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MassHealth Matters II

Long-Term Services & Supports (LTSS): Opportunities for MassHealth

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December 2nd, 2015

Agenda

- Why Focus on LTSS?
- Massachusetts LTSS Overview
- MassHealth LTSS Spending & Utilization
- Access, Workforce, & Quality
- Blueprint for the Future

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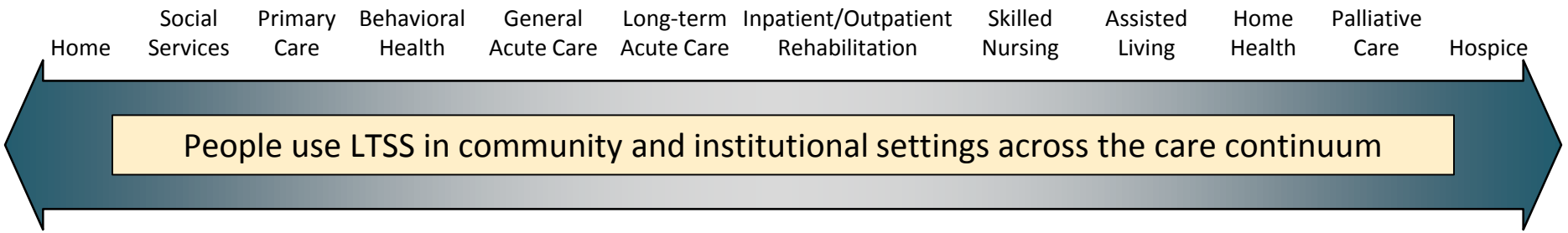
What are long-term services and supports (LTSS)?

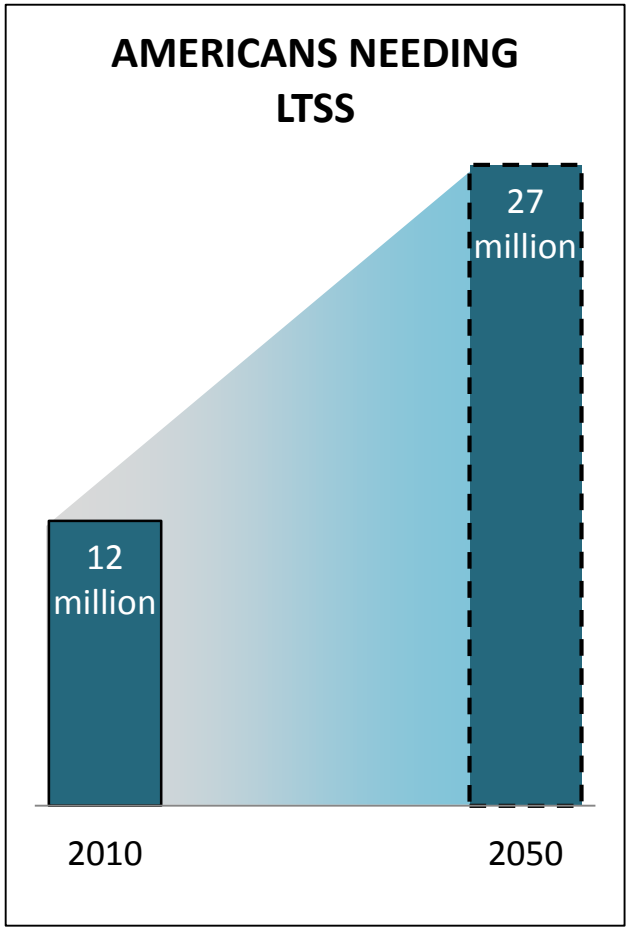
LTSS include a range of services that people with disabilities and chronic conditions use to meet their personal care and daily routine needs in order to promote independence, support their ability to participate in the community of their choice and increase overall quality of life, such as:

- *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*



A National Call to Action on LTSS

The National Commission on Long-Term Care convened in early 2013.



SOURCE: U.S. Senate Commission on Long-Term Care, 2013.

The Commission's goals included:

- ➢ Continuing the national dialogue to educate leaders and the public
- ➢ Getting ahead of the demographic challenge
- ➢ Enabling independence and choice – to the fullest extent possible

The Commission's Final Report to Congress recommended:

- ✓ Creation of a public/private financing system;
- ✓ Each patient have a point person no matter where they are in the system;
- ✓ A uniform assessment across care settings
- ✓ Sustaining and building on family caregiving;
- ✓ Setting standards and investing in a well trained formal workforce; and,
- ✓ Adopting innovative technologies

Why Focus on LTSS in Massachusetts?

PEOPLE: People of all ages use LTSS, at varying levels of duration and intensity.

- Roughly 750,000 people – or 11% of the non-institutionalized population – report having a disability.
- MA's population is projected to age rapidly, with those 65+ increasing by 46% in 20 years.
- The care system relies on informal and formal caregivers and is unprepared to handle increasing demand.
- Individuals with LTSS needs want to remain contributing and active members of the economy and their community to the fullest extent possible.

COST: LTSS accounts for nearly one-third of all MassHealth spending and is expected to grow

- MassHealth is the largest payer of LTSS in MA – with 2015 LTSS spending of $4.5 billion or 12% of the entire state budget.
- National estimates project the rate of spending growth for Medicaid LTSS to be more than 3 times that of Medicaid overall.
- Few viable private financing options exist for consumers, and many consumers are unaware of the potential financing options that do exist.
- LTSS affect other health care costs and utilization.

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Massachusetts' LTSS policy and action plan

Massachusetts has a long-standing "Community First" LTSS policy, which is to empower and support people with disabilities and elders to live with dignity and independence in the community by expanding, strengthening, and integrating systems of community-based long-term supports that are person-centered, high in quality and provide optimal choice.

Goal Area 1
Help individuals transition from institutional care

Goal Area 2
Expand access to community-based long-term supports

Goal Area 3
Improve capacity and quality of community-based long-term supports

Goal Area 4
Expand access to affordable and accessible housing with supports

Goal Area 5
Promote employment of persons with disabilities and elders

Goal Area 6
Promote awareness of long-term supports

SOURCE: The Community First Olmstead Plan: A Summary, Massachusetts Executive Office of Health and Human Services (EOHHS).

Massachusetts Has Made Significant Progress in Reforming LTSS

CARE DELIVERY: MA has expanded access to community LTSS, but there is more work to do

- MA has aggressively shifted LTSS utilization and spending to the community.
- MA is working hard to improve coordination and efficiency of care.
- MA is testing several MassHealth managed care options that include LTSS. However, most people who use LTSS remain in a fee-for-service system.
- MA is looking to bolster the workforce and recently committed to raise wages for personal care attendants to $15 per hour by 2018.

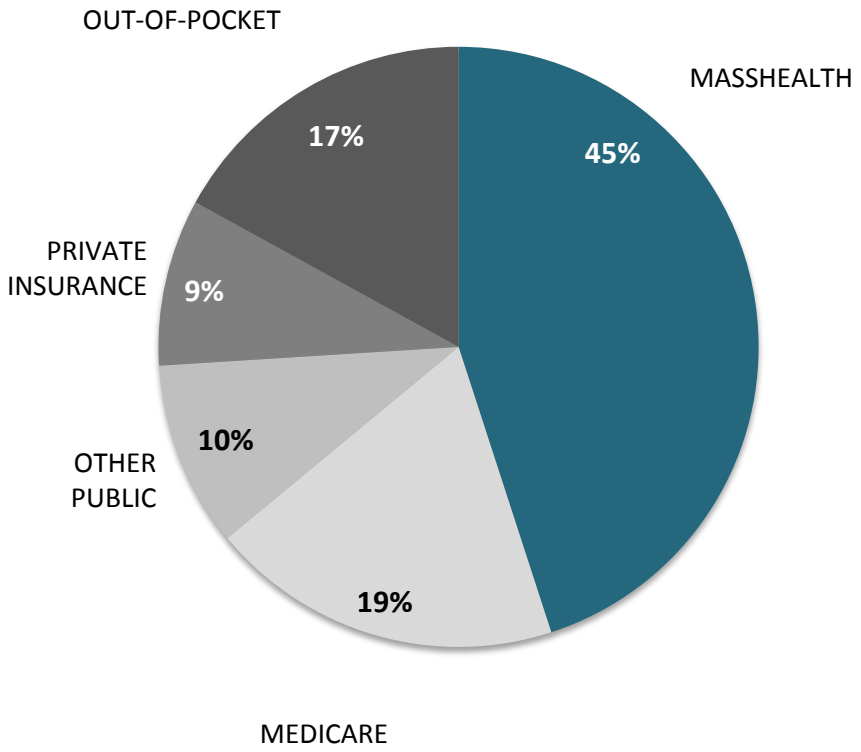
INNOVATION: MA has an opportunity to become a national leader in LTSS

- In a national ranking of states on twenty-five LTSS metrics, MA ranked 18th overall.
- MA scored in the 2nd quartile on affordability & access, choice of setting & provider, quality of life & quality of care, and effective transitions, but in the 4th quartile for support for family caregivers.
- MA now has more than 10 home and community-based services (HCBS) waivers serving over 26,000 frail elders, adults with intellectual disabilities, individuals with traumatic and acquired brain injuries, children with Autism Spectrum Disorders, and individuals transitioning from facilities.
- MassHealth Payment and Care Delivery Reform workgroups are discussing new care delivery and payment models.

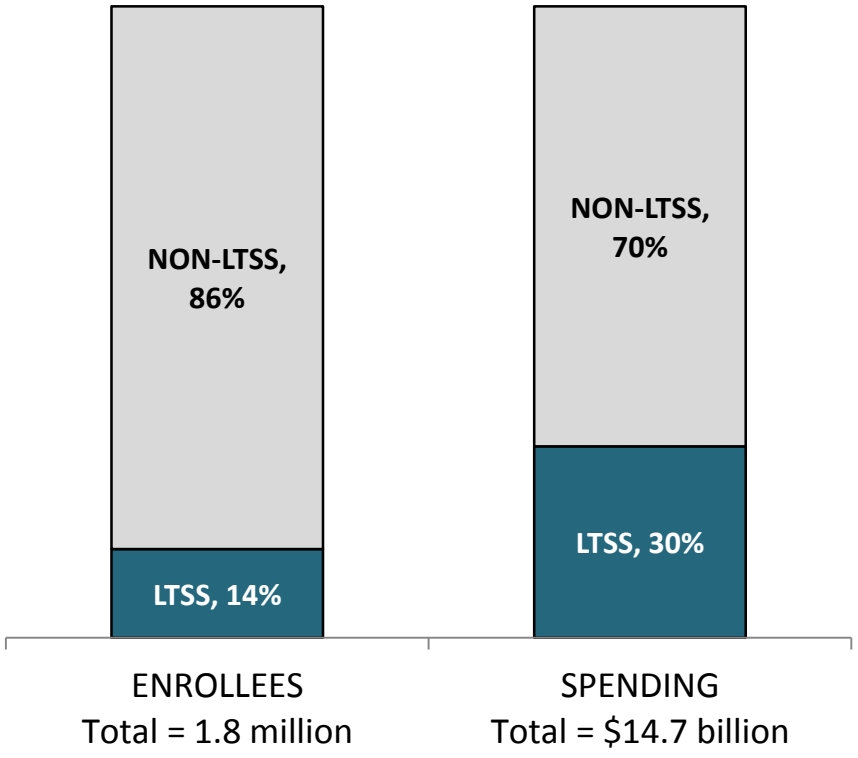
Who pays for LTSS?

MassHealth is the largest payer of LTSS, and while relatively few MassHealth enrollees utilize LTSS, their LTSS spending accounts for 30% of all MassHealth spending.

MASSACHUSETTS SPENDING ON LTSS BY PAYER, 2010



MASSHEALTH ENROLLEES AND SPENDING, 2015



SOURCE: Massachusetts Long-Term Care Financing Advisory Committee, 2010; MassHealth Office of Long-Term Services and Supports, Management Report, 2015; Massachusetts FY 2015 Budget, or General Appropriations Act (GAA).

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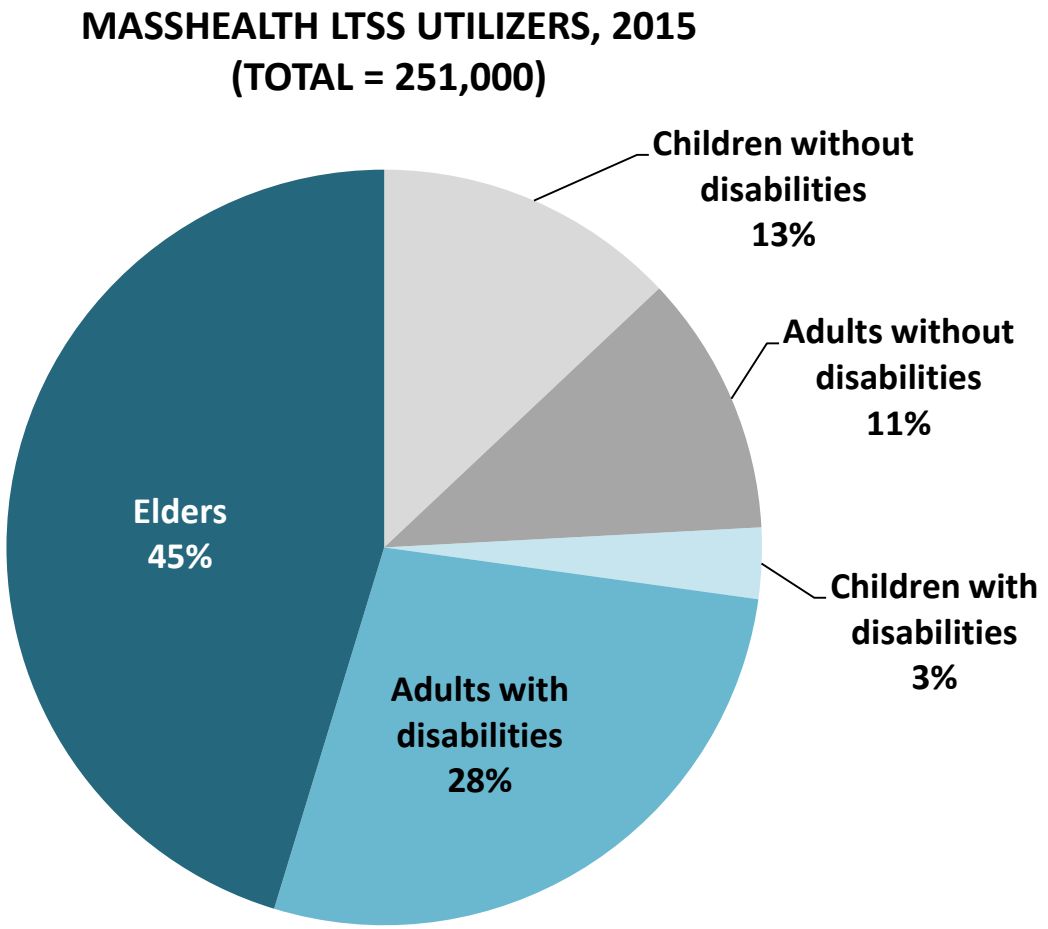
Who uses LTSS?

Roughly 14% of MassHealth enrollees – or 251,000 people – utilize LTSS, of which nearly half are elders and nearly a third are adults and children with disabilities.

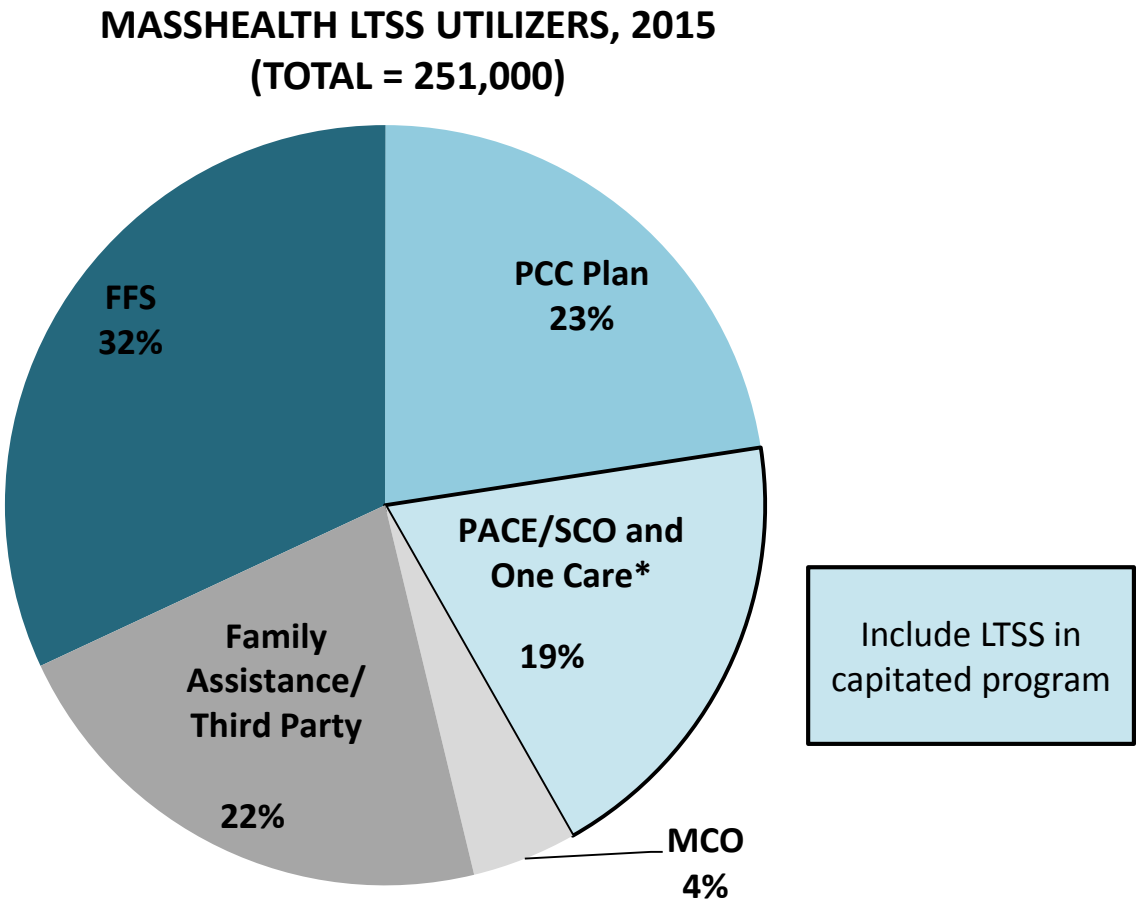


NOTE: LTSS utilizers may contain some duplication in member counts as people age into another group.

SOURCE: MassHealth Office of Long-Term Services and Supports Management Report, 2015, and includes MassHealth enrollees using fee-for-service state plan LTSS services, PACE, and SCO. LTSS enrollment for One Care is from the One Care Implementation Council's October 16, 2015, MassHealth Presentation.

How do MassHealth enrollees who use LTSS receive care?

Over 80% access LTSS in a fee-for-service (FFS) delivery system.



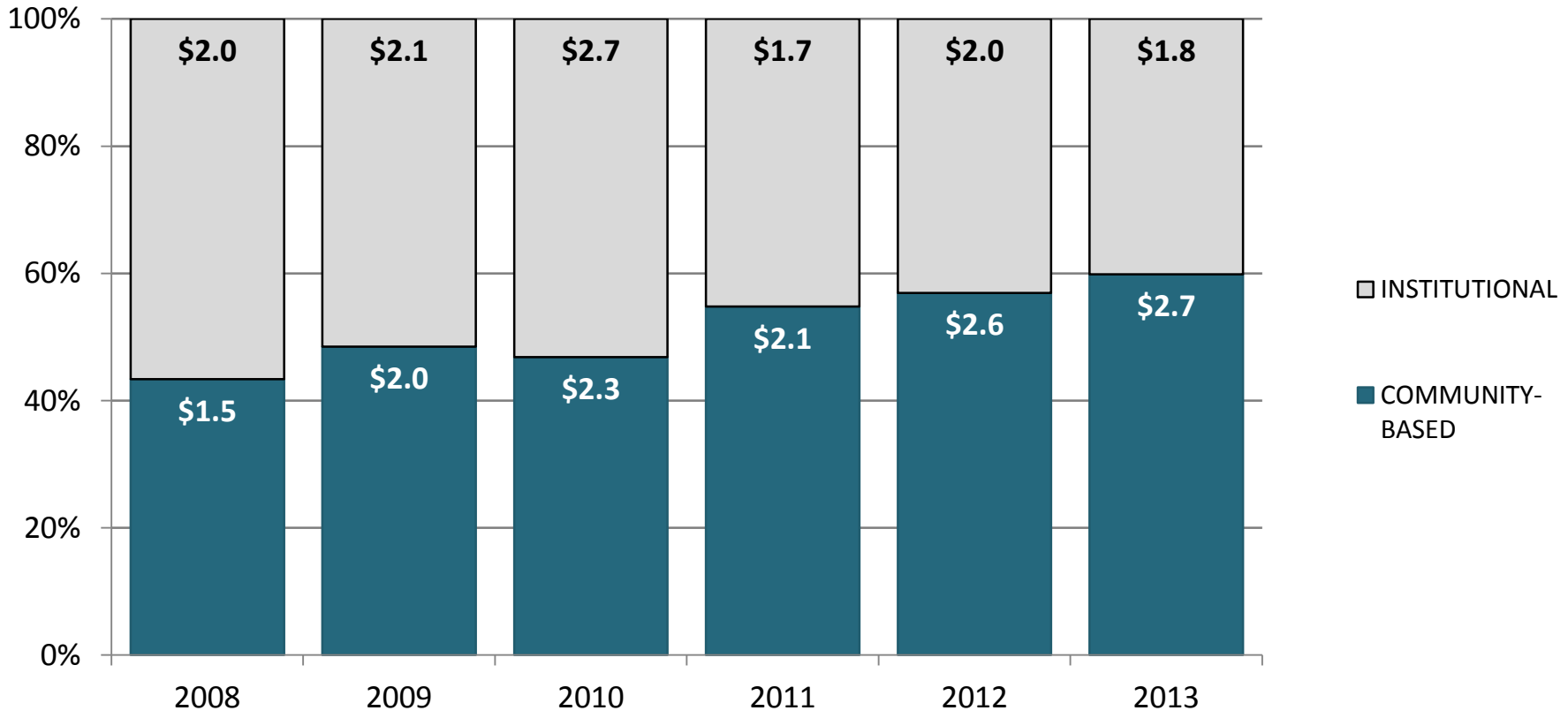
NOTE: LTSS utilizers may contain some duplication in member counts as people transition across programs. *One Care LTSS was estimated separately based on data from October 2015, and is not currently reported together with other MassHealth programs. In September 2015, roughly 4,700 One Care enrollees returned to the FFS system as one of the plans withdrew from the program.

SOURCE: MassHealth Snapshot Report, August 2015; MassHealth Office of Long-Term Services and Supports, Management Report, 2015; One Care Implementation Council's October 16, 2015, MassHealth Presentation.

MassHealth LTSS Community and Institutional Spending

As the state has aggressively focused on rebalancing efforts, the percent of LTSS spending on home and community based (HCBS) services grew from 43% in 2008 to nearly 60% in 2013.

MASSHEALTH LTSS SPENDING BY SETTING, INCLUDING HCBS WAIVER SPENDING, FY 2008 – 2013, ($ BILLIONS)



SOURCE: Eiken, S. et al., "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013," Truven Health Analytics, 2015; Massachusetts Balancing Incentive Program Application, January 2014.

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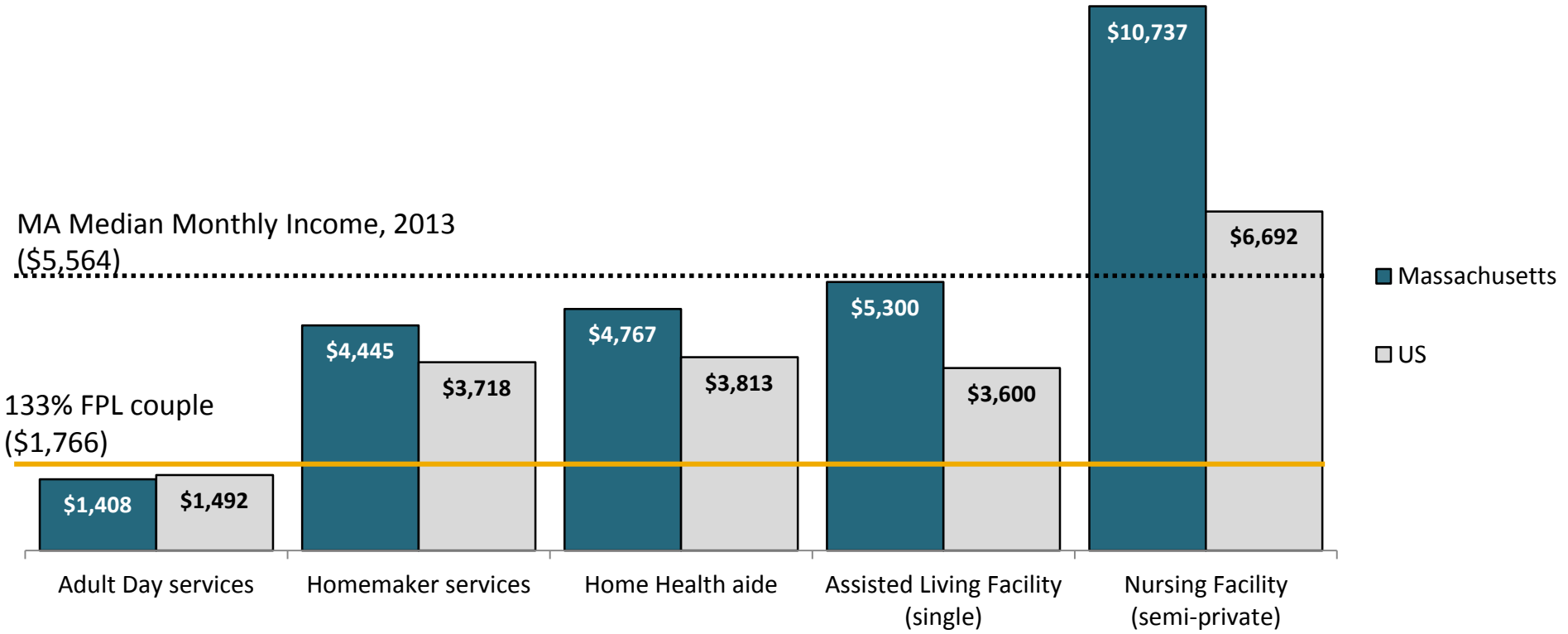
How do MassHealth LTSS costs stack up?

LTSS can be very costly and cause individuals to "spend down" assets quickly. In fact, over half of all individuals nationally who spent down assets and qualified for Medicaid did so paying for LTSS. Costs for nearly all LTSS in Massachusetts are significantly higher than the national average.

MEDIAN COSTS FOR LTSS BY SETTING (DOLLARS PER MONTH)

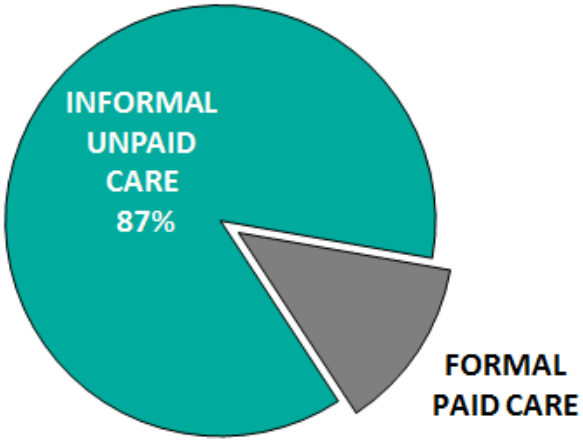


SOURCE: Genworth, Cost of Care Survey, 2015; Census Bureau, 2013; Kaiser Family Foundation, 2015; Harvard T.H. Chan School of Public Health and Massachusetts Medicaid Policy Institute, 2015.

Informal care in Massachusetts

In 2015, a RAND study estimated that informal care for elders was more than $500 billion nationwide, more than the entire federal Medicaid budget. In 2013, family caregivers in Massachusetts provided 786 million hours of care for a total economic value of care worth $11.6 billion. Only two states provided a greater economic value of unpaid care per capita.

NATIONAL RATIO OF THE NUMBER OF CAREGIVERS , 2012



MASSACHUSETTS INFORMAL CAREGIVERS, 2013

Nearly 850,000 individuals, roughly 13% of all residents, provided informal care in Massachusetts in 2013.

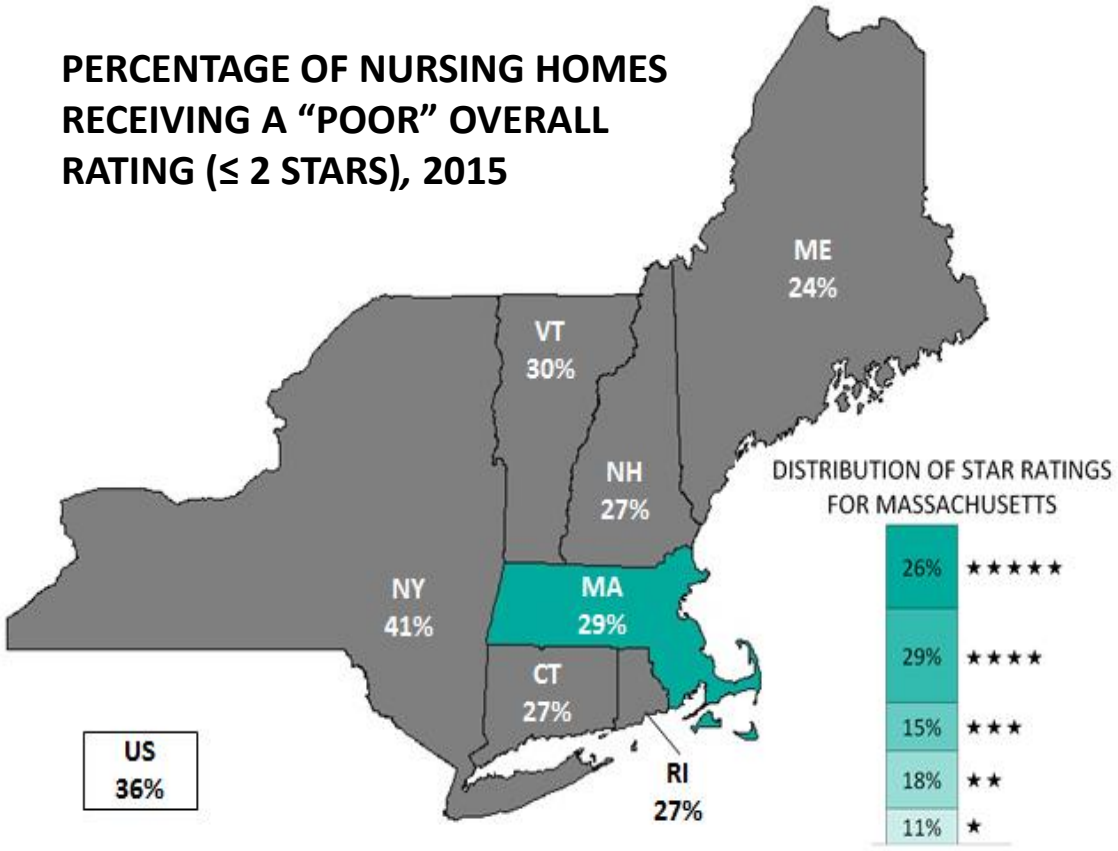
		Rank (out of 51)
Economic value of unpaid care, per 1,000 residents	$1.7 million	3
Number of informal caregivers, per 1,000 residents	126	27

SOURCE: SCAN Foundation, 2012; AARP/SCAN Foundation/Commonwealth Fund Long Term Scorecard, 2014.

Quality is variable and difficult to measure

The federal Five-Star Quality Rating System was a start, but continues to produce concerns; however, Massachusetts does have a number of Community-based LTSS Quality Initiatives.

PERCENTAGE OF NURSING HOMES RECEIVING A "POOR" OVERALL RATING (≤ 2 STARS), 2015



MA Community-based LTSS Quality Initiatives

- MassHealth recently enhanced the quality measures used in four of its HCBS waivers.
- Massachusetts also uses Quality of Life consumer experience surveys in several programs.
- There remains a lack of robust and widely-accepted community-based LTSS quality metrics.

SOURCE: Kaiser Family Foundation analysis of Nursing Home Compare data released by the Centers for Medicare and Medicaid Services (CMS), 2015.

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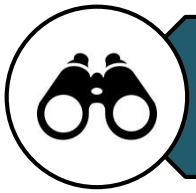
"It's always 'Sit,' 'Stay,' 'Heel'—never 'Think,' 'Innovate,' 'Be yourself.'"

Blueprint for the future of LTSS in Massachusetts

Massachusetts can significantly advance the promise and goals of its person-centered *Community First Olmstead Plan* to increase the efficiency and effectiveness of the system and attain greater value for the dollars spent, and in doing so become a national leader in LTSS:



Awareness

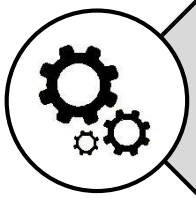
- Continue to bring attention to this pressing issue.

Capacity

- Prepare for the future financial pressure of a changing population.
- Increase support for formal and informal caregivers.

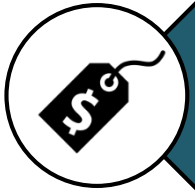
Access

- Continue to build a system that enables individuals who need assistance to get information, access services, and qualify for benefits as easily as possible.



Coordinated Care

- Better coordinate the provision of LTSS by state agencies and programs.
- Integrate the highly fragmented LTSS system both across the health care system and with other social and economic services and supports.



Value

- Expand current managed care options and determine how to integrate with emerging Medicaid ACO models.
- Develop and utilize standardized LTSS quality metrics that measure care quality, safety and outcomes.

Questions?

Biography

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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.

She 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.

She is Chair of the AARP Board and serves 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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- 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