



Future of LTSS: Advancing Integrated Care in a Changing Medicaid and Medicare Landscape Part II: Beyond Duals

May 4, 2017
AcademyHealth

Introduction

Through a two-part Retreat: “Future of LTSS: Advancing Integrated Care in a Changing Medicaid and Medicare Landscape,” the Long-Term Quality Alliance (LTQA) with our sponsors, The SCAN Foundation and the West Health Policy Center, have started a process of bringing together leading organizations in long-term services and supports (LTSS) to work through the challenges and opportunities presented by changes in the policy environment in Washington and to collaborate on advancing integrated LTSS.

The need for LTSS continues to grow. However, it is costly, and relies heavily on the Medicaid program – 6% of Medicaid beneficiaries use LTSS, and these users account for 43% of total Medicaid spending.¹ Of total spending on LTSS, Medicaid pays for 60%.² The recently passed American Health Care Act (AHCA) includes \$880 billion in cuts to federal Medicaid spending, which most health care organizations, LTSS providers, and consumer groups strongly oppose. In light of this development, it is important that LTSS stakeholders remain engaged on keeping what we have, but also not lose sight of the original mission to improve access, affordability, and the quality of LTSS.

The first session of the Retreat was held on March 8, 2017. LTQA invited 40 member and other stakeholder organizations, including included providers, payers, consumers, experts, and policymakers, to align around opportunities for advancing high-quality, person-centered, integrated services and supports in the new political environment with a focus on the

¹ MACPAC, Report to Congress on Medicaid and CHIP, June 2016. P.69.

² C. O’Shaughnessy. The Basics: National Spending for Long-Term Services and Supports (LTSS), 2012. National Health Policy Forum, Washington, DC. March 27, 2014.

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population of people dually eligible for Medicare and Medicaid. The Retreat produced a framework for further efforts to develop shared strategies across stakeholders to achieve more widespread LTSS integration with three clear priorities:

- ❖ **Coordinated Care for All** – Create access to integrated, coordinated care for all persons with functional limitations who need LTSS.
- ❖ **Quality Metrics Consistent with Person-Centered Approach** – Build a system of quality measurement that measures what is most important to the person, builds on the consumer voice, and provides accountability and transparency for government regulators, consumers, and the public.
- ❖ **A Common Framework for Integrated Plans** – Develop a common regulatory and statutory framework for plans that hold risk for and integrate medical, behavioral health and LTSS that adaptable across modalities (populations, settings, plan types).

Additional key themes from the day include a commitment to person-centeredness, the need to normalize LTSS need and avoid the over-medicalization of disability and aging, and achieving the right balance of flexibility to fit services to the needs of the consumer and simplicity for the consumer. A report of this first session is available on our website:

<http://www.ltqa.org/retreat-future-of-ltss-advancing-integrated-care-in-a-changing-landscape-of-medicare-and-medicare/>

Participants stressed that we must also consider the needs of populations with LTSS need that are ineligible for Medicaid – people with disabilities who work or have resources that preclude eligibility. LTSS financing should be broad enough to support people to remain productive and engaged in the community and not require them to impoverish themselves and disconnect from their communities and work to afford LTSS.

LTQA hosted a second session of the Retreat on May 4th, 2017 to address these areas in greater detail. The goals of the second session were to build on the priorities identified in the first meeting on March 8th, to consider the unique needs of people with disabilities who use LTSS, and to advance a vision of integrated care and a structure for federal and state financing that would promote high-quality, integrated models for those with LTSS need.

This report summarizes key themes from the second session of the Retreat, on May 4.

Supporting Independence, Integration, and Engagement

A panel of three experts in disability and long-term services and supports discussed the unique needs of subpopulations within the disability community that require supports including

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supports not traditionally thought of as LTSS, such as employment and housing supports. Many people with disabilities under the age of 65 can work in the right settings and with the right supports. The right settings and supports vary substantially for different disability subpopulations. People with intellectual and developmental disabilities (ID/DD) and people with mental illness have LTSS needs that look very different from those with physical disabilities, for example, in terms of eligibility, community integration, and housing.

Work and Disability

Kelly Buckland, Executive Director of the National Council on Independent Living (NCIL), described barriers and disincentives to work for people with disabilities.

Many people with disabilities would be able to work and remain engaged in their communities with the right supports. Nursing homes are usually not appropriate for younger people with disabilities. Once institutionalized, it is very complicated for someone to move back into the community because they need to arrange for all the services they use, they usually don't have a job, and they often need to apply for housing assistance. Living in a nursing facility makes working difficult or impossible, and if the individual was injured later in life, they may not be able to do the job they had before – retraining is necessary.

There is a widespread assumption that people with disabilities can't work, including among policymakers and health professionals. Because Medicaid benefits are tied to earnings, people with disabilities could lose their benefits if they work too much. It takes time to get services in place, and people with disabilities do not want to risk losing them by working. This assumption and resulting disincentive to work is harmful to people with disabilities who might otherwise be more empowered and involved in their communities through work with the right supports in place.

Past attempts to enable people with disabilities to work and receive benefits have not produced the intended results. Efforts to encourage return to work for Social Security Disability Insurance (SSDI) beneficiaries has had a low response rate. The Medicaid Buy-In, which allows people with functional needs and incomes above the eligibility threshold, has been more successful, but needs better coordination with the Supplemental Security Income (SSI) program and should not be restricted for people under 65.

People in the workforce with LTSS need will not meet Social Security's definition of disability, which is a requirement for receiving Medicare coverage and eventually Medicaid LTSS. Employers' health care plans do not cover LTSS. These individuals meet their LTSS needs through informal supports or by paying out-of-pocket for supports. The lack of affordability of LTSS can drive them out of the workforce and onto disability benefits.

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Community Integration for ID/DD

Julia Bascom, Executive Director of the Autistic Self-Advocacy Network (ASAN), described the unique needs of the population with intellectual and developmental disabilities (ID/DD). The ID/DD population is not always viewed as needing LTSS. Families often cobble together informal supports to provide for these needs.

The way providers perceive and approach the needs of the ID/DD population can be harmful. One error is to treat disability issues as a subset of aging issues, and another is a tendency to treat the disability population as a monolith. An example of this is using activities of daily living (ADL) impairment, which describes physical capacity as eligibility criteria for persons with intellectual disabilities. Many people with ID/DD would not have ADL limitations but would have substantial difficulty with some instrumental activities of daily living (IADLs), such as managing money or preparing meals, or “a cognitive equivalent.” Instead, many states use IQ tests for eligibility, which do not address functioning.

The ID/DD population also has a very different relationship to the terms “independence” and “independent living” than other disability groups, as people may think of it as a lack of services and supports. Most people with autism cannot live alone, so independence takes on a different meaning – to quote Judith Heumann, “independent living is not doing things by yourself, but being in control of how things are done.” Instead, terms like “self-direction” and “community integration” are preferred.

There has been a lot of progress in supporting the independence of people with ID/DD, so there is concern that any reform, including moving toward integrated care, would undermine this. Support for people with ID/DD looks very different than supports for people with other disabilities because of the cognitive, and not physical, impairment. There is fear that integration of medical and LTSS would result in a more medicalized approach that is not relevant to intellectual disabilities.

People with ID/DD often enter the service system at a very young age, and a significant investment needs to be made, particularly around the transition years (14-26) to set them up with a good life in the community with all the supports they need, education, and a job. There is also a need to coordinate the systems that are serving individuals, and the systems change when someone turns 21. Most services are received through the school system until the age of 21. When best practices are followed, the services provided for people under 21 are meant to help them direct their own lives, go to school, and work. However, at age 21, individuals begin receiving services through Medicaid, and if they can work they are ineligible. For many it's a catch-22 – they could work if they received services, but they can't receive services if they work.

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The ID/DD community is wary of congregate housing and of having their housing and employment in the same place because of the history of abuse in these kinds of settings. Adult day centers are also not optimal. The preference is for individualized services that allow engagement with the community and with people who do not have disabilities.

Finally, it is critical when we discuss the needs of people with disabilities that we look beyond merely assuring their health and safety and consider what people need to have a good life.

Health + Housing

Jonathan Hunter, formerly with the Corporation for Supportive Housing, elaborated on some of the housing issues at hand. A lot of people are homeless because they refuse to accept the prescriptions required for living in housing provided to them. Because they desired to live more independently and be more self-managed, they could not fit into prescriptive settings.

“When you talk to your doctor about your medication, that’s called self-managing your care. When I talk with my doctor about medication, I’m labeled as treatment resistant”

What he came to realize was that he was working within systems that were trying to “fix” people and make them more “normal,” but that the focus should be on fixing the way that housing is structured, financed, and operated. There is a need for a variety of models, and affordability is an enormous problem.

Creative partnerships are being developed in Los Angeles where LTSS providers are matching with the existing service structure in supportive housing developments to support people with psychiatric issues and people with complex health conditions to live successfully in the community.

Restrictions on covering housing through the Medicaid program creates a challenge for furthering goals of community integration. There is now excellent guidance to states about the type of housing support that can be provided through the Medicaid benefit. It is essential for the state to design their plan to include those supports – including housing location services, negotiating with landlords, resolving issues around tenancy, etc.

There is not only a need to integrate Medicaid and Medicare for duals, there is also a need to integrate Medicaid’s medical benefits with LTSS. We need to push this conversation on the state level.

We should move away from terms like “normative” or “normalized environments.” When we consider community integration, we need to think about what kinds of systems are necessary for people to achieve their own self-management of their lives.

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Goals and Core Principles for an Integrated System

As participants considered goals and core principles for an integrated system, the panelists described two successes in incorporating the values of integration with delivery systems: Employment First, a framework that has been adopted by the Department of Labor that prioritizes employment, and the Community First Choice option (CFC), which was enacted as part of the Affordable Care Act (ACA).

- ❖ **Employment First** is a framework for providing services that prioritizes employment. When a person with disabilities enters the LTSS system, the first goal should be integrated employment – aligning services so that the individual can work and have a career. This tends to focus on the ID/DD population, but the principles are applicable to other populations. Over 30 states have adopted employment first policies and are at varying stages of implementation.
- ❖ **Community First Choice option (CFC)** is a program that aims to put home and community-based services (HCBS) and institutions on an equal footing. Currently, state Medicaid plans are required to cover only nursing facilities, but may opt to provide HCBS and must seek waivers to do so. Under the waivers, eligibility is limited to those meeting the “institutional level of need” and limited in the number of slots available. CFC enables states to offer HCBS as a first choice under the State Plan without the waiver restrictions.

Participants discussed the following key themes:

Self Direction

The current LTSS system is not set up for self-direction – we need to build the infrastructure to make self-direction possible. An example of an aspect of the system that inhibits self-direction is electronic visit verification (EVV), a measure to reduce fraud and abuse that requires a support provider to call in regularly. However, it operates on the assumption that people are not working and are homebound, and requires that the call be made from a landline. This does not allow the individual to direct their lives if they work, or want to go out of the house with their support provider. This could be fixed by creating a mechanism that would enable EVV to be accomplished on cellphones.

Work Disincentives

There need to be other pathways to LTSS beyond Medicaid, and to the extent that LTSS is provided through Medicaid, a way to enable provision of LTSS without requiring impoverishment or disconnection from work. Youth with disabilities aging out of foster care often do not want to go on Supplemental Security Income (SSI) because they do not want to be

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labeled as disabled and unable to work. Because of the fear around the label, they cut themselves off from resources and can end up on the streets.

NCIL has worked for a few decades to change the definition of disability in the Social Security Act. Some interests (e.g., provider and parent) prefer to retain the concept of “inability to work.”

Employment Supports

We should consider opportunities to pay for employment supports outside of Medicaid. LTSS traditionally ignores employment, but for many younger people with disabilities, employment supports are a critical part of community integration and being able to live a good life.

Making an argument for employment supports in Medicaid is difficult in this political climate. Because Medicaid eligibility is linked to income benefits for people with disabilities who cannot work, there is danger that people may wonder why people who can work would need to receive Medicaid benefits. There is a fear among disability rights groups that if we start discussions about disability and employment, we might put people at risk of losing benefits. We should consider messaging on this issue.

We should also consider how to engage employers to be more flexible around their workforce – supporting people to work part-time is as important as supporting people to work full-time for some people with disabilities. Integrated plans allow for more flexibility for seamlessness across settings and employment support.

Housing

Housing is not viewed as a responsibility of the health system, but access to affordable housing has an effect on community integration and the capacity to transition from institutions and support individuals in the home and community. There may be an opportunity to put HCBS on an equal footing with institutional care at the state level if states are able to define their essential benefits packages under the new health care law to have HCBS as a mandatory service. There is also a need for housing costs, which Medicaid covers in a nursing facility, to be covered when individuals transition to assisted living or community settings.

Workforce

The direct care workforce is underpaid, with inadequate training, a lack of career paths, and high turnover. There are things we can do to reinvest in the system and achieve greater efficiency, but there also need to be more funds in the system. Increasingly, it may be of value to hire and provide training for family members or friends as care providers.

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Assessments

With regard to comprehensive assessments, we must work towards creating meaningful, person-centered assessments that get at what is important TO the individual, not what is important FOR the individual. Assessments used to diagnose disability typically focus on deficits -- they should be strengths-based.

The Limits of the Medical Model

The US has built a vast medical infrastructure that focuses on diagnosis and medical treatment. The default is to medicalize problems that occur rather than address underlying conditions that contribute to the problems. Medicaid and Medicare cover only what is medically necessary. We should consider how to change this dynamic to create a more holistic approach.

Individuals with disabilities are often the experts on what they need, not medical professionals. Services that medical professionals are comfortable prescribing may not be what people need, and may prevent people from getting the services and care they do need. Medical professionals sometimes don't know how to work with people with disabilities, particularly adults with disabilities. Adults with developmental problems often have to continue to see a pediatrician.

Finally, it is difficult to scale person-centered, consumer-driven, strengths-based supports within a system built around the medical model.

Building on Medicare

Beyond Medicaid and the Duals, we need LTSS financing solutions that build on integrated care models in Medicare and Medicare Advantage. This panel presented three different policy proposals to extend Medicare to address LTSS needs.

Expanding Medicare – Medicare Help at Home (Johns Hopkins)

Amber Willink, Assistant Scientist at John Hopkins Bloomberg School of Public Health, discussed Medicare Help at Home, a proposal that she developed with Karen Davis and Cathy Schoen.

Medicare Help at Home is an expansion of Medicare to include a voluntary, flexible, supplemental insurance benefit of about \$400 a week for HCBS that is used as dictated by a care plan. It would be financed through a combination of premiums, payroll tax, and coinsurance. Coinsurance rates would be on a sliding scale sensitive to income level. Medicare beneficiaries would have the opportunity to enroll when they join Medicare, and there would be disincentives (premium increases) to delaying enrollment to address issues around adverse selection. Beneficiaries would receive benefits once they qualify based on functional and

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cognitive eligibility criteria: two or more activities of daily living (ADLs), or a diagnosis of Alzheimer’s or dementia. This represents 17% of the Medicare population, according to their findings.

In conjunction with Medicare Help at Home proposal, this group also recommends the use of integrated care organizations (ICOs) which are similar to accountable care organizations (ACOs), but are responsible for both medical care and LTSS. Beneficiaries who opt for an ICO would receive reduced cost-sharing.

Expanding Medicare – Improving Care for High-Need, High-Cost Medicare Patients (BPC)

Peter Fise, Senior Policy Analyst at Bipartisan Policy Center (BPC), presented on the recently released BPC report: Improving Care for High-Need, High-Cost Medicare Patients. This is the third in a series on LTSS that BPC has been working on, and itself is the second in a two-part report on barriers to integration of social supports for Medicare beneficiaries who are not dual eligibles.

In order to provide social supports for Medicare-only beneficiaries with three or more chronic conditions and functional or cognitive impairments, this report proposes removing barriers that Medicare Advantage (MA) plans and ACOs face in providing these supplemental supports as a way of addressing acute care costs and reducing hospitalization. For MA plans, these barriers include the uniform benefit requirement, which requires that supplemental benefits financed through rebates must be made available to all beneficiaries and cannot be targeted, and requirements that supplemental benefits be health related. There are also financial disincentives related to risk adjustment for MA plans to take on beneficiaries with functional impairment. For fee-for-service providers, there are issues with program integrity rules – ACOs that would like to offer social services are concerned that the waivers they receive from program integrity rules would prevent them from offering social services to clients for free.

BPC conducted a data analysis of what a change to the uniform benefit requirement would look like. They found that, excluding duals, 3.6 million Medicaid beneficiaries, or 7.5% of the Medicare-only population, met the criteria of having three or more chronic conditions and functional or cognitive impairment. For the purpose of illustration, they modeled for in-home meal delivery, non-emergent medical transportation, targeted case management, and minor home modifications. They found that if plans were able to target these services to beneficiaries that met the criteria, these benefits could be financed through only a 6% reduction in the supplemental benefits currently available to everyone. This demonstrates that there is a lot that can be done with the dollars we currently have to address the social service needs of this population.

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MediCaring (Altarum Institute)

Anne Montgomery, Deputy Director for Altarum Institute’s Center for Elder Care and Advanced Illness, presented on the MediCaring delivery model.

Altarum’s model, MediCaring Communities, aims to restructure the way the services are offered to a frail Medicare-only population. This model focuses on a population with two or more ADLs or cognitive impairment over 65, or is that is over the age of 85 – groups identified as need a mix of medical and social supports. Drawing on lessons learned from PACE and Independence at Home models, the MediCaring model switches the unit of analysis from the provider to the community. The frail Medicare-only population is identified within a given community, as they require a different type of healthcare – geriatric care. This looks different from care for adults or children. It is important to reduce hospitalizations among this population and keep this population at home through HCBS, including home delivered meals, transportation, and personal care.

The MediCaring model proposes building out a system with current dollars, whether it is a PACE plan or an MA program, to offer social supports and services to the entire population of frail Medicare-only beneficiaries in that geographic area. These services are monitored by an independent monitoring system so that communities can be compared with each other, not just providers, hospitals, or nursing homes. The savings from avoided and reduced overutilization of high cost services by this population can be used to finance low cost social services and supports for this population.

Panel Discussion

Near Duals

The “near dual” population (often high-need and low-income) with LTSS need is at risk for spending down their savings and becoming eligible for Medicaid. The inability to address this need outside of Medicaid puts that program at risk.

For the near dual population with LTSS need that is already experiencing financial hardship, the cost of social supports and services – \$360 a month on average for the four social services analyzed in the BPC report – can be a burden. However, if health plans are able to target these services, they may view it as an investment. For example, providing meal delivery services for people with congestive heart failure or diabete might reduce hospitalizations.

Family Caregivers

Supports and services should be provided in the context of a comprehensive person- and family-centered care plan that involves and coordinates with family caregivers and that providers are accountable to. However, we need to bear in mind that the number of family caregivers is shrinking, and therefore reliance on them is not a “winning proposition.” We need a comprehensive care system that supports seniors, as family caregivers will not be able to fill a

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growing care gap. It is also important that we address the needs of care workers who are underpaid and overworked.

Some analysts suggest that providing paid social services would cause family caregivers to stop or lessen the amount of care they provide. There is evidence, however, that this is not the case. They provide just as many hours of care, but for different activities.

Medical Profession

Another challenge is that there is a reluctance in the medical profession to engage in LTSS. Medical professionals often don't realize how limited older patients' social supports are, and they are often ill-equipped to address them. The Geriatric Workforce Enhancement Program (GWEP) is working to incorporate geriatric education in primary care training. Beyond training, though, a culture change is needed in primary care.

Financing LTSS

Person-Centered Delivery in the Context of a Diverse Population

Solutions for financing cannot be separated from reform of the delivery system. There is a lot of diversity in the population of LTSS users, including significant diversity of needs and diversity of *direction* among users of LTSS – that is, people have different ideas about how they want to live their lives. Participants first discussed how to think about financing that supports a person-centered delivery system in the context of the diverse population.

Cash and Investment

The Long-Term Care Financing Collaborative released a financing report that recommended ending the Medicaid cliff through a declining subsidy as people earn more income until they are able to purchase their own insurance. This would be a cash benefit, along with case management or some other sort of anti-abuse mechanism. A cash benefit would allow for the flexibility necessary to meet the needs of a diverse population. It was noted that this may not make a lot of sense in the context of Medicare and Medicaid, but might make more sense in the context of Social Security – people who qualify would receive additional cash.

However, cash by itself not enough – we need to build a service delivery infrastructure that is responsive to people's needs in addition to addressing issues of financing. Many people have had the experience of having the money, but still not being able to access the services and information that they need.

More investment would result in a more robust LTSS delivery system. Right now, many people with multiple ADLs are relying only on caregivers, which means they are not spending money. If they were able to pay for the services they needed, more money would enter the system and it

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is possible that the market would respond to the additional capital. However, the funds need to be integrated across medical and social services.

The values of person-centeredness and integration may run counter to one another – giving people cash does not necessarily facilitate the integration of services.

Partial Duals and the “Spend-Down” Population

Some of the people who are spending down to Medicaid are partial duals, which means they are getting some help with Part B, or some help with everything depending on their level of need. The reason they are spending down to Medicaid is not because they want to, but because they need to in order to get their services covered, and we are essentially buying them into a program that emphasizes medical necessity. There are different ways of determining what people want and need. There is a lot of money in the system already, but we prioritize certain things within the system. If the same bundle of services is available to everyone, that is not taking individual needs into account.

Population and Community-level Data

We need data so that we can make educated policies to serve these populations more effectively. For example, for people with ID/DD in particular, only about 25% of people who are eligible are served by these programs. There is also a need for integration of health systems and social services, and it would be helpful if we could get a picture of the net economic benefit of these systems at the community level to do this more effectively.

IT Platform to Facilitate Person-Centered, Integrated Supports and Services

There is a need for investment in an IT platform to support real-time exchange of information between everyone involved with an individual’s care plan, including caregivers. It is important that care plans be person-centered and caregiver-centered, and that all the care that a person receives, whether social services or medical care, is driven by their preferences. Different service providers need to be able to be responsive to a single plan of care, and an IT platform could help facilitate this.

Integrating Resources While Keeping Out-Of-Pocket Spending in the Mix

An important first consideration is: who owns the money – the individual or the organization working on behalf of the individual? It was argued that the person should own the dollars, but they should have the opportunity to have it managed.

Reallocation of Existing Dollars; CBOs

Medicare and Medicaid are 25% of the federal budget. There is a lot of money already in the system that can be redirected to alleviate some of the burden on individuals. Sometimes it is simple fixes through social services provided by community-based organizations (CBOs) that can help people stay in their homes, and it is possible to demonstrate a reduction in cost to Medicaid.

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Cash Benefits

There is precedent for putting cash directly in people's hands. The disability community has argued for years that Ticket to Work might be more effective if money was given directly to people that need it so that they can purchase the services they want. The same has been argued for Money Follows the Person. However, the disability community has not had success in getting cash to go directly to individuals with disabilities, and there are lessons to be learned from the disability community's efforts on this. One problem is that these programs are difficult to scale.

Workforce Issues

The more diffuse and individual decisions related to services and supports are, the harder it is to set minimum standards, such as a minimum wage for the HCBS workforce. Part of building a responsive infrastructure is investing in the workforce, and we need to ensure that the workforce is paid adequately.

The disability community has long argued that HCBS is more efficient and cost-effective as an argument for reinvesting and reallocating existing funds. However, part of the reason for this is that the wages for HCBS workers have been kept very low. Low pay and rapid turnover in personnel make it difficult to improve the quality of the direct care workforce and create career opportunities in this field.

PACE Pilots

Younger people with disabilities need to be supported for a much longer period of time, and this requires a lot of flexibility in the system. The hope is that this flexibility would be offered by the PACE pilots, if CMS moves forward with them. The pilots would also hopefully address access to PACE for Medicare-only beneficiaries. The National PACE Association has a framework on their website which considers how to extend the program to at-risk Medicare beneficiaries with functional limitations. The key is providing flexible benefits with a flexible rate structure. CMS requires that PACE programs charge Medicare beneficiaries the exact same capitation rate as they get from the Medicaid program. From the Medicaid perspective, they are paying for a number of people. But for Medicare beneficiaries, they would like to be able purchase a level of services that corresponds to their level of need.

A Unified Theme for Advancing Integrated Care and Next Steps

First and foremost, we must prioritize the desire of people living with functional limitations for independence and community integration, for all age groups. LTSS stakeholders must also develop a message that educates the public on LTSS, conveys a vision of the change we want to see, and resonates with policymakers.

Carol Raphael, the LTQA Board Chair, identified some themes from the day:

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- ❖ The need for **flexibility**
- ❖ The need to look at **financing in conjunction with delivery system issues**, and not isolate the two
- ❖ **Normalizing LTSS**, de-medicalizing LTSS, moving from health care to life care
- ❖ **Person-centered and family-focused care** – to work to understand the strengths of the people we serve as well as what their preferences are
- ❖ The need for **simplicity** – to build an LTSS infrastructure that will make the system more simple and manageable (ex. IT platform that allows different service providers to share information)
- ❖ The need for **accountability**
- ❖ The need for a vehicle to bring **more dollars into the system**

Several participants called for **the convening of a working group** to consider our message should be, and to synthesize key takeaways and action steps from the two sessions of the retreat that we can all unify around. How can we get the attention of policymakers and the general population so that these issues can move from the periphery? How can we demonstrate our value?

The items addressed by this working group should include:

- ❖ Education and culture change
- ❖ Protecting what we have (ex. Medicaid)
- ❖ Integrating medical and social services, including employment and housing supports
- ❖ Building new infrastructure (ex. IT platform)
- ❖ Enabling work without losing benefits
- ❖ Supporting caregivers
- ❖ Engaging medical professionals
- ❖ Workforce issues
- ❖ Urban/suburban/rural disparities
- ❖ State solutions – 80% of state Medicaid directors have been in place for two years or less, and the bandwidth of states is quite limited

There is new leadership at HHS – it was recommended that this group craft some descriptions of key LTSS issues. Finally, there is a need to bring more diverse political and ideological voices to the table. Work we do with traditional thought leaders and progressive states to advance integrated LTSS will not appeal to Members of Congress representing the rest of America.

Appendix A: Agenda

AGENDA

Future of LTSS:

Advancing Integrated Care in a Changing Medicaid and Medicare Landscape

Part II: Beyond Duals

May 4, 2017

AcademyHealth

- 8:00** Breakfast and Registration
- 8:30** Welcome and Opening Remarks – Carol Raphael
- 8:40** Presentation and Discussion: Review of the March 8 Framework – Larry Atkins
- 9:00** Panel: Supporting Independence, Integration, and Engagement
Moderator: Merrill Friedman
- Work and Disability – Kelly Buckland
 - Community Integration for ID/DD – Julia Bascom
 - Health + Housing – Jonathan Hunter
- 10:00** Discussion: Goals and Core principles for an integrated system
Facilitator: Merrill Friedman
- 10:45** Presentations: Building on Medicare
Moderator: Jennifer Windh
- Expanding Medicare – Amber Willink
 - Expanding Medicare – Peter Fise
 - Medicaring – Anne Montgomery
- 11:15** Discussion: Financing LTSS
Facilitator: Anne Tumlinson
Meeting the needs of a diverse population
Keeping Caregivers and out-of-pocket resources in the mix
Strategies for advancing LTSS financing in Medicaid and Medicare Reform
- 12:00** A Unified Theme for Advancing Integrated Care and Next Steps
Facilitator: Carol Raphael
- 12:45** Close

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Appendix B: Participant List, May 4 2017

<i>First name</i>	<i>Last name</i>	<i>Affiliation</i>
Kyle	Allen	VAAACares
Larry	Atkins	Long-Term Quality Alliance
Edo	Banach	National Hospice and Palliative Care Organization
Julia	Bascom	Autistic Self-Advocacy Network
Alexandra	Bradley	National Academy of Social Insurance
Kelly	Buckland	NCIL
Patty	Byrnes	AmeriHealth Caritas
Henry	Claypool	Claypool Consulting
Marc	Cohen	University of Massachusetts, Boston
Peter	Fise	Bipartisan Policy Center
Peter	Fitzgerald	National PACE Association
Merrill	Friedman	Anthem
Stephanie	Gibbs	CHCS
Howard	Gleckman	Urban Institute
Amy	Herr	West Health Policy Center
Lilly	Hummel	NCAL
Gail	Hunt	National Alliance for Caregiving
Jonathan	Hunter	LeSar Development
Narda	Ipakchi	American Health Care Association
Claire	Jensen	Long-Term Quality Alliance
John	Lovelace	University of Pittsburgh Medical Center
Michael	Monson	Centene
Anne	Montgomery	Altarum
Kevin	Prindiville	Justice in Aging
Carol	Raphael	Manatt
Carol	Regan	Community Catalyst
Helen	Schaub	SEIU
Brenda	Schmitthenner	Gary and Mary West Foundation
Rene	Seidel	The SCAN Foundation
Lois	Simon	Seniorlink
Michelle	Soper	CHCS
Mary	Sowers	NASDDDS
Nora	Super	n4a
Bea	Thibedeau	Tufts Health Plan
Sarah	Triano	Centene
Aaron	Tripp	LeadingAge

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John	Tschida	Association of University Centers on Disabilities
Anne	Tumlinson	Daughterhood
Kathy	Vesley	VAAACares
Amber	Willink	Johns Hopkins Bloomberg School of Public Health
Jennifer	Windh	Long-Term Quality Alliance