LONG-TERM QUALITY ALLIANCE

Future of LTSS: Advancing Integrated Care in a Changing Medicare and Medicaid Landscape *Part I: Dual Eligibles*

March 8, 2017
Kaiser Permanente Center for Total Health

"People show up fully integrated, and we choose to disarticulate them into a variety of programs and payment streams. That's a problem with how LTSS is structured, and it's actually a problem with how healthcare is structured." – Dr. Bruce Chernof

Introduction

On March 8, 2017, the Long-Term Quality Alliance (LTQA) with our sponsors, The SCAN Foundation and the West Health Policy Center, hosted a full-day Retreat to align a broad array of long-term services and supports (LTSS) stakeholder organizations, including providers, payers, consumers, experts, and policymakers in attendance. Participants came together to align around a vision for integrated LTSS and a strategy for promoting policy to advance integrated LTSS, and to take advantage of opportunities that may be created by the new healthcare policy and legislative agenda likely to emerge from the 2016 election.

This event, the first of two in the series: "Future of LTSS: Advancing Integrated Care in a Changing Medicaid and Medicare Landscape," focused on individuals dually eligible for Medicaid and Medicare. Part II will take place on May 4, 2017, and will consider a broader population in need of LTSS.

Participants shared perspectives from federal and state government, regional and community organizations, health plans, and policy experts in panels through several discussion sessions and collectively arrived at three clear priorities for future work:

1. **Quality measures that build on the consumer voice**
2. **Access to integrated, coordinated care for all**
3. **A common framework for LTSS, adaptable across modalities**

This report summarizes the key themes from the day.

Keynote: We Are on a Journey, but the World Has Changed – Think of the Possibilities

Melanie Bella, who served as the first Director of the Medicare-Medicaid Coordination office at the Centers for Medicare and Medicaid Services (CMS), opened the retreat by challenging us to work toward **a single program that provides medical and non-medical services to those eligible for both**, and to stop using workarounds to make Medicaid and Medicare work together when they were never meant to.

There are 10.4 million dual eligibles today who have to navigate an extremely complex system to get the care they need. Much progress has been made since the programs were created 50 years ago – we have learned a lot from tests and demonstrations, and now 22% of duals are receiving all or some of their care in a somewhat integrated fashion from a D-SNP, PACE product, or MMP financial demonstration.

Policymakers have three obligations:

- To ensure that these programs are constantly improving
- To increase access to integrated programs
- To develop a long-term strategy or end goal so that we are not constantly using workarounds to "make something bad better"

It is also important to consider what is being learned from the implementation of the demonstrations to improve them, and how that information is shared with state and federal policymakers.

Discussion 1: What is the LTSS Delivery System that We Want?

In the first discussion session of the day, participants considered the most important elements of an ideal LTSS delivery system, identifying core values and key structural components.

Core values

- **Person-centeredness**

Person-centeredness is a core value of an ideal LTSS delivery system, defined as **"meeting people where they are, and providing the right care at the right time in the right way."** The preservation of beneficiary choice with regard to providers and caregivers is an important element of this. Other key points related to person-centeredness include the need for culturally competent care and services, respecting an individual's right to refuse care, portability across states (so that individuals are not tied

to a particular place), and taking a broad view of what LTSS means to the diverse population of users – it may mean different things to different people.

Family caregiving is a critical component of person-centered LTSS delivery. We should strive for not just person-centered care, but **person-centered and family-focused care**. Family caregivers should be supported within the system – it was noted that managed care organization (MCOs) are embracing this.

- **Normalizing LTSS**

It is critical that we reframe LTSS so that its importance is recognized by the general population, and so that the system can be improved in a meaningful way. There is a need to normalize LTSS and so that it is viewed as an intergenerational societal issue, and understood as something everyone is likely need it at some point in their life.

In order to normalize LTSS, there is a need to **integrate medical and non-medical (social) domains.** This includes avoiding the over-medicalization of aging, disability, and death (the core message of *Being Mortal* by Atul Gawande), and moving from "healthcare plans" to more holistic "life plans" that address the supports and services people need throughout life as opposed to only episodes that require healthcare. There remain delivery system, payment, and workforce barriers to integrating these domains.

This also means that access to LTSS should not be keyed to institutionalization or restrictive income or work tests but rather should be aimed at enabling as much independence as possible. Specifically, access to home and community-based services (HCBS) should not be based on a discharge from a medical or nursing facility or meeting an institutional level of need. By the same token, persons with disabilities should not have to leave the workforce or be homebound in order to receive supports and services that would enable them to remain as engaged and productive as possible in their communities.

Structure

- **Financing**

Pooled funding and **flexibility** in the use of that funding for whatever is necessary for the consumer – including social services, housing, transportation, and food – would improve the system. For example, the inability to use dollars for **housing support** is often a barrier to individuals moving into a more integrated setting.

An additional concern related to financing is that the current level of funding for LTSS does not meet the need. The lack of adequate financing for LTSS has resulted in a workforce that is underpaid and undertrained, and **insufficient payment for the necessary social services and supports provided by community-based organizations**

(CBOs). There is a need for more stable, predictable financing for LTSS. The greatest opportunity for additional LTSS financing will come from whatever health care savings can be captured through integrated plans.

- **Adequate infrastructure**

We need to build an adequate coordination and communication technology infrastructure for LTSS, including interoperable health information technology systems that support data exchange between organizations.

- **Care coordination**

Care management and care coordination are the most significant benefits of a Medicaid managed LTSS (MLTSS) plan or integrated plan. Everyone with significant LTSS need should have a right to care coordination. Individuals should have a "one-stop shop" or single person responsible for overall services. We should work to optimize the care management approach – it should be responsive, personalized, and professionalized.

- **Adequate, well-trained, fairly-compensated workforce**

We should work toward an adequate, professional, well-trained, and fairly-compensated workforce that is able to provide high-quality, person-centered LTSS. Currently the LTSS workforce is underpaid and lacks adequate training and opportunities to for career advancement. The LTSS workforce should be viewed as a vital infrastructure that we need to continually invest in to address care gaps.

- **Common data elements**

There is a need for common data elements that can be captured wherever an individual is in the system so that we can get a better sense of what LTSS need looks like, as well as the adequacy of services. This would allow for standardized **quality measures** and risk stratification for payment.

- **Broad coverage**

We should work toward a system that covers everyone with LTSS need. True integration goes beyond the integration of programs and the integration of primary and acute care – a single system should serve everyone, including I/DD, mental health, visible and invisible disabilities, and frail elders.

- **Informed consumers**

We should prioritize the education of consumers so that they can make informed decisions about their care (options counseling).

- **Engaged providers**

It is important that we educate providers and plans so that they buy-in to the values of person-centered LTSS.

Key themes from the first discussion

Eight key themes should guide future discussions:

1. Person-centeredness
2. Flexibility, simplicity, accountability
3. Adequate infrastructure
4. Care coordination
5. Adequate financing
6. Adequate, well-trained, fairly-compensated workforce
7. Integration of medical and non-medical domains
8. Reframing LTSS

Panel 1: Starting with the Duals – Priorities and Principles for the Future

Working with States

Michelle Herman Soper, Director of Integrated Care at the Center for Healthcare Strategies (CHCS), noted some key points of focus for states in serving Duals, including evaluating integrated approaches and effectively communicating the value of integrated care, finding a balance between payment adequacy for providers and getting the right care for individuals, finding tools to improve enrollment in integrated programs, gaining flexibility in the use of federal funds, and enhancing administrative alignment between Medicare and Medicaid.

States have several areas of interest with regard in moving towards integration. They value the three-way contract and continued collaboration with CMS, and support a larger role for the Medicare-Medicaid Coordination Office (MMCO), which has been responsive to states. States will explore opportunities to achieve integration through FIDE-SNPs. Other key areas of interest to states include finding solutions to problems of enrollment, permanency for Medicare-Medicaid Plans (MMPs), and more concrete tools to evaluate the impact of integrated plans.

Area Agencies on Aging

Kathy Vesley, President and CEO of Bay Aging, described how Virginia encouraged MCOs to work with LTSS service providers and area agencies on aging (AAAs) to meet service needs for members. Statewide AAA services exist in one state contract – the CBOs and AAA take responsibility, leveraging what they can in services and supports to meet needs. Virginia's statewide AAA initiative is focused on prevention, integration of caregivers, and use of social workers to facilitate care transitions.

Centers for Independent Living

Tim Sheehan, Executive Director of for the Center for Independent Living for Western Wisconsin (CILWW), described Wisconsin's focus on county-level resource centers that provide options counseling. Individuals have a choice of programs and providers, and Aging and Disability Resource Centers (ADRCs) serve as the arbiter. There are two components – a functional screen and a personal care screen, followed by a referral to a MCO and annual reassessment. There are a lot of states with models we can learn from, but that we need a national model that works for people, not just a policy solution.

Family caregiving is a critical component of LTSS delivery, but it is devalued by states and MCOs. Caregiving should be paid for at a professional level.

Engagement has to be person-by-person, in the most holistic way possible. A care manager should be an individual's "go-to" person for everything medical and non-medical. Managed care is also cost effective.

Discussion – Flexibility and Accountability

States seek greater flexibility in the use of Medicaid funds to meet individual needs. For states in integrated programs for Duals, Medicaid bears the costs and Medicare gets the savings. We need to balance flexibility and federal prescriptiveness, bearing in mind that there is a risk of state flexibility being used to reduce funding to CBOs and AAAs, and that flexibility for MCOs could become a tool for cherry picking.

Accountability is also important – what will states do to earn flexibility, and how will the Federal government hold states accountable? In addition to state accountability, there must also be consumer and provider accountability. We need to develop an independent standardized quality review process.

Panel 2: The Federal and State Policy Context

Federal Policy Context

Larry Atkins, Executive Director of LTQA, gave an overview of current federal policy context. Medicaid reforms, as we saw with the American Health Care Act (AHCA), are on the table, while changes to Medicare are unlikely. The intent on the Republican side with Medicaid is to cap federal Medicaid contributions and give states greater flexibility. Of greatest concern with the Medicaid proposal in the AHCA is that amount of federal money that would be taken out of the program.

Capping the federal match is not necessarily a big move from where we have been. Most of the Medicaid population is already in capitated plans and waivers for HCBS have characteristics similar to a block grant. Per capita caps would function more like an entitlement than block grants in that they adjust federal spending in relation to the number of eligible beneficiaries. However, giving states more flexibility will take away the entitlement.

CMS Duals Office Context

Edo Banach, President and CEO of the National Hospice and Palliative Care Organization and former CMS Deputy Director of the CMS Medicare-Medicaid Coordination Office, pointed out that states have a lot more discretion now than they did in the past. Innovations that we will see coming out of the Duals Office will be more state-focused, like the state innovations model.

To get anything done, the Duals Office has to navigate through these separate spheres of influence – the Innovation Center (the Innovation Center has authority, the Duals Office does not), the Medicaid program (which grants waivers), and the Medicare world (the "protectors of the trust fund"). In order for the Duals Office to get anything done, it needs to be acceptable for all three.

The focus should be on getting individual elements through that may eventually become part of the Medicare Advantage program or become baseline requirements for D-SNPs or FIDE-SNPs.

Managed care products and integrated products are much easier to navigate for most people than FFS. The default should be integration for all, with no carve outs.

State Context: Virginia

Cindi Jones, Director of the Department of Medical Assistance Services, Virginia (VA DMAS), discussed what her department has learned in implementing the financial alignment demonstration and now launching MLTSS statewide. With regard to

Medicare-Medicaid alignment issues, whenever there was a disagreement about which rules to follow, Medicare always won. Voluntary enrollment in Medicare makes it very difficult to get adequate enrollment in an aligned product, and, with Medicare turnover, it makes it difficult to achieve continuity of care. Trying to align claims processing and service authorization across three VA health plans has been critical.

VA DMAS has focused on the **consumer voice** over the past three years by holding focus groups, and talking to people who did enroll as well as those who opted out. The Duals project will end in Virginia in December, after which Virginia will "do a workaround." Their vision is to implement a coordinated system based on the lessons learned, with a focus on quality, access, and efficiency. Being community-based is also important.

On August 1, MLTSS will be statewide, have mandatory enrollment for everyone in the Medicaid program (with the exception of IDD waiver, which they are redesigning), offered through six health plans. They will need to coordinate the Medicare benefits with the D-SNP. They hope that they can eventually have the ability to do seamless conversion as in Tennessee and Arizona (regulation change needed).

Seven key considerations for states launching MLTSS programs:

- Stakeholder involvement
- Evaluation before, during, and after
- Care management ratios have to be considered
- Streamlining authorization
- Beneficiary protections
- Requiring better data and quality measures
- Strong contract monitoring

Discussion 2: Common Ground on Principles, Priorities, and Opportunities

Principles

The moderator laid out guiding principles to kick off this discussion based on the themes from the first discussion:

- **Normalizing LTSS need** – breaking down barriers between medical and non-medical (social) need, person-centeredness
- **Education** – of stakeholders, users, family caregivers, and providers (including the workforce)
- **Consistency** – of funding and coordination of care

Participants then offered additional principles.

- **Person-centeredness**

Person-centeredness should be a principle in and of itself. Person-centeredness may not be a strong enough word – it has to include a meaningful decision-making role for the consumer. "Person-centeredness" should be defined narrowly at the system level to emphasize the role of the consumer, however, there should be flexibility at the consumer level.

- **Consistency, flexibility, and simplicity**

Building on the theme of consistency, simplification is necessary to build an efficient and effective system. Though some choice is important, too much choice is confusing and inefficient – there should be "meaningful choice". We should work towards an infrastructure that is predictable, efficient, and as simple as possible to achieve our goals.

The principles of flexibility, consistency, and simplicity could be considered inconsistent with one another. However, they are not inconsistent when applied to different aspects of the system. For example, simplicity is needed at the consumer level, flexibility is needed at the regulatory level, and consistency is needed with regard to funding. Defining things differently at the consumer level and the system level also came up in discussions of person-centeredness in this session.

- **Fiscal and social responsibility**

Fiscal and social responsibility should be guiding principles – these values do not need to be at odds with one another.

Since LTSS generates savings, LTSS should benefit from those savings. However, savings alone may not solve the whole equation. The demographic need for LTSS is such that additional resources will be necessary – care coordination, closing care gaps, and improving quality of life cost money.

- **Comprehensiveness**

Comprehensiveness should be a guiding principle, to capture the range of services needed by the diverse population of users of LTSS. There also needs to be financial support of comprehensiveness in LTSS.

- **Actionable**

We need to be able to translate whatever comes out of this day to specific steps that can be taken.

Priorities

- **Break down barriers between medical and non-medical (social)**

We need to make breaking down barriers between medical and non-medical (social) supports and services a priority. Within the current system, medical necessity is the "holy grail," and we need to break away from that. We also need to think about how non-medical need is determined.

- **Developing data and promulgating research**

As was discussed previously, we need common data elements and producing and promoting research around LTSS.

- **Workforce issues**

Workforce issues are not only issues of capacity, but issues of economic development. Healthcare is a large part of our economy, and it continues to grow. The Home Health Aide and the Personal Care Assistant are two of the fastest growing jobs in the country – and the need will only increase. These jobs need to be restructured to be desirable.

Panel 3: Advancing Integrated Care – Models and Proposals

Managed LTSS Plan Perspectives

Michael Monson, Corporate Vice President of Long-Term Care and Dual Eligibles at Centene, first framed out some of the perspectives MLTSS plans have on how to advance integrated care:

- Financing system is a big problem – there are disincentives for Medicaid to save Medicare money and a limited ability to share savings from Medicare back to Medicaid
- Programs (MMP, FIDE-SNP, PACE) should all be on a level playing field with similar frameworks
- Pooled funding at both the state and federal level is critical
- Care management for all – all duals have a right to care management (could be in managed FFS, PACE, ACO, or a health plan)
- Person-centeredness
- Accountability and quality – MLTSS health plans are working on person-centered quality measures that health plans think are important and could start to measure soon

Mr. Monson then presented recommendations:

- States should not be disincentivized from moving toward MLTSS

- ❖ Alignment – at the bare minimum, there should be alignment between D-SNP and MLTSS plans. At the top level, there should be care management for all
- ❖ Ensure that the financial alignment demonstration is continued and improved
    - Elements of MMP structure making their way into the regular structure – this should continue – shared savings, single care plans, single care manager, a single ID card
- ❖ Standard quality metrics that will drive the system towards accountability

Bipartisan Policy Center Recommendations

Katherine Hayes, Director of Health Policy at the Bipartisan Policy Center, presented the following recommendations:

- ❖ MMCO should have regulatory authority over all programs involving duals
- ❖ A common framework, using the three-way contract – BPC has recommended the secretary work with stakeholders to develop a model three-way contract
- ❖ Full integration and pooling of Medicare and Medicaid funding – there should be audits to ensure fiscal integrity, there should be quality reporting
- ❖ Plans should be required to put together person-centered care plans, and plans should have ability to cover **anything that is reasonably related to optimizing or maintaining health or functional status**
- ❖ Plans should have the ability to target services, but should not be able to market them
- ❖ Greater shared savings to states
- ❖ Quality measures based on what we are learning – NCQA, NQF, etc
- ❖ Duals demonstrations should continue, and states should not be required to produce expected savings (deficit neutral) in the first five years – to invest in infrastructure, and to address unmet need
- ❖ Aligning appeals process and addressing overlapping benefits
- ❖ Permanent authorization of D-SNPs, with full integration by 2020
- ❖ Additional recommendations for PACE demonstrations

See the full BPC report here: https://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/

Discussion

Participants discussed the importance of robust data exchange and ensuring that states have sufficient resources to develop programs, and three way contracts giving states a pathway to coordinate with Medicare.

Discussion 3: Shared Ideas and Approaches

There were several points of overlap in the recommendations above:

- **One framework or program:** a single integrated model with common elements, including a three-way contract
- **Pooled funding** with flexibility on how that funding is used
- **Shared savings:** more shared savings going back to the states
- **Quality measures**
- **Continue and improve the financial alignment demonstration**
- **Coordination for all**, not just for duals
- **Simplicity for the consumer**

In response to these points of overlap, there was discussion around financing, the financial alignment demonstration versus other frameworks, and defending Medicaid as an entitlement.

Financing – Pooled funding, shared savings, investment, and reinvestment

With regard to **pooled funding**, pooling should exist at the plan level so that plans are able to use resources to meet beneficiary need as appropriate.

With regard to **shared savings**, we should take a broader view of who should share in savings, including the workforce and providers. Currently, the workforce and many servicers are underpaid-for – savings should be reinvested in the workforce and services. As many states do not begin to generate savings until several years down the line, we may want to think of it as "bending the cost curve" instead of savings. However, we also need to consider the needs of legislators, who lack resources. Allowing more shared savings will incentivize them to move in this direction, and those savings could be reinvested into the program by the state.

To solve this language problem, it was suggested that we could say instead – **"flexible revenue that could be shared with the states and other stakeholders within the LTSS system."** States, plans, and other stakeholders should be encouraged to reinvest whatever benefits are generated from the management of pooled resources into the LTSS system to build capacity and expand access.

We also need to think about **how to generate more dollars for investment** to build infrastructure and capacity – considering that CBOs are "capital-starved" and the workforce is underpaid. The demographic need for LTSS is such that savings will not solve the whole equation – it calls for a certain level of investment. Public-private partnerships could help with this.

Frameworks – Financial Alignment Demonstration and SNPs

The financial alignment demonstration is not the only option on the table. The financial alignment demonstration improved upon items that the SNP framework does not allow for – no more bid process, better alignment of administrative structures, opportunity to share savings with states and all-around more flexibility. However, in the interest of simplicity, the ultimate goal should be to work toward one program that accomplishes what both the financial alignment demonstration and the SNP framework were intended to do. There is cost associated with having two frameworks, especially for plans that are multistate.

Defending the entitlement

There is a real danger of Medicaid moving from an entitlement to discretionary spending. Any per capita cap would be an arbitrary cap and not reflect the actual cost of care.

Discussion 4: Framework for a Shared Strategy

At the end of the day, participants were asked to identify building blocks to reach the ideal system, and finally to vote on three top priorities.

Data and measurement

With regard to data and measurement, we need **quality measures that build on the consumer voice**, and to build up the feedback loop from consumers. Standards should be actionable and reflect the realities on the ground – people are being served in the environment in which they live, which looks different in different places. Finally, we should measure the sufficiency and efficacy of the HCBS workforce.

A common framework

We need a **common statutory and regulatory framework that would apply to all types of plans.** Quality measurement and accountability are important first steps. To reach a common framework, we should pursue policies and payments that don't disincentivize integration, and build on programs that work. There are actionable goals around continuing D-SNPs, financial alignment, and the PACE program – we should keep moving forward on program and policies we know that work to eventually move toward a single framework.

It was noted in earlier discussions that this should include a three-way contract.

Care coordination

We need to create **access to integrated, coordinated care for all persons with functional limitations who need LTSS**. Everyone has a right to a care managed that is responsible for their full benefit.

Financing and investment

We need to invest in LTSS infrastructure, to demonstrate the business case for integrated LTSS, and to not further stress the funding of LTSS. We should also highlight the historical commitment of the government to pay for these services.

Other key points that came up over the course of the day on this topic included conversations around pooled funding and flexibility in the use of that funding to better meet the needs of users of LTSS, and increased shared savings for states that providers and the workforce should also share in.

State accountability and variability

We should work to increase accountability for states, reduce variability between states, and map flexibility across states. States are transferring a lot of risk to private plans, but ultimately they are responsible. States should be responsible for the percentage of people who need care that are getting it. With regard to state variability, it was argued that wherever there is variability, there is an opportunity for downward pressure.

Education

We should prioritize education about who is covered by Medicaid. We need to tell beneficiary stories to increase understanding that states are trying to cover people with the most expensive care needs. We should also document unmet need.

Other conversations that came up throughout the day on this topic included education for consumers so that they are aware of their options (options counseling), education for providers and plans so that there is buy-in to the values of person-centered LTSS, and increased training for the workforce.

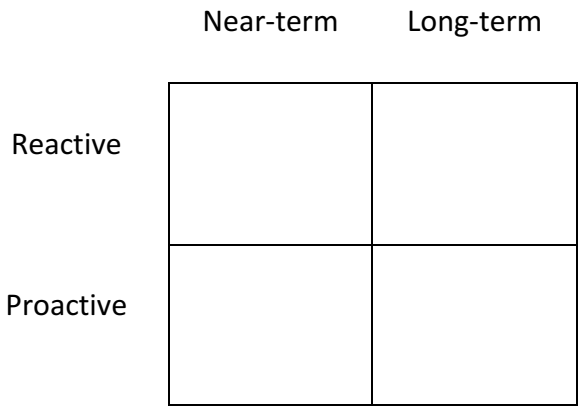
Top three priorities

1. **Quality measures that build on the consumer voice**
2. **Access to integrated, coordinated care for all**
3. **A common framework for LTSS, adaptable across modalities**

Closing

For the second session of the Retreat on May 4, 2017, we need to broaden the discussion. This event was focused on Duals, but there are many high-cost, high need Medicare-only beneficiaries living on very limited means that we also need to think about – the system is broken for them too.

LTQA's strength in bringing organizations together to arrive at a common agenda. As a group, we need to come to actionable next steps from the priorities above. As we think about what it means to be actionable, we should consider both reactive and proactive steps, as well as near-term and long-term steps. Participants were left to consider how the priorities above might fit into the following quadrants:



It was also noted that LTQA and each organization around the table have different strengths, and that we should consider where each organization would add value.

Appendix A: Agenda

Future of LTSS:
Advancing Integrated Care in a Changing Medicaid and Medicare Landscape
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8:30 Breakfast and Registration

9:00 Welcome and Opening Remarks (Carol Raphael, Bruce Chernof, Tim Lash)

9:15 Keynote: We Are on a Journey, but the World Has Changed – Think of the Possibilities
Speaker: Melanie Bella, Independent Consultant

10:00 Discussion: What is the LTSS Delivery System that We Want?
Facilitator: Carol Raphael, Chair, LTQA

11:00 Panel: Starting with the Duals – Principles and Priorities for the Future
Moderator: Gretchen Alkema, The SCAN Foundation

- **Michelle Soper, CHCS**
- **Kathy Vesley-Massey, VAAA, VA**
- **Tim Sheehan, NCIL, WI**

12:30 Lunch -- Panel: The Federal and State Policy Context

- **Erin Dempsey, Health Care Policy Advisor, Senate Finance Committee (invited)**
- **Edo Banach, CEO of NHPCO, Former CMS Depty Dir MMCO**
- **Cindi Jones, Director, VA Dept. of Medical Assistance**

1:30 Discussion: Common Ground on Principles, Priorities and Opportunities
Moderator: Tracey Moorhead, VNAA

2:15 Panel: Advancing Integrated Care – Models and Proposals

- **Michael Monson, Chair, National MLTSS Health Plan Assn**
- **Katherine Hayes, Bipartisan Policy Center**

3:00 Discussion: Shared Ideas and Approaches (common ground/priorities)
Facilitator: Sarah Triano, Centene Corporation

3:45 Discussion: Framework for Shared Strategy (Facilitated: proposed framework)
Facilitator: Carol Regan, Community Catalyst

4:30 Summary of Outcomes and Next Steps
Facilitator: Bruce Chernof, The SCAN Foundation

5:00 Close

Appendix B: Participant List, March 8 2017

First Name	*Last Name*	*Affiliation*
Sharon	Alexander	Amerihealth Caritas
Gretchen	Alkema	The SCAN Foundation
Joseph	Baker	Medicare Rights Center
Edo	Banach	National Hospice and Palliative Care Organization
Melanie	Bella	Independent Consultant
Michelle	Bentzien-Purrington	Molina
Bruce	Chernof	The SCAN Foundation
Marc	Cohen	University of Massachusetts, Boston
Samantha	Crane	Autistic Self Advocacy Network (ASAN)
Nicole	Fallon	LeadingAge
Stephanie	Gibbs	CHCS
Howard	Gleckman	Urban Institute
Jennifer	Goldberg	Justice in Aging
Katherine	Hayes	Bipartisan Policy Center
Amy	Herr	West Health Policy Center
Gail	Hunt	National Alliance for Caregiving
Amy	Ingham	Anthem
Narda	Ipakchi	American Health Care Association (AHCA)
Cindi	Jones	Department of Medical Assistance Services, Virginia
Gavin	Kerr	Inglis Foundation
Timothy	Lash	West Health Policy Center
John	Lovelace	University of Pittsburg Medical Center (UPMC)
David	Machledt	National Health Law Program
Barbara	Merrill	ANCOR
Michael	Monson	Centene
Anne	Montgomery	Altarum
Tracey	Moorhead	Visiting Nurse Associations of America (VNAA)
Carol	Raphael	Manatt
Carol	Regan	Community Catalyst
Susan	Reinhard	AARP
Helen	Schaub	SEIU
Brenda	Schmitthenner	Gary and Mary West Foundation
Tim	Sheehan	Center for Independent Living for Western Wisconsin (CILWW)
Lois	Simon	Seniorlink
Michelle	Soper	Center for Health Care Strategies

Mary	Sowers	National Assoc. of State Developmental Disability Directors (NASDDDS)
Nora	Super	n4a
Sarah	Triano	Centene
Aaron	Tripp	LeadingAge
Chris	Van Reenen	National PACE Association
Bobby	Vassar	Bay Aging
Benjamin	Veghte	NASI
Kathy	Vesley	VAAACares

Staff

Larry	Atkins
Henry	Claypool
Tzvetomir	Gradevski
Claire	Jensen
Andrew	MacPherson
Anne	Tumlinson
Jennifer	Windh

Appendix C: Discussion Outlines

1) What is the LTSS Delivery System that We Want?

Core values

- Person-centeredness
  - "Meeting people where they are, and providing the right care in the right way"
  - Preservation of beneficiary choice
  - Culturally competent care and services
  - Respecting an individual's right to refuse care
  - Portability across states (so an individual is not tied to a particular place)
  - Acknowledgement and support of role of family caregivers
- Normalizing LTSS
  - Integrate medical and non-medical (social) domains
    - Avoid over-medicalization of aging, disability, death
    - Move from "care plan" to "life plan" (care plan is short-term)
    - Emphasis on preferred settings
      - Eligibility – individuals should not have to demonstrate that they are unable to work or homebound to receive LTSS
      - Nursing home should not be access point to the LTSS system

Structure

- Adequate infrastructure
  - Need to build fully-leveraged coordination and communication technology infrastructure for LTSS
- Care coordination
  - "One-stop-shop" or single person responsible overall services
  - Optimization of care management approach
- Broad coverage
- Financing
  - Flexibility, pooled funding
  - Payment adequacy for CBOs
- Adequate, well-trained, fairly-compensated workforce
- Common data elements, quality measures
- Education

2) Common Ground on Principles, Priorities, and Opportunities

Principles

- Normalizing LTSS need
- Person-centeredness
- Consistency, flexibility, and simplicity (discussion of whether they are inconsistent, and of
- Education
- Comprehensiveness
- Fiscal and social responsibility
- Actionable

Priorities

- Break down barriers between medical and non-medical (social)
    - Thinking about how non-medical need is determined
- Developing data and promulgating research
- Workforce issues

3) Shared Ideas and Approaches

- **One framework or program:** a single integrated model with common elements, including a three-way contract
- **Pooled funding** with flexibility on how that funding is used
- **Shared savings:** more shared savings going back to the states
- **Quality measures**
- **Continue and improve the Financial Alignment Initiative (FAI)**
- **Coordination for all**, not just for duals
- **Simplicity for the consumer**

Further discussion on **financing** (pooled funding, shared savings, investment, and reinvestment), **frameworks** (financial alignment demonstration and SNPs), and **defending the entitlement** (see write-up for these)

4) Framework for a Shared Strategy

Data and measurement

1. **Quality measures that build on the consumer voice**
2. Actionable standards that reflect the realities on the ground
    - Standards should reflect people being served in the environment in which they live, which could look different in different places
3. Building up feedback loop from consumers
4. Measure the strength of the HCBS workforce

A common framework

5. **A common framework, adaptable across modalities**
    - ❖ Quality and accountability are important first steps
6. Pursuit of policies and payments that don't disincentivize integration. Build on programs that work.
    - ❖ Actionable goals around continuing DSPs, financial alignment, PACE program
    - ❖ Keep moving forward on programs and policies we know that work to eventually move toward a single framework

Care coordination

7. **Access to integrated, coordinated care for all**
    - ❖ Everyone has a right to a care manager that is responsible for their full benefit

Financing and investment

8. Investing in infrastructure
9. Not further stressing the funding of LTSS
    - ❖ Highlight the historical commitment of the government to pay for these services
10. Demonstrate the business case for integrated LTSS

State accountability and variability

11. Accountability for states
    - ❖ States are transferring a lot of risk to private plans, but they are ultimately responsible
    - ❖ States should be responsible for the percentage of people who need care that are getting it
    - ❖ Performance accountability is also important
12. Reduce variability between states
    - ❖ Wherever there is variability there is an opportunity for it to experience downward pressure
13. Articulate and map flexibility across states

Education

14. Education about who is covered by Medicaid
    - ❖ Tell the stories – these are people with the most expensive care needs that states are trying to cover
    - ❖ Document unmet need

Top three priorities:

- ❖ Quality measures that build on the consumer voice
- ❖ A common framework for LTSS, adaptable across modalities
- ❖ Access to integrated, coordinated care for all