

**Written Testimony Submitted to the Finance Health and Human Services Subcommittee Hearing – May 24, 2017**

Good morning, Chairman Hackett, Vice Chair Tavares and members of the Committee. Thank you for the opportunity to submit testimony. My name is Pam Coleman and I am a consultant with Sellers Dorsey, a national Medicaid consulting firm. I am here at the request of the Ohio Association of Health Plans. I have over 30 years' experience in Medicaid and was instrumental in the design and implementation of one of the first state mandatory MLTSS programs in the country. That program, Texas STAR+PLUS, was started in 1998 as a pilot in Houston Texas. Today the program is statewide in Texas with over half a million members.

Here we are 25 years later and there are 22 states, including Ohio with programs that manage LTSS under a capitated arrangement. There are 5 other states including Ohio moving to or looking to expand MLTSS in 2017 and another 5 exploring the possibility. We have learned a lot in the last 25 years from the successes and challenges of implementing these programs and states keep raising the bar. A recent study from the Centers for Health Care Strategies (CHCS) and National Association of States United for Aging and Disabilities (NASUAD) who surveyed 12 states with MLTSS programs found that states have been achieving the goals set for their programs including rebalancing LTSS spending to the community, improving member experiences, quality of life and outcomes, reducing waiver lists for home and community based services and in increasing budget predictability and managing costs.

In Texas our MLTSS program continues to evolve and improve each year in response to new learning and best practices from innovative initiatives in Texas and other state MLTSS programs. In 2011 Texas changed their managed care agreement to a value based purchasing contract. The contract included sanctions for activities that MCOs must all get right such as paying claims timely and timely response to members' complaints and grievances. To drive performance improvements Texas put part of the capitation payment at risk – currently 4%. The managed care plans must score well on national performance measures and reduce potentially preventable events in order to earn the full capitation payment. The incentives have been successful in improving outcomes. The STAR+PLUS the program has effectively reduced ER visits by 40%, inpatient hospitalizations by 28%, increased community care by 70% and eliminated a 60,000 persons from the waiting list for HCBS.

STAR+PLUS has also proven cost effective. A recent actuarial report issued by Milliman, which evaluated the cost impact of managed care in Texas as compared to FFS, data showed that Texas' MLTSS program created cumulative savings of \$172M from 2010-2015, an average annual savings of 3.7%.

The state also operates a number of quality incentives programs aimed at improvements in LTSS care. A Quality Incentive Payment Program (QIPP) has been designed to encourage nursing facilities to improve quality and innovations in their services, using the CMS 5-star rating system to measure success. This model provides nursing facilities with additional funding to implement programs that enable these innovations as well as dollars for proven achievements through the rating system. Texas is still in the process of finalizes payments for 2016. However, it is estimated that greater than \$500 million will be paid out in the state fiscal year 2016.

I have been working with your neighboring state, the Commonwealth of Pennsylvania for the last one and a half years on the design and implementation of their new MLTSS program Community Health Choices which will start enrolling members next year.

The program will be rolled out by region and will provide services to more than 420,000 individuals who are dually eligible for Medicare and Medicaid and individuals with disabilities. Of that total, approximately 130,000 individuals are receiving either HCBS or nursing facility services.

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Pennsylvania implemented a broad-based stakeholder participation strategy that was applauded by CMS. They initially released a concept paper for CHC and received 2300 comments from stakeholders. These comments were used to inform the program design and the subsequent RFP. They also engaged the AAAs with the redesign of the participant assessment for LTSS and medical necessity. The AAAs formed a consortium called Aging Well who will hold the contract for completing medical necessity assessments using the Minimum Data Set assessment.

For a minimum of the first six months of CHC implementation, the MCPs will be required to include all willing LTSS providers in their network to ensure continuity of care for participants. They will also be required to pay the prevailing rates during the continuity of care period. Each of the plans have indicated that their provider contracts are good for a year so no LTSS providers will be dropped (unless for cause) or have their rates lowered during this time.

Pennsylvania did a new procurement for CHC and selected three MCPs. The MCP agreements include value-based purchasing concepts and continue the Departments' increased focus on greater coordination between the physical, behavioral health, and LTSS. The managed care plans are currently engaged in readiness reviews.

The MyCare experience in Ohio has resulted in positive outcomes for members and seen improvements year over year. The Department of Medicaid has assessed the central challenges faced by providers during the implementation and transition issues faced by members. Their planning for MLTSS implementation recognizes and addresses those challenges including a phased implementation, member transition assistance, improved system integration, extensive provider training and need for value-based contracting. In addition Ohio has the support and experience of other states including access to contracting agreements, readiness review tools and monitoring resources to help guide a smooth and unified transition to MLTSS.

In summary MLTSS programs have evolved and states can look to achieve program objectives by following best practices recommends for a successful MLTSS Implementation Including:

- State led forums: Workgroups like those formed by the Department of Medicaid that encourage providers, advocates, stakeholders, community partners and health plans to offer implementation and policy recommendations.

- Proactive provider engagement: Require health plans to employ dedicated provider relations staff responsible for supporting LTSS providers and cultivating effective relationships.
- Provider education: Require health plans must provide comprehensive on the ground assistance and technical training to providers to support them with submitting clean claims, following prior authorization requirements, and other administrative processes to ensure a smooth transition.
- Continuity of Care period: Require health plans to not reduce service authorizations for a period of time (usually 6 months) and to contract with all current LTSS providers serving members during that time frame.
- Value-based purchasing and incentive programs. The implementation of MLTSS affords new opportunities for many traditional providers. Through state, MCP and provider collaborations states have implemented innovative models that enable value-based purchasing agreements and incentive programs that provide additional funding to providers, such as nursing facilities, for achievements in quality that result in savings to the overall program.
- Streamlining Administrative Processes. Both institutional and HCBS LTSS providers grapple with the transition from a single state payer to multiple payers involved in the enrollment, claims processing and authorization process. Perhaps the most important process adopted is the dedicated staff that many plans deploy to serve as LTSS experts and work hand-in-hand with providers to support them through the enrollment and implementation process.