MLTSS
LEADERSHIP SUMMIT

National MLTSS Health Plan Association

OCTOBER 4, 2022

The National Press Club, Washington DC

SUMMIT OVERVIEW

The National MLTSS Health Plan Association hosted an inaugural Leadership Summit to create a collaborative platform for government officials, heads of Managed Care Organizations (MCOs), and MLTSS providers to present and debate the biggest challenges facing managed long-term services and supports (MLTSS) today.

National MLTSS Health Plan Association

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SUMMIT EXECUTIVE SUMMARY

- **MCOs are driving innovation.** The pandemic drove progress, accelerating MCOs' deployment of creative technology solutions and collaboration with stakeholders. State regulators continue to emphasize the ongoing need for MCOs to share new evidence-based solutions across all elements of MLTSS, such as technology-enabled caregiver support, advancing value-based arrangements, addressing workforce shortages and health disparities, and helping to drive increased integration to reduce complexity for the beneficiary.

- **The LTSS population is disproportionately affected by health disparities; however, they are often not included in health equity discussions.** LTSS members have a unique set of needs that often intersect with historically marginalized identities. Additionally, the workforce shortage is even more acute in underserved communities, further hindering the quality of delivery in those areas. MCOs recognize MLTSS is not traditional managed care and continue to request greater flexibility from state regulators in determining the optimal approach for this population to help address health equity challenges.

- **Integrating Medicare and Medicaid is critical to reducing costs and complexity.** States should focus on alignment and integration with Medicare to reduce costs and complexities for beneficiaries. States and MCOs are seeing successful outcomes when integrating care. Further, the Administration is prioritizing the integration of care, for the dually eligible population, to streamline care and reduce confusion for these members, many of whom may have low health literacy. Panelists discussed opportunities for further integration and recognized the inherent effort required to educate members on the benefits of alignment.

- **Integrating physical and behavioral health is also critical to achieving optimal outcomes.** Panelists discussed the challenges of coordinating and delivering care when behavioral health is not carved in at the MCO level, including the resulting dependency on states to help exchange data between the physical health and behavioral health MCOs. Even when carved in, panelists acknowledged the higher barriers this vulnerable population faces to access behavioral health providers. They discussed mitigation approaches underway such as training front-line staff and LTSS providers to look for the behavioral needs of beneficiaries, partnering with community organizations for trusted support, and employing telehealth solutions.

- **States, MCOs, and other key stakeholders need to define a standard set of LTSS quality measures and desired outcomes to advance quality and outcomes across the industry.** States are already looking to each other for best practices and looking to MCOs to bring forward evidence-based ideas. A common rule of measure tailored to the uniqueness of the LTSS population will allow states to not only link programmatic goals to metrics and outcomes but also more clearly compare results to other states. Despite the inherent difficulty of defining value in the future state, panelists believe it is foundational to align value-based payment to program goals, both at the state level and the individual level.

- **The direct care workforce crisis remains the key issue facing the LTSS population.** States, MCOs, and providers are collaborating to develop innovative methods to support the workforce, including education, digitization, and value-based payment. MCOs are seeing meaningful impact when supporting the informal caregiver by helping them self-identify, providing coaching, teaching them to identify risk and report it, and empowering them to support the management of their loved ones' care.

PERSPECTIVES FROM THE STATES

PANEL OVERVIEW: By 2021, half of all states had shifted to MLTSS programs to manage the long-term care needs of individuals with complex health due to aging, chronic illness, or disabilities. MLTSS programs continue to evolve as some states expand the scope of their programs while others weigh the benefits of moving to a MLTSS model given the increased demand for LTSS and fiscal impact on individual states. Across the country, MCOs and states are continuously seeking best practices for how to collaborate and achieve collective LTSS goals. This panel highlighted the role of states in MLTSS advancement from the perspective of State Medicaid Directors, and how MCOs can support the achievement of collective goals by sharing challenges, best practices, and innovative solutions.

MODERATOR: Gary Jessee, Managing Director, Sellers Dorsey

PANELISTS:

Elizabeth Matney, Medicaid Director, Iowa Department of Human Service
Jennifer Jacobs, Assistant Commissioner, Division of Medical Assistance & Health Services, State of New Jersey

KEY THEMES:

- **States can look to other states for best practices when launching an MLTSS program.** To effectively drive advancements in LTSS, states and MCOs need to learn from each other and collectively understand common challenges and promote proven solutions. While states have tailored MLTSS programs to meet the specific needs of their local markets, some structural commonalities emerge as a result of states sharing their experiences with other states. The panelists emphasized the importance of learning from each other and the opportunity to leverage insights and program elements from other states for adoption in their market. For instance, New Jersey Medicaid agency staff studied the MLTSS programs in Tennessee, resulting in some of the Tennessee programmatic elements being incorporated into New Jersey's MLTSS program design. The Pennsylvania MLTSS program was also cited as having some similarities to the New Jersey market, based on sharing best practices.

  Panelists also reiterated that state regulators are seeking innovative ideas from all stakeholders and discussed opportunities for industry forums to promote transparency and advancement of care solutions.

- **Measure what matters.** States and MCOs are aligning to set system-level LTSS goals that matter most to beneficiaries. Panelists noted too many measures dilute focus and recommended that states select a core set of intentional measures to drive the program direction. Favorable outcomes should be communicated on an ongoing and frequent basis to share the value of LTSS.

  Panelists discussed the difference between measuring and meeting regulatory minimums versus measuring and achieving desired outcomes. For example, MCOs can meet the necessary network adequacy requirements set by the state but may not have enough capacity within their provider networks to meet all the specific needs of the population they serve across different geographies. The goal is to focus on metrics that are person-centered, not just operational in nature. Panelists shared that impactful metrics they look at include consumer experience surveys (e.g., NCI-AD), care plan development metrics, caseloads, grievances, and the average length of stay in facilities and hospitals. Other examples include days awaiting placement, including in-home and foster care, where the longer the member waits for service placement, the more stressed the family becomes, and the risk of crisis increases.

- **Effective partnerships are transparent about both innovation and challenges.** States and MCOs are forming close relationships and sharing challenges, best practices, and tested data-driven innovation to collaboratively align on shared goals and solutions. To begin addressing significant challenges within the health care system, candid conversations about the realities of MLTSS care delivery are critical to driving solutions. Panelists emphasized how a consistent communication channel between states and MCOs can build goodwill that will help weather challenging situations, as experienced during the pandemic.

  Panelists challenged MCOs to continue to bring solutions to state leaders, as Medicaid agencies are highly interested in emulating successes that MCOs are experiencing in other states. They recommended that new initiatives should demonstrate data-driven outcomes that show a pathway to scale such that they can appropriately share the benefits of such programs with their state leadership and with the public.

TO ADVANCE THE EFFECTIVENESS OF MLTSS PROGRAMS, STATES AND MCOS NEED TO ENGAGE IN TRANSPARENT DISCUSSIONS ON HOW THINGS ARE WORKING TODAY AND FOSTER INNOVATION ACROSS THE SYSTEM.

- **Keep the member central to your vision.** States and MCOs understand the importance of maintaining a member-centric view when supporting MLTSS members. Panelists challenged MCOs to rise above just meeting state requirements and focus on measuring long-term goals focused on how MCOs impact member lives. Wrapping structured reporting and accountability around this philosophy will improve member-centered quality of care and deliver favorable downstream reductions in cost.

PERSPECTIVES FROM CMS

KEYNOTE SPEAKER: Chiquita Brooks-LaSure, Administrator, Centers for Medicare and Medicaid Services

MODERATOR: Christopher D. Palmieri, President & CEO, Commonwealth Care Alliance

KEY THEMES:

- **Improving care for dually eligible beneficiaries and those with LTSS needs is inherent to promoting health equity.** To advance health equity, CMS is focused on improving access to affordable coverage and quality services, including for those with LTSS needs.

    - **CMS believes integrated care models are essential to improving care for dually eligible beneficiaries.** Only 18% of full-benefit dually eligible beneficiaries were in integrated care models in 2021. CMS believes MCOs are valued partners in ensuring members are enrolled in integrated care models; and there is a need to increase the participation of dually eligible enrollees in these models.. Greater enrollment in integrated care models will help streamline the care experience and reduce confusion for members. Dually eligible beneficiaries have lower health literacy and complex needs, increasing challenges to navigating a more complex system. CMS indicated the 2023 Part C and D rule represents one of the most significant duals-related regulatory activities in years, which will support integrated models.
    - **Simplifying Medicaid eligibility and enrollment enhances access to care.** If finalized, the recent proposed rule is expected to reduce enrollment barriers by enhancing beneficiary protections, relaxing timeliness requirements, easing transitions between programs, and simplifying reporting.
    - **Developing technical assistance toolkits to help states monitor and oversee Managed Care programs.** In June 2022, CMS published the MLTSS Access and Monitoring Toolkit, which can help states to improve access and quality.

- **The Long-Term Care population is a priority for the Administration.** This vulnerable population is a focus for CMS. This population often experiences more transitions of care and interacts with the health care

system frequently. The disparities in this population, particularly around race and ethnicity, are quite stark and warrant greater attention from CMS and MCOs to help improve care. CMS has the desire to hold MCOs

IT IS A HUGE PRIORITY FOR THE ADMINISTRATION TO THINK ABOUT LONG-TERM CARE...SOME PEOPLE DON'T UNDERSTAND HOW MUCH WE SEE DISPARITIES IN THE LONG-TERM CARE POPULATION, ESPECIALLY WHEN YOU BREAK IT UP BY RACE/ETHNICITY...THIS IS A POPULATION WHERE WE NEED TO THINK ABOUT HOW TO DELIVER THAT CARE BETTER, AS WE CONSIDER WHAT INNOVATION MODELS TO PURSUE, PLACES TO INVEST IN, AND EVALUATE WHAT IS HAPPENING TO BENEFICIARIES ACROSS OUR PROGRAMS.

- CHIQUITA BROOKS-LASURE, ADMINISTRATOR, CMS

accountable and measure what matters.

- **CMS calls MCOs to action.** The CMS Administrator challenged MCOs to prioritize the following initiatives:
  - Collaborate with the Administration to improve vaccination rates
  - Support states by sharing beneficiary information to ensure data is accurate and updated for eligibility redeterminations
  - Focus on transitions of care between settings to ensure individuals receive care in the appropriate settings
  - Develop innovative partnerships to drive improvements in equity, address social determinants of health, and shift to value-based payment to promote better care

SOLUTIONING FOR HEALTH EQUITY

PANEL OVERVIEW: CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geographic location, preferred language, and other factors that affect access to care and health outcomes." While health equity affects many different populations, disparities are even more pronounced among the population needing LTSS, whose disability status often intersects with other historically marginalized identities. This session explored the role of LTSS in achieving health equity for vulnerable populations, including which policies are needed to improve equitable access and quality of health care services.

MODERATOR: Izzy Lopes, Senior Director, Equity, Education, and Engagement, Commonwealth Care Alliance

PANELISTS:

Hany Abdelaal, DO, President, Health Plans, VNS Health
Cait Kennedy, Head of Strategy and Development, Vesta Healthcare

KEY THEMES:

- **Disability often intersects with other forms of marginalization, compounding health disparities for many individuals with LTSS needs.** Panelists explored ideas for how to bring the LTSS population to the forefront of health equity discussions. Panelists urged the industry to increase messaging about whom these beneficiaries are, highlighting their diverse contributions and histories. There is an opportunity to educate the public on the systemic factors that drive disparities beyond behavioral choices. Internally, there is also an opportunity for increased training and dialogue within plan and provider organizations about how to promote health equity at the intersections of disability, race, geography, gender, etc., as well as opportunities to advance language access, health literacy, and culturally tailored services.

- **MLTSS is not typical managed care**. Many LTSS members access care on a daily basis, which requires greater levels of engagement than do other members requiring less complex care. Due to the frequency of interaction, plans and providers know their members and their communities and are well-positioned to address the complicated factors that lead to disparities in access and care. Further, traditional care measures (e.g., HEDIS) may not

apply well to LTSS. Rather than cost reduction and utilization prevention, the goals of MLTSS are to promote independence, safety at home, and patient choice. Panelists discussed how select metrics should be curated to measure these goals when compared to the broader Medicaid population with different incentives and acuity of services.

To help innovate, panelists requested greater flexibility from state regulators in determining the optimal approach for this population and noted that current restrictions (e.g., related to telehealth and out-of-state behavioral health providers) make it challenging to implement one solution to fit all LTSS circumstances. MCOs request that states allow MCOs to set optimal provider ratios (i.e., using telehealth and behavioral health providers) rather than dictating them at the state level. Further, there is a desire by MCOs to be held to outcomes measurement that makes sense for this complex population, rather than process or provider ratio measurement.

- **The workforce shortage is a challenge to achieving health equity for the LTSS population.** While workforce shortages are pervasive, they are more dire in hard-to-serve regions due to factors such as rate issues, challenges with recruiting, and public safety concerns. This is resulting in provider deserts where providers are no longer providing services, primarily affecting access and quality in historically underserved areas (e.g., remote areas or those perceived to pose a risk to personal safety). For instance, one MCO noted they are unable to serve all of the referrals they receive due to these provider deserts.

  To improve access and address the inequities that are prevalent in this population, panelists discussed opportunities to increase all forms of accessibility to health care services and coverage, including investing in provider deserts, working with providers that serve minority subpopulations, and providing in-home vaccines. Panelists emphasized the need for plans to have greater flexibility to innovate, through leveraging other healthcare workers, telehealth, out-of-state behavioral health providers; and then by measuring and holding providers accountable to the desired outcomes through VBP arrangements.

SOLUTIONING FOR VALUE

PANEL OVERVIEW: Half of the states currently provide Medicaid coverage for LTSS through contracts with Medicaid MCOs. The panel examined the need for greater articulation of the value of MLTSS programs for consumers, state governments, and federal taxpayers. Demonstrating value will require advancing value-based contracting in MLTSS programs and greater promotion of quality and more uniform measurement of MLTSS.

MODERATOR: Brendan Harris, Vice President, Community HealthChoices, UPMC Health Plan

PANELISTS:

Rick Frederickson, Regional Vice President Long Term Care Programs, Centene
Katie Lavelle, Executive Director, Medline Managed Care, Medline Industries
Elizabeth Klunk, Senior Vice President, Versant Health
Liz Miller, EVP, Client Success & Regional President – East, CareBridge

KEY THEMES:

> THE INDUSTRY NEEDS TO COALESCE ON A SET OF PRIORITY MEASURES ACROSS PROGRAMS AND STATES TO STANDARDIZE HOW QUALITY IS MEASURED IN MLTSS PROGRAMS.

- **The industry should collectively define the goals for achieving value and quality for this unique population.** Due to the heterogeneity and the long-term care needs of the LTSS population, the goals for MLTSS often differ from traditional Medicaid, and there can be very different goals for various subpopulations within MLTSS. These unique and nuanced aspects of the MLTSS population present a critical opportunity for the industry to collaboratively identify a common vision for LTSS and a set of goals and principles around defining value and quality (e.g., quality of life, independence, community inclusion, beneficiary choice). Once the overarching goals are identified, metrics can be mapped to those goals and plans and providers can focus their resources on improving those metrics. For example, the Medicare STAR ratings program set forth a common set of industry goals and metrics, for which plans then put resources behind improving performance. This has accelerated the movement to value-based payment for the Medicare sector. Panelists highlighted a similar opportunity for the LTSS industry to develop a

common vision for value and quality that is more person-centered and reflects the uniqueness of the LTSS population.

- **Measures should align with the program goals and desired outcomes.** Once the goals for value are defined, a standardized set of metrics should be identified that further those goals. States have an opportunity to include core measures in their contracts with MCOs, which will help drive standardization across the industry. However, metrics should not only be at the systems level but also capture person-centeredness at the individual level. Panelists recognized the inherent challenges of defining measures, since individuals may need very different supports depending on their acuity, natural supports, etc.; but challenged the audience to not let that stop progress. For example, panelists highlighted how the Tennessee TennCare Medicaid program set a program goal of improving independence and employment rates and aligned incentive payment to individual job placement, retention in placement, and reduction of other supports.

- **Promoting value-based models is paramount.** Panelists stressed the need to redefine value-based payment more broadly as a 3-legged stool which in addition to cost savings includes efficiency and effectiveness of care coordination (e.g., length of stay, SNF avoidance) and member satisfaction (e.g., receipt of services, timeliness, according to expectations). Panelists noted that there are standard evidence-based tools to measure patient experience and existing VBP for skilled nursing facilities (SNFs) that MLTSS plans and providers can leverage and tailor to their unique populations. Rather than trying to quantify all aspects of care, plans and providers should choose a lane, set a target, start reporting, and adjust as necessary.

  Panelists also remarked that providers face challenges with value-based contracting due to exclusive MCO deals and a lack of transparency and engagement when developing value-based metrics. Consequently, providers often must report on myriad measures that vary widely from contract to contract. As noted above, states can play a role in requiring the reporting of core metrics to facilitate standardization.

SOLUTIONING FOR BEHAVIORAL HEALTH

PANEL OVERVIEW: The current US health care system provides fragmented care for primary health, behavioral health, and LTSS. This panel examined the need for care integration, the implications of behavioral health being carved out of MLTSS, and meeting the challenges of capacity constraints. Panelists shared lessons learned and opportunities to further integrate behavioral health care and improve access and utilization for LTSS beneficiaries.

MODERATOR: John Lovelace, President, Government Programs, UPMC Health Plan

PANELISTS:

Michelle Bentzien-Purrington, SVP, MLTSS and SDOH Innovation, Molina Healthcare
Cindy Leach, Vice President, Long-Term Care, Mercy Care/Aetna
Sandra Berg, Ph.D., Senior Director, Complex Health Solutions Behavioral Health and Programs, CareSource
Lily Rager, Chief Growth Officer, Pyx Health

KEY THEMES:

> **GREATER INTEGRATION AND COORDINATION OF BEHAVIORAL HEALTH AND PHYSICAL HEALTH ARE REQUIRED TO ENHANCE QUALITY AND ACCESS WHILE DECREASING COSTS AND COMPLEXITIES.**

- **MLTSS plans bridge connections with their state and provider partners to address their members' behavioral health needs.** Carving out behavioral health results in fragmented care and lack of transparency between the various entities managing a beneficiary's health and goals. However, even when behavioral health services are carved out, MLTSS plans play a key role in facilitating cross-system communication and collaboration to address the behavioral health needs of their members. MLTSS plans invest additional resources to engage with the state Medicaid agency and providers to coordinate on provider support needs and challenges, policy, access to services, and even individual members.

- **Training frontline and non-clinical workforce to identify behavioral health needs can improve coordination, reduce stigma, and prevent crises.** Lack of training and stigma around behavioral health can impede effective management of the behavioral health needs of LTSS members. For example, Kansas carved in all populations into MLTSS at the same

time, which created challenges as some providers expressed hesitation towards working with individuals with behavioral health needs due to stigma. It can be valuable to train various provider groups on behavioral health to support the continuum of behavioral health needs present in the MLTSS population. LTSS and behavioral health care coordinators would benefit from understanding each other's roles and the other care plans of the beneficiaries they are supporting. MLTSS plans can also leverage staff including peer supports, community health workers, community-based organizations and other non-clinical supports to identify signs of escalation and stymy crises for some members so that more specialized staff can be directed to focus on higher-need/complex members.

- **Technology can increase access to behavioral health care and social isolation interventions.** Virtual care offers greater member choice and improves access for a population that struggles with mobility challenges. Panelists discussed the expansion of telehealth and the federal programs underway to expand broadband, particularly for rural areas where in-person interactions are more limited/less frequent and adequate transportation may be limited. The panel recognized the value of offering virtual health as an option to all members who prefer it and encouraged use beyond provider appointments and medication adherence to access peer support and substance use disorder groups.

  Panelists are finding the benefits of technology are expanding beyond just care visits to facilitating companionship and social connectedness. As a result, LTSS visits are becoming shorter as some social needs are being fulfilled through other avenues, including virtual interactions. Given the value of technology for delivering both behavioral health care and social isolation interventions, the panel challenged MCOs to think about how they engage with community partners (e.g., CILs, AAAs) to make technology more accessible, more interoperable, and more engaging for members. Technology was viewed as an enabler of connection, helping to reach people who may not be willing to let someone into their homes.

- **A continuum of services and provider types is needed to support individuals with behavioral health needs.** Community partners can also be leveraged to build trust and connection, and as a point of access for other valuable resources members may not be utilizing. Panelists also discussed other solutions to combat the shortage of behavioral health specialists, such as increasing wages, reducing prior authorization requirements, and lessening reporting burdens.

SOLUTIONING FOR NEW POPULATIONS

PANEL OVERVIEW: Several MLTSS programs have key populations carved out, including members with intellectual and developmental disabilities (I/DD). This panel examined opportunities to better serve populations who are often carved out of MLTSS & "new" populations, including informal caregivers. Panelists explored how states, MCOs, and providers can work together to tailor services for optimal outcomes, and shared lessons learned from states that have included specialized populations in their MLTSS programs.

MODERATOR: Serena Lowe, Ph.D., Senior Director, LTSS, CareSource

PANELISTS:

Kris Kubnick, Chief Member Experience Officer, Inclusa, Inc.
Mark Lashley, Chief Executive Officer, Caregiver, Inc.
Eric Daniels, EVP, Chief Growth Officer, SeniorLink
Patti Killingsworth, SVP, Strategy & Industry Relations, CareBridge

KEY THEMES:

- **Engagement of all stakeholders early in the process is critical.** Sub-populations under the umbrella of the LTSS category require significantly different networks and care models. As states look to carve new populations into the MLTSS program, they should focus on seeking comprehensive feedback from all relevant stakeholder groups, including specialized LTSS providers (e.g., I/DD providers), individual beneficiaries, families, MCOs, and local community support organizations. A formal process of compensating individuals and experts is recommended in exchange for their expertise and insights from their "lived experience." Panelists noted that it's important to "hear the member's voice at the table," not just other stakeholder voices speaking on behalf of the member. Through this process, states are able to clearly align the outcomes desired from managing the population with the defined metrics, incentives, and funding for services.

  Additionally, the state's MCO procurement process (i.e., credentialing, VBP requirements) presents a powerful opportunity for stakeholder engagement to drive towards positive outcomes for serving new sub-populations. However, it is insufficient for states to set a goal of the percentage of contracts that must be in VBP arrangements if the outcomes are not the ones that matter to the individuals being served. In Tennessee, prior to making contract changes, the state partnered closely

with plans and providers to identify meaningful outcomes and metrics for their VBP programs.

Critical Questions States Should Ask When Carving in New Populations:

1) Why are we adding this population to our MLTSS program?
2) What are the policy goals we hope to achieve in partnership with the MCOs?
3) How will we measure success?
4) How do we align incentives to help support outcomes?
5) How do we structure our payments to incentivize the right behavior?

- **MCOs must invest in provider networks to develop capacity to serve new populations, such as individuals with I/DD.** Once states outline the outcomes and metrics that will be used to measure performance for the new sub-population, MCOs need to build capacity both in terms of network and care capabilities to meet the needs of these new populations. MCOs need to build networks with providers with demonstrated expertise delivering on the desired outcomes. MCOs must be willing to invest in in developing provider capacity, both up-front and through VBP arrangements (e.g., staff training, agency accreditation, technology).

  In designing and implementing VBP arrangements, panelists shared that it is important for MCOs to "have skin in the game" and invest in provider capacity upfront. MCOs should work collectively with providers to define desired outcomes, identify delivery gaps, and develop capacity. For example, one MCO offered provider grants, online learning modules, and opportunities to co-create VBP models with the MCO. The MCO spent over a year working with supported employment providers to develop and implement a VBP program that paid the provider for the number of hours an individual actually works, as opposed to the number the provider offers. The MCO and provider worked in partnership to identify desired outcomes, identify deliver gaps, develop capacity, and measure and pay for outcomes.

AS NEW POPULATIONS, LIKE INDIVIDUALS WITH I/DD, ARE ADDED TO MEDICAID CONTRACTS, MCOS NEED TO BUILD STANDARDIZED AND STRONG PERSON-CENTERED PLANNING PROCESSES FOCUSED ON COMMUNITY INTEGRATION.

- **MCOs are seeing a meaningful impact when supporting the informal caregiver.** The informal caregiver is often one of the most critical components of a member's health journey. Panelists discussed the importance of identifying these caregivers, engaging with them (including during the assessment process), and providing them with the necessary support to manage care.

  Panelists highlighted Indiana's recent MLTSS Request for Proposals (RFP) as an example of how states are asking MCOs to leverage caregivers to support members. Indiana will fund several different programs to meet caregiver needs (e.g., structured family caregiving, caregiver coaching, behavior management support and goal engagement) through a variety of funding vehicles, including state funding and capitated rates to MCOs to support caregivers. Panelists noted this example will likely not be the last state to ask MCOs to extend support to informal caregivers. They acknowledged the future potential of better empowering caregivers to help them offset the direct care workforce shortage and to help improve the quality of care for the individual member they are supporting.

SOLUTIONING FOR THE DIRECT CARE WORKFORCE

PANEL OVERVIEW: Central to challenges in caring for the MLTSS population are difficulties related to the direct care workforce. Panelists discussed potential solutions to mitigate the direct care workforce shortage in both the short-term (e.g., engaging family caregivers) and long-term (e.g., building up the workforce through training and retention initiatives).

MODERATOR: Gary Jessee, Managing Director, Sellers Dorsey

PANELISTS:

Jonathan Davis, Founder & Chief Executive Officer, Trualta
Sue Chapman Moss, SVP and Managing Director of Payer Contracting and Strategic Partnerships, BAYADA Home Care Health
Rachel Turner Chinetti, Staff Vice Present, Elevance Health
Linda Kurian, MD, Chief Medical Officer New York, and Pennsylvania, Aetna

KEY THEMES:

- **The direct care workforce challenge is an industry problem.** The shortage of direct care workforce is not new, and it continues to be the single biggest challenge facing the LTSS system today. It impacts beneficiaries, family members, providers, communities, MCOs, and states. There is no silver bullet to solve this issue. Creating a long-term solution will require professionalizing the industry to build a supply pipeline, adopting operational efficiencies and new technology, funding creativity, and focusing all stakeholders on improving outcomes.

  Panelists noted it will be important for the LTSS industry to look at other industry-wide provider shortages, such as primary care and nursing, to identify lessons learned that can be applied to the direct care workforce challenge. The panel recognized that to attract purpose-driven talent, the industry will need to reduce the stigma of this type of career and address the inherent challenge many caregivers face as Medicaid beneficiaries living at or below the poverty level.

MCOS CONTINUE TO WORK WITH STAKEHOLDERS, STATES, AND LEGISLATURES TO HELP BRING VISIBILITY TO DIRECT CARE WORKFORCE CHALLENGES, WHICH CONTINUE TO BE THE SINGLE BIGGEST CRISIS FACING THE LTSS INDUSTRY.

Panelists believe new funding scholarships are needed to foster home aides to attend nursing schools, peer mentoring programs to help recent nursing graduates join the home care nursing program, and simulation room experiences for nurses to prepare for in-home emergencies which do not have the same backup support or controlled environments as found in hospitals and other provider facilities.

- **Operational efficiency can help improve access in the short term**. Smaller provider groups can still benefit from investments in operational efficiency and increased coordination with MCOs. One panelist shared how its MCO is establishing data sharing and capacity tracking capabilities with smaller LTSS providers to overcome inherent challenges in verbally communicating referral and capacity needs.

  The panel acknowledged that some state programs, such as the Aged and Disabled Waiver in Indiana, do not provide enough transparency into capacity today. Panelists also discussed how MCOs are investing in building internal workforce development bench strength by adding team members with previous experience dealing with provider staffing challenges to work directly with targeted LTSS providers on recruitment and retention strategies.

  Further, panelists identified opportunities to better align caseloads to match membership with local workforce geography, reducing travel time and improving the speed of response. This includes looking at network adequacy beyond just the number of LTSS providers per county and begins tying network adequacy to quality and capacity needs. Panelists recognized MCOs can help drive the discussions, share best practices from other markets, and help the industry optimally use the supply that is currently available.

- **Innovation is necessary to solve the long-term workforce need.** MCOs and providers must think creatively about how to reduce capacity traps. Such collaborative solutioning discussions can be supported by leveraging technology, aggregating existing data, and using it to identify where care or long-term support gaps exist.

  Panelists discussed potential solutions, including elements of education, digitization, and value-based payment. They discussed how MCOs could partner with local agencies and organizations that have a strong competency in building a workforce. Panelists pointed out there is a precedent for such models, citing how before the pandemic Arizona provided funding for home care agencies to build up agency capacity.

The panel also discussed the benefits of “digitizing a home” to help monitor that care is being delivered in a timely manner. While there is some industry debate about the application of tracking technology for the workforce and potential risks of fraud and abuse, the panel acknowledged it is being used effectively in other industries and could be explored to find a "sweet spot” that would allow some greater transparency into in-home care. However, they noted that such innovations or even wage increases alone won’t be enough to support the workforce without industry-led workforce development.

- **States can help to streamline administrative burden.** States have the opportunity to help establish greater operational efficiency in the overall administration of LTSS services within the state. Today, many LTSS providers receive multiple requests from MCOs for data and information that MCOs need to comply with state requirements. If a state articulates what it specifically needs from providers (particularly when adding new populations to MLTSS), it can help create a uniform approach for MCOs to engage with providers, which can drive consistency and reduce provider burden. Panelists encouraged MCOs and providers to jointly share existing challenges and potential solutions (e.g., standardized provider training, templates, and support tools) with states to gain input that reflects all voices.

- **MCOs are seeking input and engagement from members and family caregivers.** There is an opportunity for participants and informal caregivers to provide input on how solutions can be more consumer-orientated, especially for those related to technology. Panelists recognized the importance of the lived experiences of caregivers and believe there is a significant opportunity to have their voice help shape the design of tech-enabled care.

  MCOs are working to help caregivers self-identify, engage them in a collaborative way to learn of rising risks or issues faced in the home, and help them successfully provide the highest level of care. By focusing on improving caregiver resiliency and skills, MCOs want to empower the member and caregiver to manage their care in the home.

TECH-BASED SOLUTIONS DESIGNED FOR CAREGIVERS CAN IMPROVE TRAINING, ONE-ON-ONE COACHING OPTIONS, ACCESS TO PEER SUPPORT GROUPS, AND SOLUTIONS AIMED AT PREVENTING CAREGIVER BURNOUT.

ABOUT THE NATIONAL MLTSS HEALTH PLAN ASSOCIATION

The National MLTSS Health Plan Association ("MLTSS Association") is the leading organization in Washington, DC promoting Medicaid managed long-term service and supports (MLTSS) and integrated care. We represent health plans that contract with states to provide long-term services and supports to beneficiaries through the Medicaid program. Our members assist states in delivering high quality long-term services and supports with a focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Learn more at mltss.org.

ABOUT HEALTHSCAPE

Founded in 2009, HealthScape is a management consulting firm that is dedicated to the healthcare industry and helping our clients grow intelligently, improve performance, and transform their businesses. We are devoted to supporting our clients navigate the changing Medicaid market, particularly with the unique challenges of long-term support services.

We are recognized experts in helping our Medicaid clients with the end-to-end strategy, capture, and execution related to major government healthcare program opportunities. Our services encompass initial opportunity evaluation, partnership evaluation, proposal and application development, implementation management, and ongoing performance improvement support services. Learn more at healthscape.com.

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