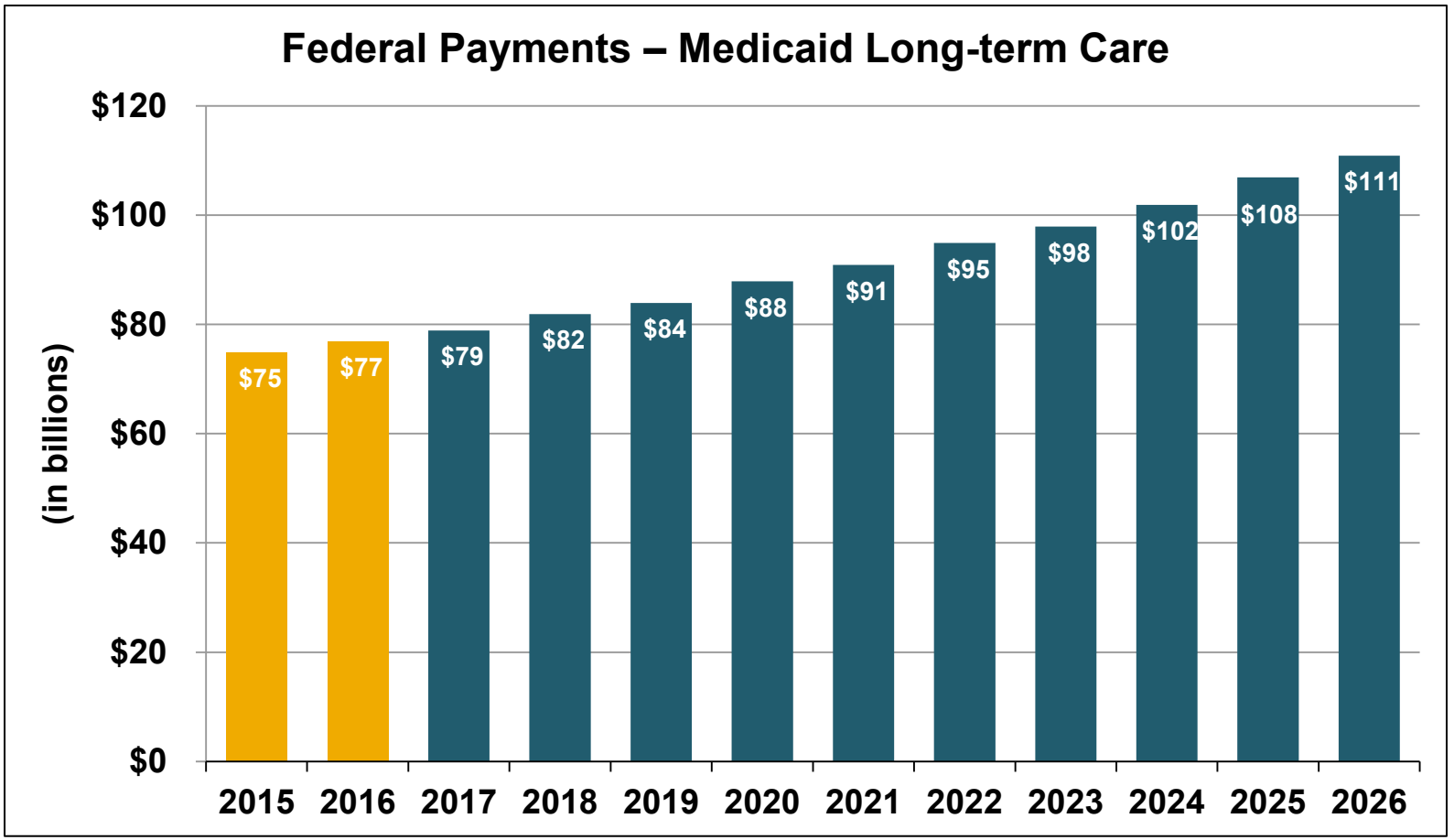
State Spotlight

LTSS provided by MassHealth, Massachusetts' Medicaid agency, already account for $4.5 billion (including federal Medicaid matching funds), or about 12% of the state budget

Source: Manatt Health analysis of CBO Data, 2013; *Medicaid Expenditures for LTSS in FY 14*, Truven Health Analytics, July 2016; *Massachusetts Long-Term Services and Supports: Achieving a New Vision for MassHealth,* MMPI and Manatt Health, May 2016.

Imperative for Reform

Federal LTSS costs are projected to increase by more than 44% in the next decade



Source: CBO Baseline Budget Estimate, March 2015

Imperative for Reform

The nation's LTSS workforce is overwhelmingly built on a foundation of informal, unpaid caregivers

In 2009, it was estimated that **more than 8 in 10** of Americans who need long-term care received it from informal caregivers

More than 4 in 10 Americans 40+ report having past or current experience providing long-term care to family or friends

$470 billion

estimated worth of unpaid care provided by families caregivers (2013)

Source: *Caregiving in the US,* National Alliance for Caregiving & AARP, November 2009; *Long-Term Care in America: Expectations and Preferences for Care and Caregi*ving, The Associated Press & NORC, May 2016; *Valuing the Invaluable: 2015 Update*, AARP Public Policy Institute, July 2015.

Imperative for Reform

Informal caregivers face great physical, emotional, and financial stressors and the availability of family care givers is declining

The ratio of potential family caregivers for individuals ages 80+ is estimated to rapidly decline

Ratio of family caregivers to individuals ages 80+	
Year	**Ratio**
2010	7:1
2030	4:1
2050	3:1

40-70%

of caregivers have clinically significant symptoms of depression and studies consistently report higher levels of mental health problems for this population

$304,000

average lifetime wage and benefit loss for family caregivers who leave the workforce to care for a parent

Source: *Valuing the Invaluable: 2015 Update,* AARP Public Policy Institute, July 2015; Understanding the Impact of Family Caregiving on Work, AARP Public Policy Institute, October 2012; *Caregiver Health*, Family Caregiver Alliance.

Imperative for Reform

It is estimated that the direct-care workforce will add 1.6 million new jobs by 2020, totaling nearly five million people and becoming the largest occupational group in the country

Occupation	Number of New Jobs (projected), 2014-2024	Rank (out of 20)	Median Annual Wages (2015)
Personal Care Aide	458,100	1	$20,980
Home Health Aide	348,400	3	$21,920
Nursing Assistant	262,000	6	$25,710

Source: *Most New Jobs*, Bureau of Labor Statistics, December 2015.

Imperative for Reform

The supply of direct care workers is inadequate to meet increasing demand, in part due to a lack of incentives

From 2003-2013 the rate of workers leaving direct care occupations outpaced the rate of those entering

Direct Care Workers Face Many Challenges:

- Low wages
- Trouble finding affordable housing
- Often work less than 40 hours/week
- Receive little training
- See few career options beyond their current position

Source: *Massachusetts Long-Term Services and Supports: Achieving a New Vision for MassHealth,* MMPI and Manatt Health, May 2016; *Entry and Exit of Workers in Long-Term Care*, UCSF Health Workforce Research Center on Long-Term Care, January 2015.

Imperative for Reform

Increasing Demand for LTSS + **Rising Costs** + **Workforce Pressures** + **Lack of Meaningful Quality Measures**

x

Lack of integration into the healthcare system

=

An LTSS system that may be providing suboptimal care while also creating serious budget pressures on the Medicaid program

- The fragmented LTSS system is difficult to access and navigate and not well understood by consumers, caregivers, or health care systems
- Care is not always aligned with consumers' needs and preferences or payer goals to prevent unnecessary utilization of avoidable medical interventions and admissions
- ***The stakes are too high for inaction***

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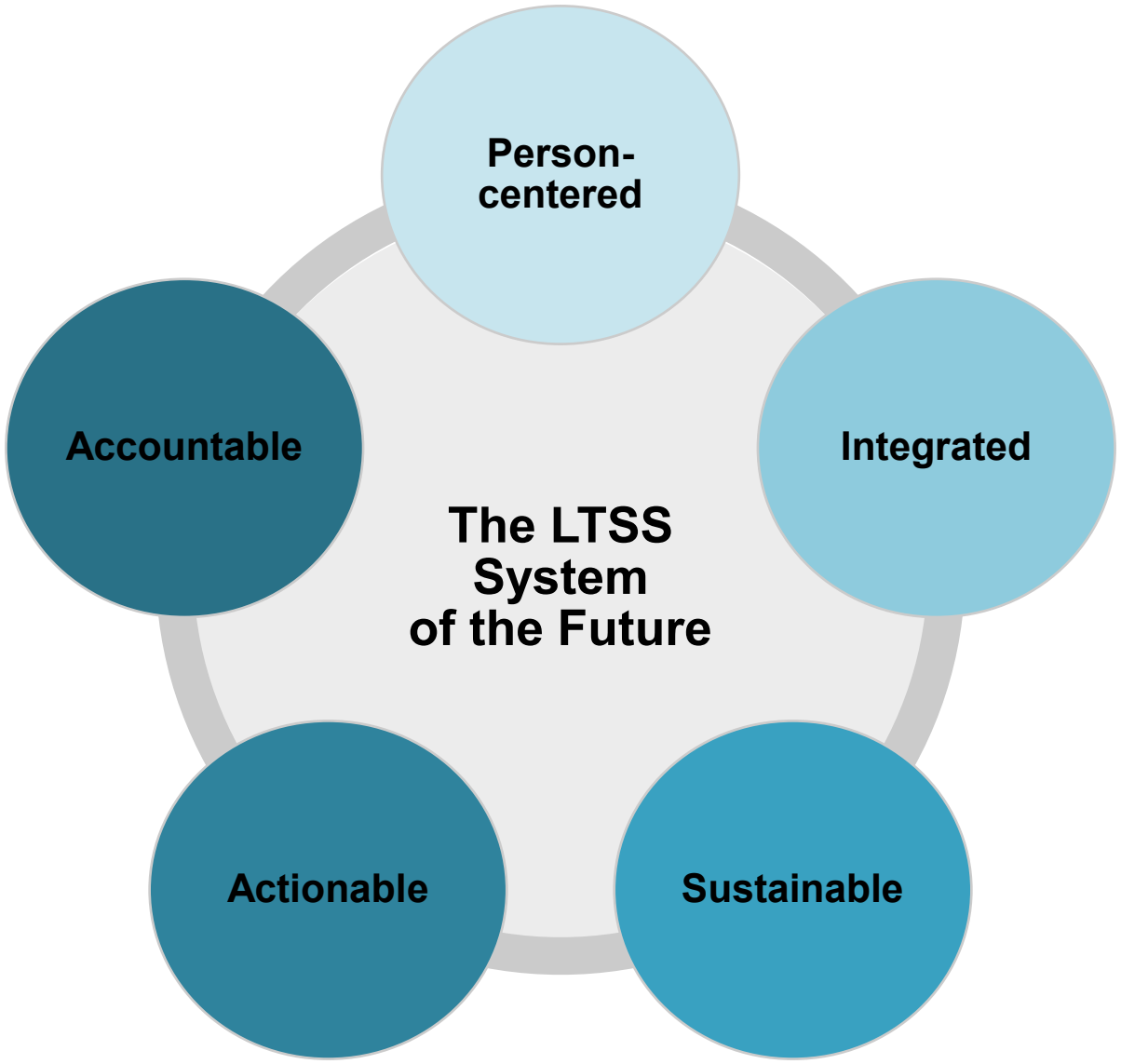
A Vision for Reform: System Goals



Vehicle for Change

The system of the future can be achieved through different models, but the best is one in which a single entity or network of entities assumes financial responsibility and performance accountability and is vigorously monitored by the state

Options include Medicaid ACOs, integrated care plans, consortiums of community-based organizations, partnerships among such entities, or a combination

Risk-adjusted, global, or shared savings payment arrangements and leveraging Medicare financing for dual eligibles

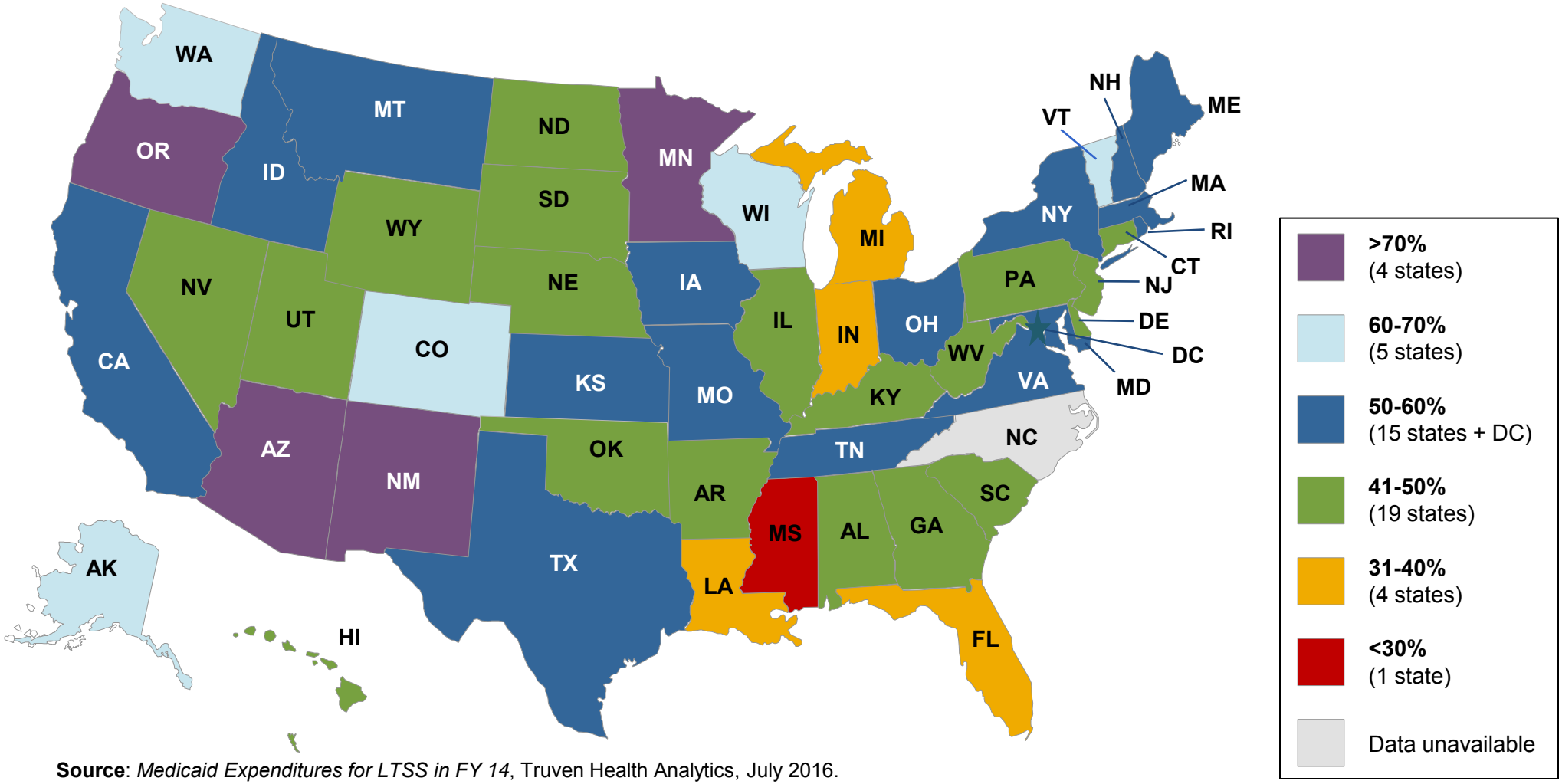
Improved technological solutions

A designated senior government official

States Are Shifting Care to the Community

HCBS accounted for 53% of total LTSS spending in FY 2014, up from 36% in FY 2004

Proportion of Medicaid LTSS Spending for HCBS by State (FY 2014)

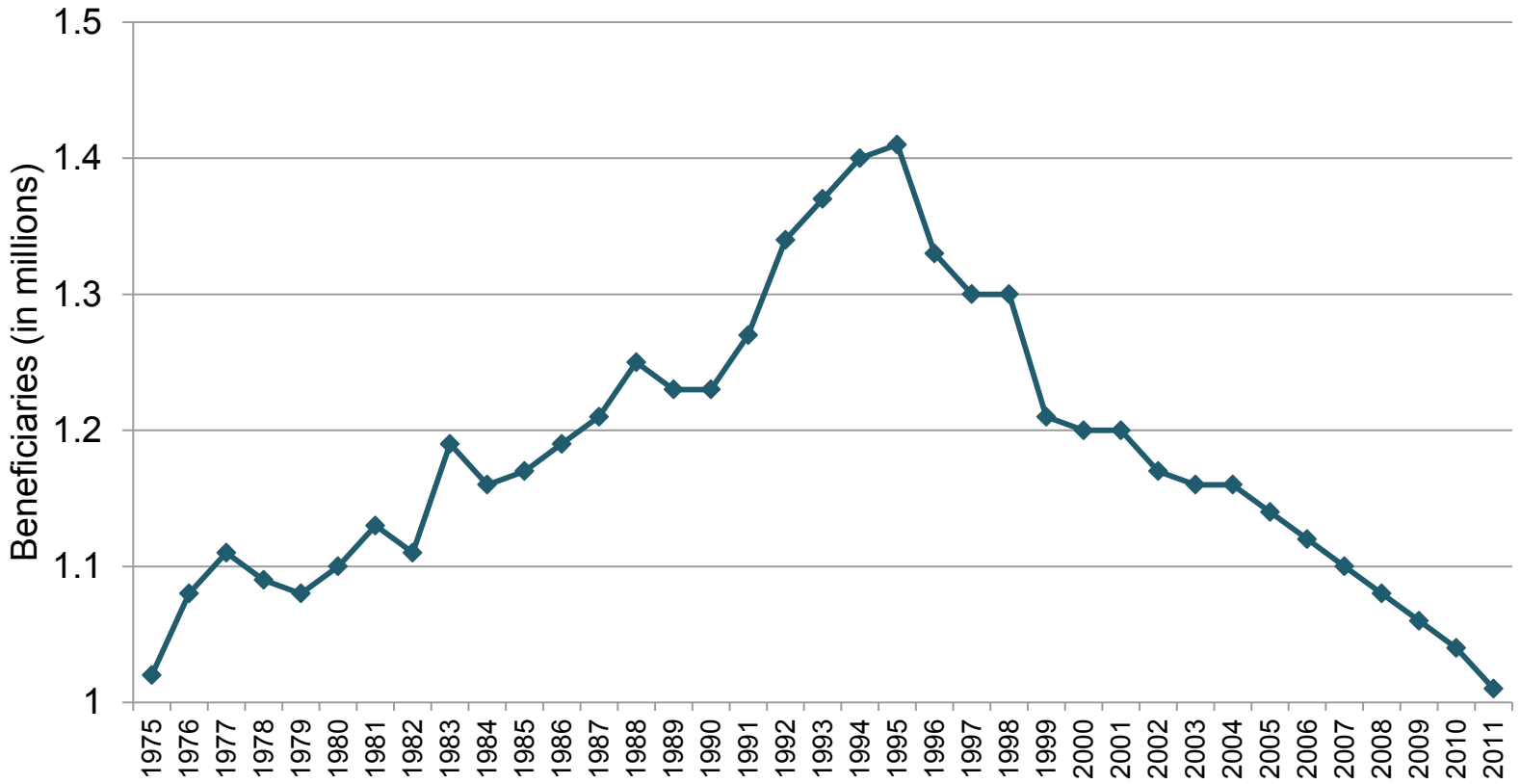


Source: *Medicaid Expenditures for LTSS in FY 14*, Truven Health Analytics, July 2016.

Nursing Home Use Is Declining

Although the population is aging, nursing home use among Medicaid beneficiaries has steadily declined since 1995

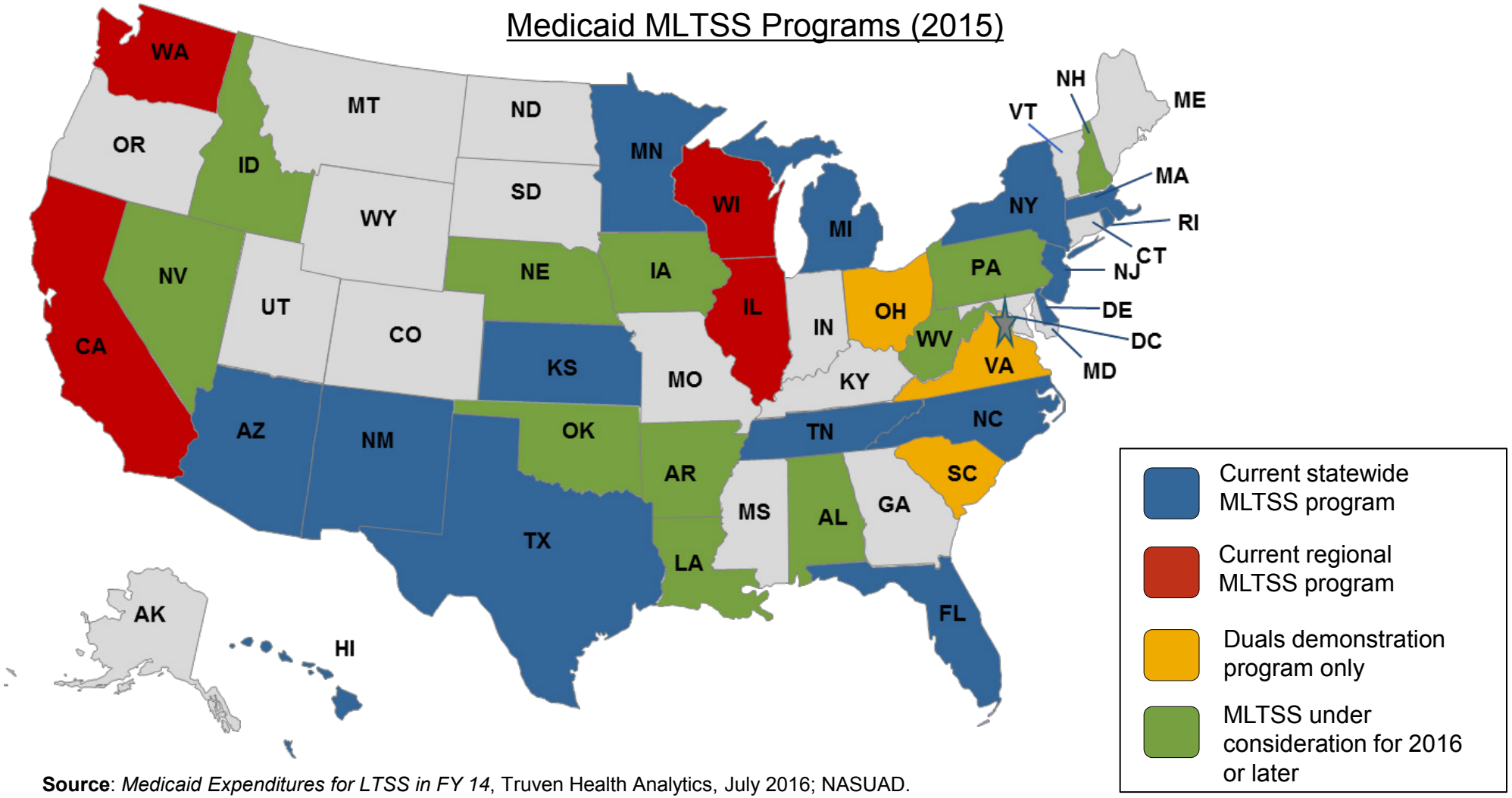
Number of Aged Medicaid Beneficiaries Using Nursing Facility Services, 1975-2011



Source: *Medicare & Medicaid Statistical Supplement – Table 13.8*, CMS, 2013.

States Are Moving To Managed LTSS (MLTSS)

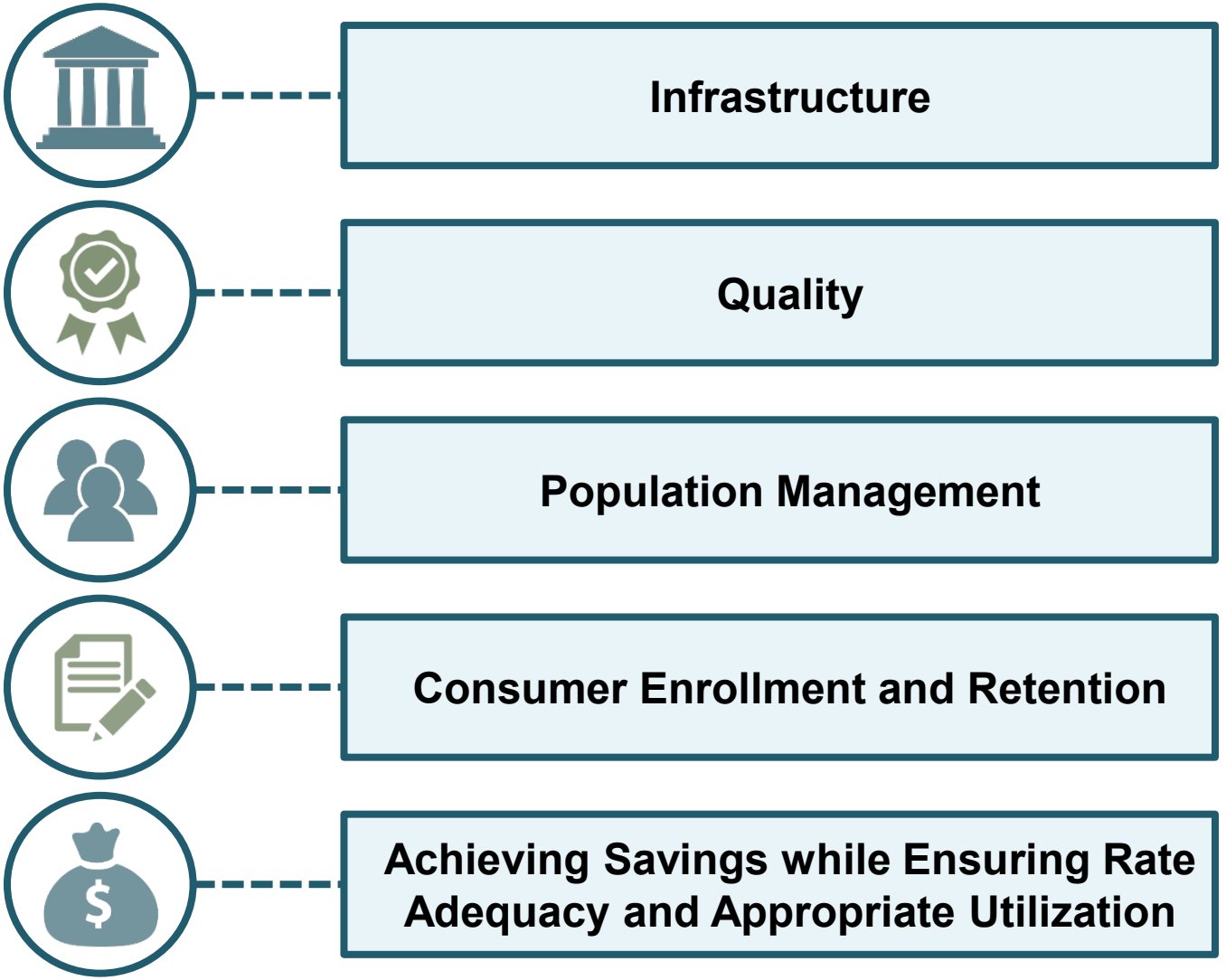
Managed LTSS spending increased 55% from FY 2013 to FY 2014, accounting for $22.5 billion in spending (15% of total Medicaid LTSS spending)



Source: *Medicaid Expenditures for LTSS in FY 14*, Truven Health Analytics, July 2016; NASUAD.

Shifting to MLTSS Presents Challenges

The transition to Medicaid managed LTSS has been challenging in a number of areas

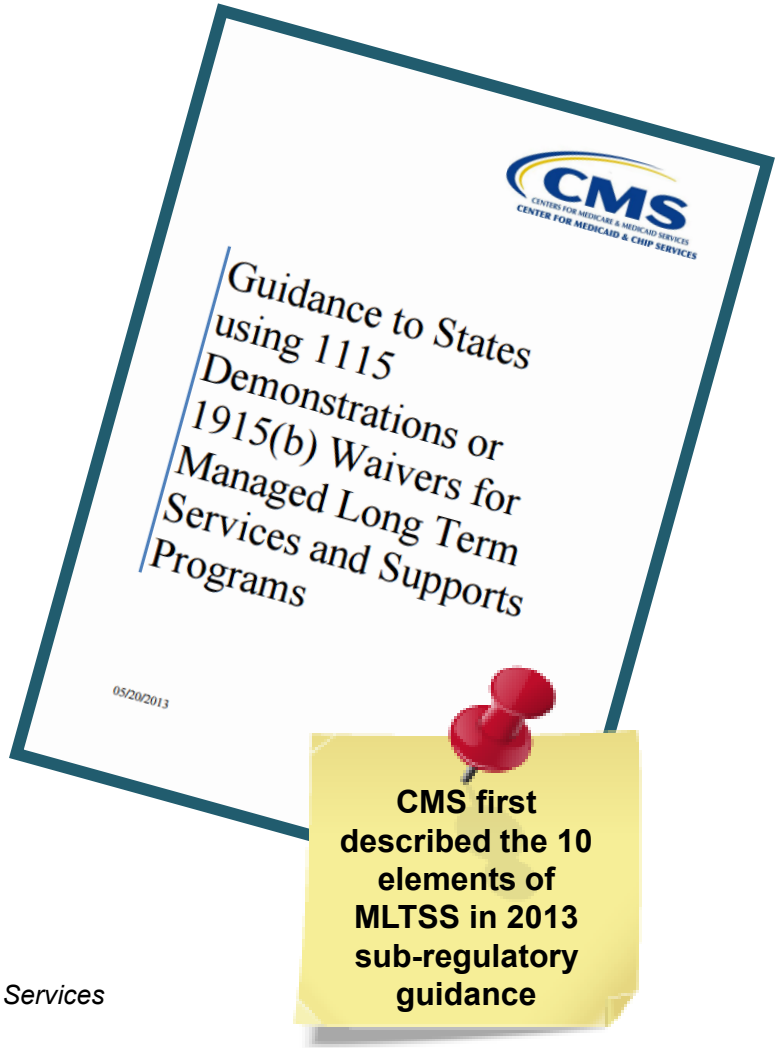


New Medicaid Managed Care Rule Supports Shift to MLTSS

New Medicaid Managed Care regulations specifically include MLTSS programs for the first time and incorporate ten elements of high-performing programs

CMS's Required Elements of MLTSS

1. **Adequate planning**
2. **Stakeholder engagement**
3. **Enhanced provision of HCBS**
4. **Alignment of payment structures and goals**
5. **Support for beneficiaries**
6. **Person-centered processes**
7. **Comprehensive, integrated service package**
8. **Qualified providers**
9. **Participant protections**
10. **Quality**



Source: *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs,* Centers for Medicare and Medicaid Services, May 20, 2013.

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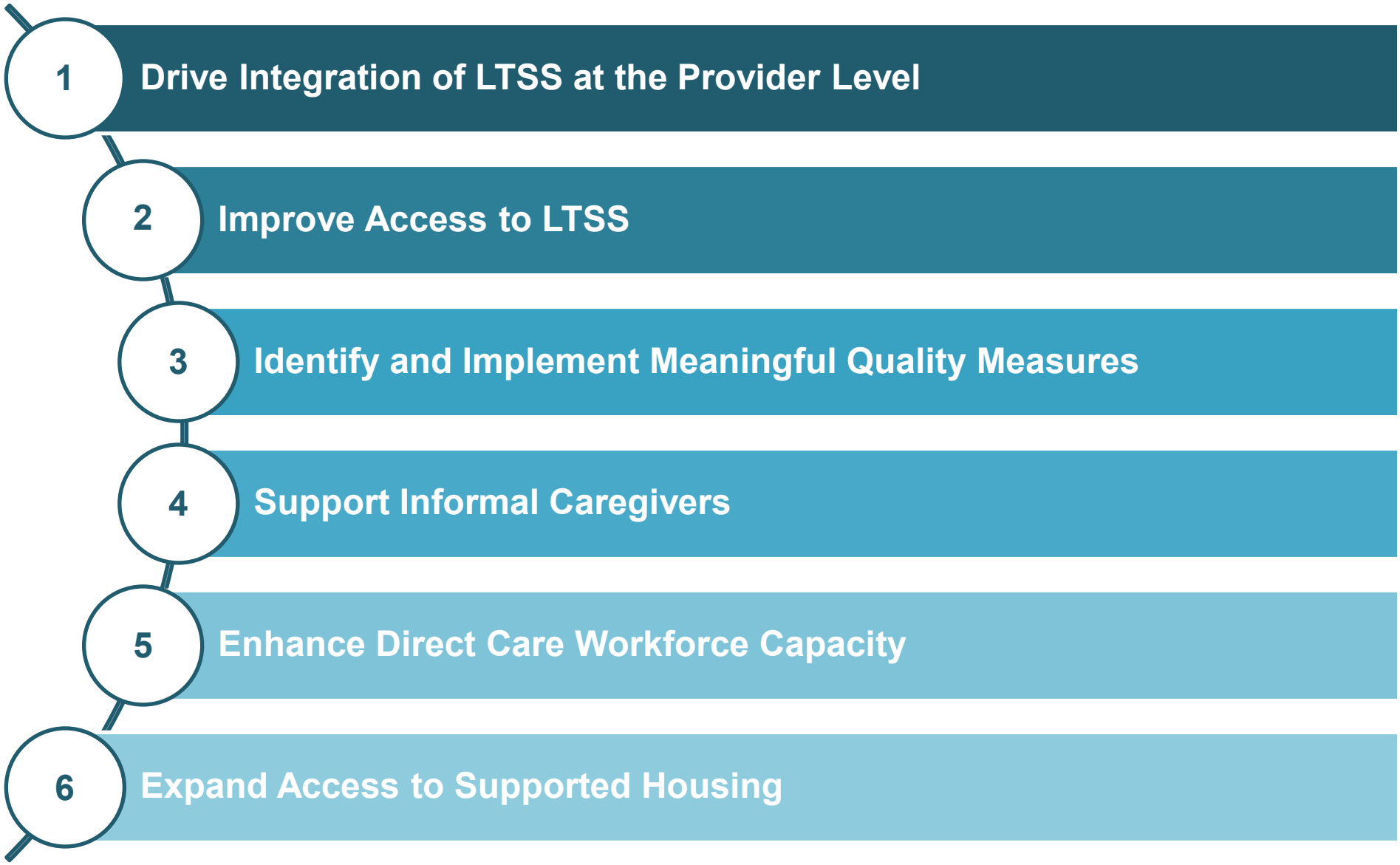
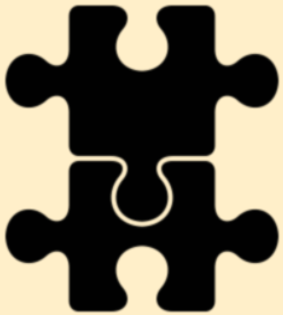
Foundational LTSS Reforms



Foundational Reforms

1 Drive Integration of LTSS at the Provider Level

State Strategies



- Stimulate and require partnerships between LTSS providers, the health care sector, and broader community networks
- Expand opportunities for physical health, behavioral health, and LTSS providers to participate in cross-provider education and training, which should promote respect and enhance medical providers' awareness of the critical role LTSS providers can play
- Align provider and program rules across state agencies and provider systems
- Invest in LTSS system infrastructure (e.g., capital, HIT)

Foundational Reforms

2 Improve Access to LTSS

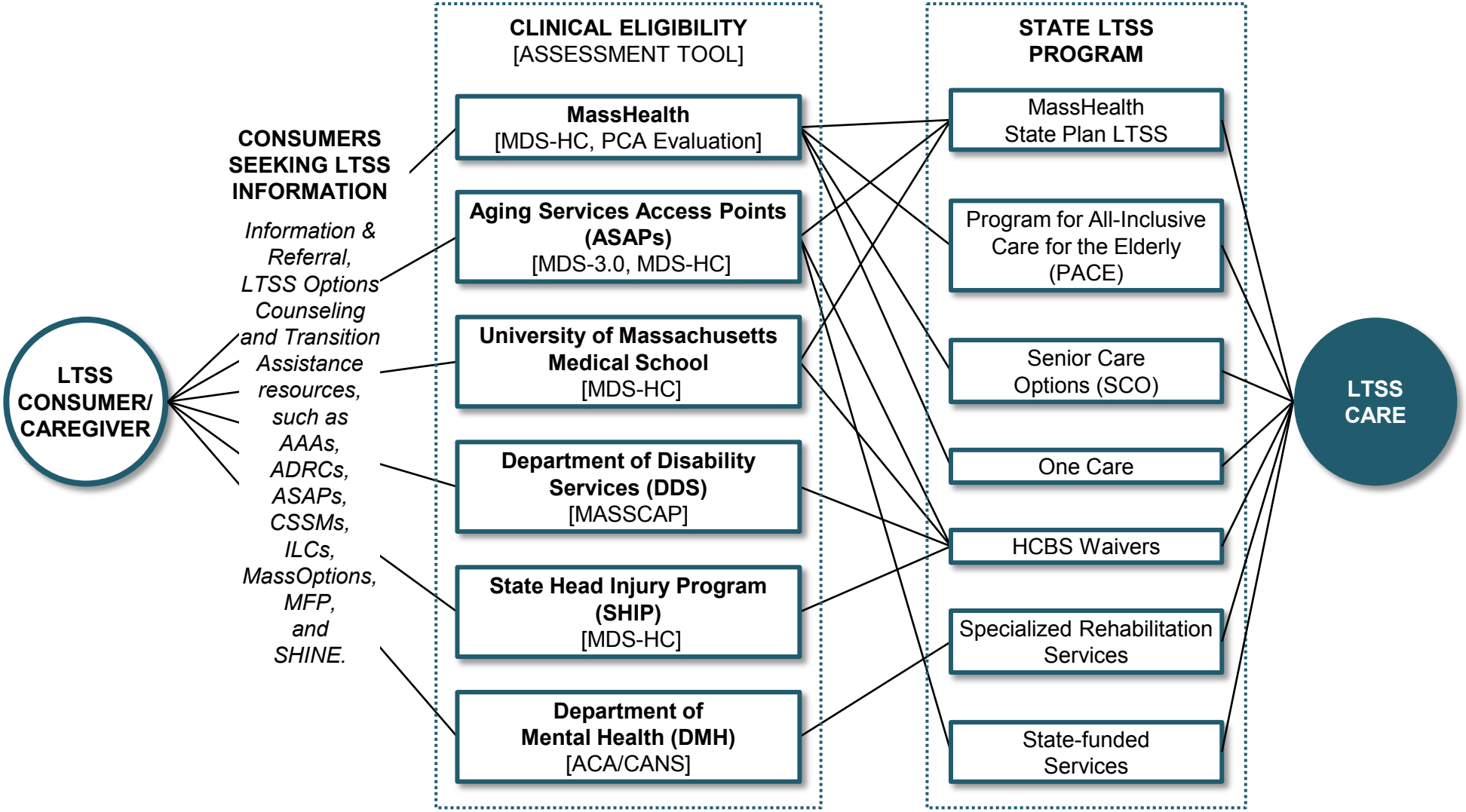
State Strategies

- Conduct an in-depth assessment of how and when individuals and families currently seek out and receive LTSS information
- Develop options counseling programs

- Simplify where and how consumers and their families access LTSS information

- Streamline financial and clinical eligibility requirements across agencies and programs
- Implement uniform assessments to assure the right placement at the right time

Improve Access to LTSS: MA Example



Notes: AAA = Area Agencies on Aging, ACA = Adult Comprehensive Assessment, ADRC = Aging and Disabilities Resource Consortia, CANS = Child and Adolescent Needs and Strengths, CSSM = Comprehensive Screening and Service Model, ILC = Independent Living Center, MASSCAP = Massachusetts Comprehensive Assessment Profile, MDS = Minimum Data Set, MDS-HC = Minimum Data Set-Home Care, MFP = Money Follows the Person, PCA = Personal Care Attendant, and SHINE = Serving the Health Information Needs of Everyone.
SOURCE: Massachusetts Balancing Incentive Program Application, January 2014.

3 Identify and Implement Meaningful Quality Measures

State Strategies

- Work with consumers and other stakeholders to develop a comprehensive set of agreed upon LTSS metrics
- Identify and require providers to report on a manageable set of measures
- Make existing quality information more readily available to the public

Foundational Reforms

4 Support Informal Caregivers

State Strategies

- Expand access to respite services for certain populations
- Allow family members to be paid caregivers
- Work with public and private employers to provide paid family leave as a benefit
- Increase awareness of and enhance any existing tax incentives for family caregivers
- Connect informal care givers with dedicated care coordinators

Foundational Reforms

5 Enhance Direct Care Workforce Capacity

State Strategies

- Establish a minimum wage for all direct service workers in all care settings
- Support efforts to professionalize the LTSS workforce while protecting consumers' need for person-centered care
- Construct and communicate a clear career ladder for the direct care workforce to promote recruitment and retention of workers in this field

Foundational Reforms

6 Expand Access to Supported Housing

State Strategies

- Implement cross-agency and cross-sector initiatives to craft viable housing solutions
- Analyze the nursing home capacity required to meet future demand and assess how nursing homes might be updated and/or converted for mixed use
- Assess current housing programs in place throughout the state

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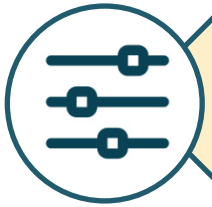
Conclusion

The number of Americans needing LTSS will continue to increase and care will continue to shift to community settings

The current LTSS system may be providing suboptimal care while also creating serious budget pressures on the Medicaid program



States, plans, and providers are adjusting to the shift to managed LTSS and must figure out how to deal with high-risk populations

The system of the future may be achieved in a variety of ways, but will require increased financial/performance accountability from providers & plans, monitoring by government agencies, and consumer engagement

States are beginning to implement strategies to achieve the system of the future, but much work remains

Questions?

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Education

- Harvard University, Kennedy School of Government, MPA
- City University of New York, B.A.

About

Ms. Raphael is a nationally recognized expert in healthcare policy and in particular, post- acute, long term care and hospice and palliative care as well as care management models. She served as President and Chief Executive Officer of the Visiting Nurse Service of New York (VNSNY), the largest nonprofit home health agency in the United States from 1989 to 2011. Ms. Raphael expanded the organization's services and launched innovative models of care for complex populations with chronic illness and functional impairments.

Prior to joining VNSNY, Ms. Raphael held executive positions at Mt. Sinai Medical Center and in New York City government. In 2013, Ms. Raphael was appointed by President Obama to the Bipartisan Commission on Long Term Care. In 2012, Ms. Raphael was an Advanced Leadership Fellow at Harvard University. She is chair of the Long Term Quality Alliance and is a Board member of the New York eHealth Collaborative, a public-private partnership to advance the exchange of health information. Ms. Raphael is a member of the National Quality Forum Coordinating Committee where she chairs its Post Acute, Long Term Care and Hospice Workgroup. She served on numerous commissions including MedPAC , the New York State Hospital Review and Planning Council and several Institute of Medicine Committees.

Ms. Raphael was a member of New York State Governor Cuomo's Medicaid Redesign Team. In 2012 and 2013, Ms. Raphael was involved in a Commonwealth Fund Project to spur the development of high-performing integrated health plans for dual eligibles.

Ms. Raphael recently concluded her six-year term as Chair of the AARP Board and continues to serve on the boards of Henry Schein, Inc., the Primary Care Development Corporation, Pace University and the Medicare Rights Center. She co-edited the book "Home Based Care for a New Century" and was a Visiting Fellow at the Kings Fund in the United Kingdom.

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Education

- Yale University School of Medicine, Department of Epidemiology and Public Health, M.P.H. with distinction, Health Policy and Administration, 1997
- St. John's University School of Law, J.D., 1994
- Boston College, B.A., English, 1991

About

A veteran of state and federal healthcare administrations with experience in program design and implementation, Stephanie Anthony provides research, analysis and advisory services on health policy and health law to public and private sector clients.

Clients turn to Stephanie for counsel on healthcare reform, Medicaid and Children's Health Insurance Program (CHIP) financing, program design and waivers, post-acute care, and long-term services and supports. She also advises on best practices in care management, integrated care models, and coverage options for the uninsured.

Before joining Manatt, Stephanie was with the University of Massachusetts Medical School's (UMMS's) Center for Health Law and Economics, where she helped Massachusetts become the first state to implement a demonstration program of integrated care for individuals with dual eligibility for Medicare and Medicaid.

Stephanie oversaw strategic planning, policy development and analysis, program design, data analytics, and stakeholder engagement efforts. She was also the lead consultant providing analytic and staff support to Massachusetts' Long-Term Care Financing Advisory Committee.

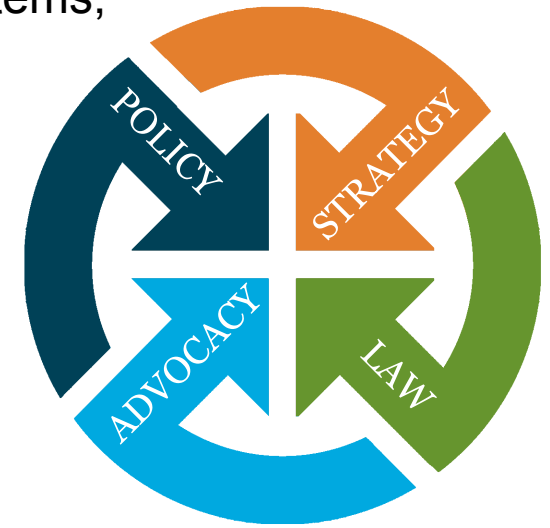
Prior to UMMS, Stephanie was deputy Medicaid director in the Massachusetts Executive Office of Health and Human Services. A member of the executive management team, she worked with the federal Medicaid oversight agency and was integral to the development and implementation of the Commonwealth's landmark healthcare reform law. Stephanie also oversaw CHIP and the MassHealth 1115 Waiver, the primary financing mechanism for the publicly funded healthcare reform coverage expansions.

Stephanie's government service also includes work as a director of federal and national policy management within EOHHS's Medicaid office and as a legal advisor and policy analyst for the Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services. She also was a senior policy analyst for the Economic and Social Research Institute.

Manatt Health

Our mission is to be a practice whose multidisciplinary professionals, through excellence, deep substantive knowledge and teamwork, support clients seeking to transform America's health system by expanding coverage, increasing access and creating new ways of organizing, paying for and delivering care.

- Interdisciplinary team with over 80 professionals
- Provider strategy: academic medical centers, acute health systems, post-acute and long-term care providers, ACO/IDS formation, care management
- Payer strategy: provider-sponsored plans, care management
- Health information exchange, health IT
- Medicaid program redesign and evaluation
- Mergers, acquisitions, joint ventures
- Corporate structure and governance
- Pharmaceutical strategy: health reform, pricing, Medicare reimbursement, regulation of research, approval, manufacturing and marketing of medicines



Manatt's Breadth of Experience Across Health Industry

Associations

- AAMC
- California Children's Hospital Association
- Children's Hospital Association
- Alabama Hospital Association
- Georgia Alliance of Community Hospitals
- UHC

Government

- CMS Centers for Medicare & Medicaid Services
- NYeC New York eHealth Collaborative
- Missouri Department of Health and Senior Services (dhss)
- nc department of health and human services
- Tennessee Department of Health
- HealthConnector
- Maryland Department of Health and Mental Hygiene

Providers

- Kindred Healthcare
- Yale-New Haven Hospital
- Ascension Health
- Dignity Health
- Loma Linda University Medical Center
- Sutter Health — With You. For Life.
- Visiting Nurse Service of New York (VNSNY)
- Maimonides Medical Center
- Saint Luke's Health System
- UCSF Medical Center

Health Plans

- Blue Shield of California
- Humana
- BlueCross BlueShield
- AHIP
- Coalition of New York State Public Health Plans
- aetna

Foundations

- United Hospital Fund
- The Commonwealth Fund
- Robert Wood Johnson Foundation
- The Atlantic Philanthropies
- NYS Health Foundation — Improving the state of New York's health
- California HealthCare Foundation

Manatt Locations

At a Glance

400
Attorneys & Professionals Firmwide

80
Attorneys & Professionals in Healthcare

8
Offices Nationwide