Testimony of UnitedHealthcare Community Plan of Ohio, Inc.
House Finance Committee
Subcommittee on Health & Human Services
March 21, 2017

Good morning Chairman Romanchuk, ranking member Sykes and members of the Sub-Committee. My name is Tracy Davidson and I am the Chief Executive Officer for UnitedHealthcare Community Plan of Ohio. On behalf of UnitedHealthcare, thank you for the opportunity to address the Sub-Committee regarding the creation of the managed long term services and supports (MLTSS) program for Ohio Medicaid.

UnitedHealthcare is a part of UnitedHealth Group, a *Fortune 6* company. We are proud to employ over 3,200 Ohioans and honored to provide health care benefits to over 2 million individuals in Ohio.

UnitedHealthcare has participated in Medicaid MLTSS programs since 1989 and currently supports MLTSS in 13 states, serving nearly 309,000 members, [1] with our 14th state, Virginia, going live on August 1. We are an experienced statewide health plan, working successfully to deliver MLTSS in both urban and rural settings.

My comments today will center on the insights and lessons learned we have gained from almost 30 years of experience that can help Ohio in its design of an effective MLTSS program.

MLTSS is not one size fits all

Long-term services and supports (LTSS) are not only health care services; rather they are a range of services coordinated across many providers and settings to address the needs of individuals who have functional limitations that impair their ability to carry out activities of daily living.

Individuals who need and access LTSS constitute several overlapping populations, each requiring varying levels of care, including individuals of all ages – elderly and non-elderly – those with physical disabilities, behavioral health diagnoses, traumatic brain injuries, or disabling chronic conditions.

Because of these unique characteristics, the Ohio MLTSS program will differ from, but build upon, the experience gained in the MyCare program. MyCare serves older Ohioans and consumers under 65 with a disability in select regions of the state, coordinating Medicare and Medicaid benefits, including LTSS. The managed care delivery system has moved the needle on several key metrics in the MyCare program. UnitedHealthcare Community Plan, for example:

- Staff assessed and transitioned 1,530 members to Home and Community Based (HCBS) waiver programs in 2015;

[1] AZ, DE, FL, HI, IA, KS, MA, NJ, NM, NY, OH (MMP), TN, TX, VA (8/1/17)

- Achieved a nursing facility diversion rate of 93%; and
- Repatriated 340 members back to the community.

The managed care industry has lessons learned from the MyCare program that will inform how we approach MLTSS. For example, we experienced challenges with claims payment stemming from the loss of a key claims clearinghouse for independent providers days before the launch of the program. As an industry we learned a great deal from that experience and developed systems and processes to ensure non-traditional Medicaid providers are reimbursed appropriately and in a timely fashion while saving them money they would have normally had to spend on clearinghouse services.

Successful MLTSS programs

Similar to Ohio, most states do not undertake MLTSS programs with the goal of saving money. Typically, states are looking to reach long term system sustainability, achieve a greater level of community-based service delivery, and increase program quality and accountability.

Currently, 22 states[2] operate Medicaid MLTSS programs while six others[3] in addition to Ohio are considering or planning to develop MLTSS programs. Nationally, the enhanced care coordination approaches of MLTSS have driven success for these states. For example:

- **Texas**: A national study found that individuals enrolled in MLTSS had shorter hospital lengths of stay, fewer emergency room visits, and much lower health care costs overall than a comparison group of beneficiaries who were not enrolled in a managed care plan for LTSS.[4]
- **Delaware**: The implementation of MLTSS has led to the increased use of participant-directed service models by LTSS participants.[5]

States across the country have seen significant successes in rebalancing LTSS in the community driven by the managed care delivery system, for example:

- **Arizona**: Increased their rate of care in the community from 5% to over 70% over the lifetime of the MLTSS program from 1989 to 2015.[6]
- **Tennessee**: MLTSS has allowed the state to shift community care from only 17% of LTSS spending in 2010 to 44% by 2015.[7]

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[2] Arizona, California, Delaware, Florida, Hawaii, Illinois, Iowa, Kansas, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, North Carolina, Ohio, Rhode Island, South Carolina, Tennessee, Texas, Virginia and Wisconsin.

[3] Alabama, Nebraska, New Hampshire, Oklahoma, Pennsylvania and Virginia

[4] Medicaid Managed Care. Issue brief no. IB79. AARP, n.d. Web. <http://assets.aarp.org/rgcenter/il/ib79_mmltc.pdf>

[5] Kasten, J., Saucier, P., Burwell, B. How Have Long-Term Services and Supports Providers Fared in the Transition of Medicaid Managed Care? A Study of Three States. Truven Health Analytics prepared for Office of Disability, Aging and Long-Term Care Policy Office of the Assistant Secretary for Planning and Evaluation. U.S. Department of Health and Human Services. December 9, 2013.

[6] Nebraska Long Term Care Redesign — DRAFT Prepared by Mercer. March 2017
<http://dhhs.ne.gov/medicaid/Documents/Long%20Term%20Care%20Redesign%20Plan%20-%20Draft%20by%20Mercer%20Health%20Benefits,%20Inc%20v2.pdf>

[7] Ibid.

Gary Jesse and Patti Killingsworth, the Medicaid Directors for the states of Texas and Tennessee, respectively, are nationally-recognized Medicaid leaders and champions of MLTSS. In addition, Martha Roherty and Camille Dobson of the National Association of States United for Aging and Disabilities (NASUAD) are national thought leaders in the MLTSS arena. I would be happy to connect you to them to learn more about their perspectives on MLTSS.

Additionally, UnitedHealthcare has achieved success through our approach to care coordination in MLTSS programs across the country:

- **Florida**: A 2016 survey of MLTSS members found that 73% of respondents reported that their quality of life had improved since enrolling in MLTSS.
- **Texas**: Through our work in the MLTSS program, we have reduced emergency room use among enrollees by 38%.

As they have in Ohio, Area Agencies on Aging (AAAs) and other community-based organizations (CBOs) have historically played a significant role in the LTSS system across the country. Successful MLTSS programs in other states, such as New Jersey, leverage the local expertise, connections, and commitment to community that the AAAs and CBOs bring to the table. Here in Ohio, the AAAs and CBOs should serve a critical role, working with individuals enrolled in the MLTSS program, maximizing their capabilities by providing critical waiver service coordination and ensuring that individuals' needs are assessed and met. Such a role would demonstrate Ohio's meaningful commitment to and investment in our community assets.

Measuring quality the right way

Just as MLTSS differs from traditional Medicaid services and populations, measuring the quality of an MLTSS program should also differ from traditional programs. Current national managed care quality measurement systems, such as HEDIS and CAHPS, do not appropriately capture the impact of LTSS on quality of life.

In deploying MLTSS, Ohio has the opportunity to truly measure the entirety of the delivery system that individuals accessing MLTSS touch. By leveraging person-centered metrics, Ohio will be able to measure quality of life outcomes, rather than processes, and functional activities of daily living, rather than clinical services.

UnitedHealthcare engaged the expertise of a National Advisory Board to develop an MLTSS quality framework based on nationally-recognized tools that apply to the functional and clinical needs of LTSS enrollees. We recommend that Ohio consider these measurements as a core component of an effective, evidence-based MLTSS program and I would be happy to share those measures with you today.

Thank you for the opportunity to testify today. I would be happy to answer any questions from the Committee at the appropriate time.

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Enclosed: *Managed Long-Term Services & Supports – A Proposed Framework*