A LeadingAge CAST Report

COLLABORATING ON CHANGE:

How Payer, Health Care and Academic Partnerships Can Advance the Missions of Aging Services Organizations

Proceedings of the CAST Commission Meeting
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LeadingAge™ CAST
center for aging services technologies

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A program of LeadingAge

2519 Connecticut Ave., NW
Washington, DC 20008-1520
Phone (202) 508-9438
Fax (202) 939-5812
Web site: LeadingAge.org/CAST

LeadingAge Center for Aging Services Technologies:

The LeadingAge Center for Aging Services Technologies (CAST) is focused on accelerating the development, evaluation and adoption of emerging technologies that will transform the aging experience. As an international coalition of more than 400 technology companies, aging-services organizations, businesses, research universities and government representatives, CAST works under the auspices of LeadingAge, an association of 6,000 not-for-profit organizations dedicated to expanding the world of possibilities for aging.

For more information, please visit LeadingAge.org/CAST

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Executive Summary

Imagine that your organization has been given 36 months to transform its thinking and solve its most pressing problems.

Where would you begin?

The CAST Commissioners explored this question during their Oct. 18, 2014 meeting in Nashville, TN.

Commissioners agreed that no organization, however advanced, could possibly meet this aggressive goal by itself. Instead, innovative organizations must connect with different partners that can bring a variety of capabilities to the table. Those partners must work proactively to share experiences, learn together, and collect information that will help them find new ways to solve problems together.

During a presentation by Pete Wendel of The Difference Collaborative, the Commissioners explored the role that connected networks could play in helping long-term and post-acute care (LTPAC) organizations accelerate the speed at which they address complex challenges and bring about needed change.

In order to be most effective, these networks must exist both within and outside organizations. Providers must break down internal silos while, at the same time, reaching out to prospective partners in other organizations and sectors. They must also be committed to the hard work involved in initiating and sustaining meaningful collaborations.

What kind of partnerships would result from these connected networks?

CAST Chair Mark McClellan explored several partnership models within the world of Accountable Care Organizations (ACO). He suggested, for example, that an ACO would be most interested in forming a selective referral relationship with LTPAC providers who were willing to work closely with ACO physicians and patients.

Rhys W. Jones of WellPoint/Anthem told Commissioners that managed care organizations (MCO) want and need to work with LTPAC providers, particularly in states that allow older adults and people with disabilities to enroll in Medicaid managed care programs. The ability to meet certain criteria will make a provider more attractive as a MCO partner. For example, providers need appropriate state licensure, adequate levels of liability insurance, a robust quality improvement program, an ability to serve the MCO's geographic area, a willingness to submit electronic claims, and the ability to contribute data about the population served.

Finally, CAST Commissioners from three universities described how they have partnered with LTPAC providers and businesses to develop and test technology solutions that improve the lives of older people. Securing funding and champions for these research initiatives can be challenging. But when they are successful, the initiatives yield significant benefits for students, universities, LTPAC providers, technology developers and, ultimately, for society.

List of Participants

Commissioners

Casey Blumenthal
Vice President
MHA...An Association of Montana Health Care Providers
Helena, Montana

Thomas E. Brown, Jr., Dr.Ph., MBA
President and Chief Executive Officer
Lutheran Homes of South Carolina
Irmo, South Carolina

Patrick Clark
Information Technology Director for Continuing Care
St. Peters Health Partners, The Eddy
Albany, New York

Marcia Conrad-Miller
Senior Director
Research and Development Competency Centers and Global Technology Operations
Philips Home Monitoring
Framingham, Massachusetts

David Finkelstein
Chief Information Officer
Hebrew Home at Riverdale
Bronx, New York

W. Bryan Fuhr
Vice President, Business Development
Healthsense, Inc.
Mendota Heights, Minnesota

Joe Gerardi
Senior Vice President and Chief Information Officer
American Baptist Homes of the West
Pleasanton, California

Carl Goodfriend
Chief Information Officer
ProviNET Solutions
Tinley Park, Illinois

Stephen Hopkins
Executive Director
LifeChoice Solutions
Saline, Michigan

Stuart Kaplan
Chief Executive Officer
Selfhelp Community Services
New York, New York

Peter Kress
Vice President and Chief Information Officer
ACTS Retirement-Life Communities, Inc.
West Point, Pennsylvania

Rear Admiral Kathy Martin
CAST Vice Chair
Chief Executive Officer
Vinson Hall Corporation
McLean, Virginia

Mark B. McClellan, MD, Ph.D.
CAST Chair
Director, Engelberg Center for Health Care Reform
Leonard D. Schaeffer Chair in Health Policy Studies
Brookings Institution
Washington, D.C.

Jim Osborn
Executive Director and Co-Founder
Quality of Life Technology Center
Pittsburgh, Pennsylvania

Debi Sampsel
Chief Officer of Innovation and Entrepreneurship
University of Cincinnati
Cincinnati, Ohio

Kian Saneii
Chief Executive Officer and Chairman
Independa, Inc.
San Diego, California

Jon Sanford, M. Arch
Director
Center for Assistive Technology
and Environmental Access
Associate Professor of Industrial Design
Georgia Tech
Atlanta, Georgia

Rich Schutt
Chief Executive Officer
Providence Life Services
Tinley Park, Illinois

Mary Senesac
Director of Health Systems
HealthMEDX
Ozark, Missouri

Jack York
Chief Executive Officer
It's Never 2 Late
Centennial, Colorado

Guests

Ginna Baik
Strategic Business Development Executive
CDW Healthcare
Glenview, Illinois

Robert Baker
President
LG CNS
Georgetown, TX

Jeff Bolivar
Director of Information Services
Lutheran Homes of South Carolina
Irmo, South Carolina

Lee Callaway
Director
AT&T's Digital Life Business
Atlanta, Georgia

Robert Choi
Chief Strategy Officer & Founding Partner
Collain Healthcare, 370 Vision
Austin, Texas

John DiMaggio
Chief Executive Officer
BlueOrange Compliance
Columbus, Ohio

David Dring
Executive Director
Selfhelp Community Services
New York, New York

Rhys W. Jones, MPH
Director
Medicaid Business Development Government Business Division
WellPoint/Anthem
Virginia Beach, Virginia

Randy Kirk
Executive Vice President and
Chief Scientist
Direct Supply
Milwaukee, Wisconsin

Jeannette C. Pette
(On behalf of Candace LaRochelle)
Chief Nursing Officer
eHealth Data Solutions, LLC
Beachwood, Ohio

Karissa Price-Rico, Ph.D.
Chief Marketing Officer
Intel-GE Care Innovations
Roseville, California

Pam Pure
Chief Executive Officer
HealthMEDX
Ozark, Missouri

Chris Rogers
Managing Director
Health Care Banking
Ziegler
Nashville, Tennessee

Pete Wendel
Principal, PDW Consulting, LLC
Co-Founder, The Difference Collaborative
Chicago, Illinois

CAST/LeadingAge Staff

Majd Alwan, Ph.D.
LeadingAge Senior Vice President of Technology
CAST Executive Director

Scott Code
CAST Aging Services Technologies Manager

Part I

The Future of LTPAC: ACO Partnerships and Payment Reforms

Mark B. McClellan, MD, Ph.D.
CAST Chair
Director, Engelberg Center for Health Care Reform
Leonard D. Schaeffer Chair in Health Policy Studies
Brookings Institution
Washington, DC

CAST Executive Director Majd Alwan facilitated a far-reaching discussion between CAST Commissioners and CAST Chair Mark McClellan. The following is a summary of the question-and-answer session.

ACO Outcomes

What is your perspective on the Accountable Care Organization (ACO) movement in this country, especially in light of recent reports about early ACO outcomes?

There are now more than 350 ACOs in the Medicare program. The vast majority of these ACOs have achieved performance levels in areas like patient experience and care that are significantly better than the average health care provider serving Medicare fee-for-service beneficiaries.

Overall, Medicare ACOs have achieved savings of around one to two percent since they launched in 2012. That's not too bad for a period when Medicare costs have been relatively flat because of the squeezes on payment rates and the movement toward new payment arrangements. However, one might wonder if ACOs shouldn't be able to achieve greater savings than this.

As best as we can tell from published reports and analytical studies, some of the private sector ACOs are doing considerably better, on both quality and cost, than the Medicare ACOs. These differences can be attributed, in part, to how ACO sponsors view risk and infrastructure requirements.

The vast majority of Medicare ACOs are Shared Savings ACOs. Providers participating in these ACOs can recoup some of the savings they create as they lower costs. However, these ACOs don't face any financial risk if their costs are higher than the benchmark set by Medicare.

Providers in private sector ACOs, on the other hand, have both upside and downside risk. They are willing to take on that risk because they typically have strong support from the health plans that sponsor them. These plans will typically make large up-front investments to pay for activities like care coordination, medical homes, and case managers. On the back end, they will also require more accountability on the part of the ACO for cost reductions.

Factors in ACO Success

Based on your observations, what are the factors that help some ACOs succeed? What are the reasons that others are not doing well?

A successful ACO typically has leaders who are committed to changing the culture of the organization so it is focused on delivering better care and lowering costs, while disrupting traditional approaches to care. These ACOs believe that health care is changing. They want to be leaders in the new financial models that will feature accountability and financial risk.

Successful ACOs also seem to be focusing on a few—maybe four or five—specific, concrete and meaningful steps to raise quality and lower costs.

For example, they may try to modify their referral patterns by selecting providers that have a better track record and are willing to work together. They may also undertake some specific programs for individuals who are at risk for becoming high-cost patients over the next 6-12 months.

Partnerships with LTPAC and LTSS Providers

Are you seeing any new examples of ACOs partnering with long-term and post-acute care (LTPAC) and long-term services and supports (LTSS) providers?

The typical approach to these partnerships involves forming a referral relationship between an ACO group and certain post-acute and LTSS providers. Some ACOs actually have arrangements whereby, in exchange for a more selective referral arrangement, a provider from the post-acute or LTSS organization will work closely with ACO physicians. These providers get to know patients, help to develop and implement treatment plans, and review some of the ACO's more complicated or problematic cases.

IMPACT Act

What are the most significant implications of the IMPACT Act for LTSS providers?

The Improving Medicare Post-Acute Care Transformation Act of 2014—better known as the IMPACT Act—is designed to move us to a consistent set of methods and quality measures for patients who are using post-acute services, regardless of setting. It's important to note that this legislation had strong bipartisan support.

At the Spring 2014 meeting of the CAST Commissioners, I told you that many policy makers were concerned about the variability of Medicare payments for patients and populations that appear to have similar needs. The IMPACT Act represents a first step in addressing these concerns.

The goal of the IMPACT Act is to establish a consistent set of measures regarding such factors as patients' functional status, complications, and experience of care. The legislation does not actually tie these consistent measures of quality and patient status to the payments that providers receive. But we are clearly headed in that direction.

LTPAC and LTSS Payment Reform

What else should we expect in the days ahead in terms of health and payment reforms that may affect LTPAC and LTSS providers?

Now that the IMPACT Act has passed, the next shoe to drop will be the actual payment reforms behind these measurement systems. The IMPACT legislation requires that the Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Committee (MedPAC) submit reports to Congress that describe how Medicare could transition to a more consistent payment system.

Rising costs associated with Medicare, Medicaid and the Affordable Care Act subsidy exchanges are going to put increasing pressure on the federal budget. As the need to save money becomes more pressing, we could see additional movement toward adopting payment reforms in long-term and post-acute care. This would be an alternative to simply

cutting reimbursement rates across the board for skilled nursing or home health services.

The strong political support that the IMPACT legislation received is strong evidence that payment reform will soon be coming to the LTPAC and LTSS sectors. The same kind of political alignment that helped to pass the IMPACT Act could lead to payment reforms that build on the foundation that the IMPACT Act established.

The Republican Congress

What effect will a Republication-controlled Congress have on health reform, payment reform and other programs that affect LTPAC providers?

Republicans will be under more pressure to show that they can actually govern and pass legislation.

Back in the late 1990s, President Clinton actually got more legislation passed when the Republications were in control of Congress. It's not clear whether President Obama has the interest, the infrastructure and the support to work with Congress in areas where they have a mutual interest.

For example, the President and Congress might work together to give states more flexibility to implement the choice-based Medicaid reforms that Arkansas, Tennessee, Ohio and potentially Pennsylvania are using to expand Medicaid through competing private plans.

One thing is clear. People generally are not asking whether payment and delivery reform will happen. Rather, they are wondering how quickly these reforms will take place and what types of reforms are going to succeed.

LeadingAge and CAST will continue to be right at the center of this discussion, showing how technology and payments can be better aligned so we can achieve improved outcomes and lower costs for patients.

A Timetable for Payment Reforms

When will payment changes start to become a larger issue for LTPAC providers?

Some time after the election, CMS will put out its next round of regulations for ACO 2.0, which will accelerate the implementation of more meaningful ACO reforms.

These regulations are probably not going to have an effect for another year. But CMS will be sending the signal that it is trying to put more support behind the ACO program so it will work better, especially when it comes to beneficiary engagement and the desire of providers to share in more savings.

CMS has shown some early signs that it will be changing the quality measure reporting for ACOs. It also has announced more than $100 million in upfront payments to help ACOs in rural areas make infrastructure investments. You are going to see more of that, and it is going to accelerate the ACO piece of health care reform.

In addition, policy makers will need to find savings somewhere in Medicare or Medicaid to pay for the goals of the Affordable Care Act. There will be new Sustainable Growth Rate (SGR) legislation by next March or April, when the latest SGR short-term patch runs out. We'll have to find some offsets elsewhere in the budget to pay for this legislation. There is no question that some of that will come from the LTPAC side.

The IMPACT Act showed that there is potential to achieve savings without cutting reimbursement rates further. As a result, it seems likely that there will be a move toward patient-based payments rather than just the across-the-board cuts.

No Direct Support for Health IT in LTPAC Settings

Public policy is placing a new emphasis on keeping people at home. However, federal funding for health information technology (IT) has gone to hospitals and physicians, but not to the LTPAC providers who are seen as part of the solution. Is there any way to establish policies that get funds into the LTPAC sector so we will be ready to keep people out of emergency rooms and reduce readmission rates?

It is unfortunate that the federal government hasn't given more support to LTPAC providers over the last half decade since Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH was intended to support interoperable health IT. Yet, we don't have interoperable exchange of information to any measurable extent, especially with community-based providers that help prevent complications that land patients in the hospital.

The government is not going to put more money into building the health IT infrastructure. That funding has run its course. There have been concerns from many members of Congress about whether it really has achieved its intended goals. Those concerns, along with the tight budget situation, will be enough to prevent any kind of major expansion of direct funding for health IT in community-based LTPAC settings.

That said, I do think there will be more opportunities for LTPAC providers to receive up-front payments to build a more general infrastructure to support better care and lower costs. CMS has already announced several rounds of Innovation Grants to help states build out their health IT infrastructures so they can exchange data. There could be more funding for LTPAC providers lucky enough to be located in a state that is getting this support.

But, clearly, there is not a lot of direct financial support for the kinds of investments that many of you are making. That's another reason why implementing these programs is going slowly.

ACOs haven't been trying to build fully integrated data systems. Instead, they are doing limited, short-term work that will lay a foundation for more data exchange in the future. They are using web-based approaches, as well as existing Continuity of Care Documents (CCD) information, to fill the gaps in full electronic health record interoperability.

This is probably going to be the reality for the next 10 years. We will take limited steps that help promote care coordination but, unfortunately, there will be no easy path to interoperable, well-supported, integrated electronic health records. But I do think we are gradually getting there.

Indirect Support for LTPAC Providers

Is there interest in offering indirect support to engage LTPAC providers in the next wave of health information exchange?

Yes. The Office of the National Coordinator for Health IT (ONC) is definitely putting an emphasis on promoting practical steps to achieving information exchange, rather than some big theory

that doesn't get us anywhere. I have worked very closely with National Coordinator Karen DeSalvo on this. Karen's interest in all this is a very good sign for the future.

Part II

Bringing the World to Your Doorstep: Designing Collaboration with LTPACs and Partners

Pete Wendel
Principal
PDW Consulting, LLC
Co-Founder, The Difference Collaborative

A growing number of organizations around the world are beginning to launch initiatives that are specifically designed to quickly bring about change by connecting different kind of partners, people and capabilities in new ways.

This model of change is becoming increasingly relevant to the field of long-term and post-acute care (LTPAC) as it deals with foundational shifts in the way health care in this country is being provided.

Pennsylvania is a good example of the challenges that lie ahead. The state just received a $60 million Innovation Grant to overhaul its health care system. The catch? The change process must be completed in three years. Basically, the state has 36 months to build an integrated care system that features meaningful engagement with populations that have the greatest need.

The speed of change is accelerating, even though the problems we face are becoming more complex. Our task is made more challenging because we are attempting to bring about dramatic changes while working in organizations with hierarchical models that aren't very flexible and don't change very quickly.

At times like this, Albert Einstein's words are particularly relevant:

"We can't solve problems using the same kind of thinking we used when we created them."

Let's assume, like Pennsylvania, that we have 36 months to transform our thinking about how to solve pressing problems. We can't accomplish this goal without intentionally designed and connected platforms that enable people to share experiences, learn together, and keep track of information that they will need to solve problems differently. These multi-stakeholder platforms can produce more meaningful change than any single organization could bring about alone.

The first steps in creating these platforms involve:

- **Breaking down silos:** We need to find a way to connect capabilities across the silos of our current organizational boundaries. That's the only way we'll come up with new ways to create, deliver and capture value.
- **Cross-Pollinating:** Transformational change requires that we reach across traditional industry boundaries and collaborate with stakeholders in the for-profit, not-for-profit, and academic worlds.
- **Working more like a hive:** We're probably not collaborating very effectively right now. Since we are out of practice, we'll have to expend quite a bit of energy to initiate meaningful collaborations.

Three Connected Platforms

Transformative change initiatives are aimed at creating new markets, rather than tweaking the markets that already exist. This positive disruption affects business models. But it also increases the organization's opportunities and its level of engagement with partners and audiences.

Three connected platforms are essential to bringing about this kind of change:

- **The Exploration Platform: Research and development to identify and define a problem.** The organization builds a diverse coalition of stakeholders, gives stakeholders a forum to air their concerns, and then encourages those stakeholders to create shared definitions of problems and potential solutions.
- **The Experimentation Platform: Prototyping and pilots to test solutions for a problem.** The organization integrates ideas from diverse stakeholders and offers neutral environments to test those ideas. If the process works well, the organization ends up with an assessment of possible solutions and recommendations for implementation.
- **The Execution Platform: Scaling of solutions in a market/region to achieve outcomes.** The organization scales its solutions and its markets so it can achieve its intended outcomes. This platform is transformative. It positively disrupts other business models within the broader industry or social system.

The most sustainable transformations cut across industry boundaries.

Case in Point: Fitwits

Carnegie Mellon University's School of Design created Fitwits, a program that has 5 years of research and positive outcomes behind it. Fitwits developed a system for community stakeholders to work together to produce a series of health literacy tools that functioned like a game. Parents could use the tool to teach their children about exercise and nutrition while they were waiting in the doctor's office.

The game was fun. It gave parents facts and information that they didn't have before. The kids remembered what they had learned. And the parents felt empowered.

The tool worked so well at the doctor's office that the developers rolled it out to schools that agreed to combine it with their curriculum. After that, the program found a variety of partners that made the tool available in restaurants, health clinics, pharmacies, grocery stores, and community venues like the Boys and Girls Club.

The Fitwits system has a variety of distinguishing features. The tool:

- Is disseminated and promoted by stakeholders and sponsors in the local community.
- Was designed with consumers, not for them.
- Uses entertaining content and a multimodal learning model to engage audience members in improving their health.
- Rewards users for good behavior. The ability of users to earn points that lead to rewards has helped increase healthy behaviors and has strengthened the relationship between users and the community organizations that sponsor the tool.

The Fitwits system of health education could easily be expanded to include multi-generational learning. In the LTPAC context, for example, the tool might be used to help care providers connect with older adults and their family caregivers in the community venues they frequently visit.

The point of Fitwits is that it serves as a vehicle for collaboration and shared value among patients, providers and payers in a given community. Fitwits not only gets results; its participants enjoy spending time and further developing the program.

Fitwits is a system of engagement that influences behavior and increases healthier choices. The health insurance company Cigna is now piloting Fitwits in California. Memory "games" are now being designed that will use the Fitwits system to connect with intergenerational users (elderly, caregivers, family members and young people) in a way that's engaging and relatable, no matter the age or ability.

Creating Connected Platforms

Organizations can become effective change agents by partnering with other organizations, institutes or consultants. But keep in mind that you won't succeed if another organization owns your initiative. Any successful change initiative

must have support and commitment from the core leadership of your organization. And it must be led by an internal "mobilizer" who will forge connections with stakeholders within and outside the organization.

Everyone is a Designer

Nobel Laureate Herb Simon was one of the most influential social scientists of the 20th century. Simon once said, "Everyone designs who devises courses of action aimed at changing existing situations into preferred ones."

It's your job to design courses of action that change existing situations into preferred one. Everyone in this room is a designer.

Creating connected platforms makes better use of resources, enabling your organization to focus more on its core competencies. Through cross-industry/cross-community collaboration, you increase your ability to find innovation opportunities that would otherwise remain invisible. Creating intentionally connected platforms can empower your organization and community to address pressing problems and take advantage of new opportunities—and do it quickly.

Part III

Payer Perspective: What MCOs Seek in LTSS Provider Relationships

Rhys W. Jones, MPH
Director, Medicaid Business Development
Government Business Division
WellPoint/Anthem
Virginia Beach, Virginia

WellPoint, Inc., one of the nation's largest health insurance companies, officially became Anthem, Inc. in early December 2014. The company's Government Business Division serves 7.7 million Medicare and Medicaid beneficiaries in 24 states. Anthem affiliated health plans also enroll about 4 million people in Medicaid Managed Care plans in 19 states.

How Medicare and Medicaid are structured has everything to do with what opportunities are available for payer organizations to partner with providers of long-term services and supports (LTSS).

Facts about Medicare

The Medicare program is a highly standardized federal program covering 54 million Americans. Eligibility is based on entitlement. People either qualify for the program because they are over age 65, or because they have a qualifying disability. Beneficiaries share the cost of many Medicare services.

Medicare's focus is on diagnosis and treatment, not on long-term care. Medicare Part A covers hospital, skilled nursing facilities, home health and inpatient rehabilitation services. Part B covers physician

outpatient services and a host of outpatient diagnostic laboratory procedures. Medicare Part D is the program's prescription drug coverage.

Facts about Medicaid

Medicaid is a joint federal/state program that covers 66 million Americans. Eligibility is based on income. In addition, there are multiple needs-focused Medicaid programs.

Medicaid is more socially focused and wide ranging than Medicare because it addresses the needs of a wide variety of individuals. Aside from its largest population segment (pregnant women and children), Medicaid serves people with special needs, including frailty, functional deficits, and physical, intellectual and developmental disabilities.

Medicaid follows the same acute-care medical model that we see in Medicare. But it also covers long-term nursing home care, home and community-based services, and prescription and over-the-counter drugs. Generally, there is no cost sharing in Medicaid, with the exception of some programs for nursing homes and long-term services and supports.

Special Medicare Plans

Within Medicare, there are three kinds of special needs plans (SNP) that limit enrollment to specific types of beneficiaries. All SNPs cover Medicare Part A, Part B and Part D services.

- **A Dual Eligible SNP** focuses on beneficiaries who are eligible for both Medicare and Medicaid—the so-called "dual eligible" population. Dual SNPs may include Medicaid benefits at the state's discretion.
- **A Chronic Disease SNP** focuses on beneficiaries with one or more of 15 specific chronic conditions, including congestive heart failure, chronic obstructive pulmonary disease (COPD), diabetes and end-stage renal disease.
- **Institutional SNPs** are available to people who have a nursing home level of care and need, whether they are in a nursing home or they live in the community.

Medicare and Medicaid Financial Alignment Plans, like the Commonwealth Coordinated Care Initiative in Virginia, are demonstration programs that combine Medicare and Medicaid in a much more integrated fashion than the Dual Eligible SNP. The benefits package includes the full range of Medicare Part A, Part B, Part D, and all the Medicaid LTSS benefits in the Medicaid State Plan.

Another integrated model is the Program of All-Inclusive Care for the Elderly (PACE). This program focuses on beneficiaries with a nursing home level of need who typically have both Medicare and Medicaid.

MCOs and LTSS Providers: Opportunities for Partnerships

Government-based managed care programs are incredibly regulated and they leave managed care organizations (MCO) with very little leeway in how they implement those programs.

Populations, benefits and eligibility are often determined by statute or regulations, both at the federal level for Medicare and the state level for Medicaid. State Medicaid agencies develop a state plan that must be approved by the Centers for Medicare and Medicaid Services (CMS). States

can also file for waivers to allow exemptions from the normal way of doing things in Medicaid. If these waivers are approved, the states can do some innovative things.

It's important to note that the state Medicaid agency controls the overall vision and structure of how Medicaid works in that state. Given the fact that we have 50 states and five territories, we have 55 versions of Medicaid in this country.

The availability of Medicaid Managed Care varies, depending on the state. Similarly, opportunities for MCOs to procure Medicare and Medicaid contracts—and to partner with LTSS providers—will also vary, depending on program variations.

For example:

Contracts: Medicare is an open procurement system. If a health plan meets the program's qualifications, including the network adequacy standards, it will get a Medicare contract. In contrast, the process of procuring a Medicaid contract is competitive in most states.

Participation: Participation in Medicare managed care is voluntary and three-quarters of Medicare beneficiaries still get their care from the Medicare fee-for-service program.

A state Medicaid program, on the other hand, can require that beneficiaries join a managed care plan, although beneficiaries may be able to choose which managed care plan they will join. Beneficiaries enrolled in the Temporary Aid for Needy Families (TANF) for the Child Health Insurance Program (CHIP) usually are the first to be required to join a managed care plan. In many states, managed care is still voluntary for dual eligibles.

Politics: The politics of a state is often manifested in its Medicaid plan and in the way Medicaid rolls out in that state. These political factors will often determine the feasibility of LTSS-MCO collaborations.

Indiana, for example, has put its toe into the managed care waters but still has a small number of Medicaid beneficiaries enrolled in managed care plans. The state offers Medicaid managed care only for TANF and CHIP beneficiaries. Programs for other populations—including older adults, people receiving Supplemental Security Income, and people with intellectual and developmental disabilities—are still fee-for-service. Since moms and kids don't use much in the way of long-term care services, there is not a lot of opportunity for MCOs to partner with LTSS providers in Indiana.

Kansas is a different story. You won't find anyone in Kansas who is still in a fee-for-service program. And all the service categories—including physical health, behavioral health, LTSS, prescription drugs, transportation, consumer directed—are within the scope of the MCO's contract. As a result, MCOs, LTSS and long-term care providers can have very meaningful discussions in Kansas about how they can partner to serve Medicaid beneficiaries.

What LTSS Providers Must Bring to an MCO

What are MCOs looking for from our LTSS partners? In order to partner with MCOs, you will need:

- Appropriate state licensure. If you are a nursing home, you need to be licensed as a nursing home in your state.

- Liability insurance coverage. Typically, the liability insurance must be $1 million per occurrence and $3 million aggregate (though this may vary by state). For large organizations, this usually isn't a problem. But for smaller home and community-based organizations, it can be a rude awakening.
- Accreditation by an agency like CMS or the state survey agency. If you don't have a survey, MCOs will likely require an onsite visit.
- A physical infrastructure that is compliant with the Americans with Disabilities Act.
- Medicare certification, particularly if you are a skilled nursing facility or a home health agency.
- A sanctions/exclusions check from the Office of the Inspector General.
- The ability to serve the MCO's geographic area.
- An ongoing quality improvement program that has an engaged staff and clear procedures.
- A willingness to submit electronic claims and receive electronic payments. WellPoint/Anthem is working on a number of programs that will take member data from disparate sources and pull them into a provider portal that can be accessed by any member of a beneficiary's designated care team. Obviously, any provider that can contribute to that data on line will have an advantage in partnering with us.

What You Might Get from an MCO

If you become an MCO partner, you may be able to participate in programs that offer:

- **Service bonuses that promote continuity of service.** If an MCO member in your nursing facility develops a urinary tract infection, the MCO might pay you a higher "intensive service day" rate to treat that person in place, rather than sending him or her to a hospital. The MCO might also pay a lower "hold rate" to hold the bed of someone who has to go to the hospital.
- **Quality bonuses promoting independence.** The LTSS provider would receive a bonus for helping certain nursing home residents successfully transition to a community setting. The bonus would be paid after a period of sustained transition.
- **Quality bonuses promoting outcomes.** The MCOs may pay bonuses based on the LTSS provider's ability to meet quality and performance measures in such areas as reducing falls, avoiding unnecessary hospitalizations and readmissions, reducing frequent Emergency Room visits, and improving diabetes care and medication adherence.

Opportunities for Partnerships

The opportunities for partnerships between MCOs and LTSS providers are more limited in Medicare because long-term care is not really part of Medicare's responsibility. But in Medicaid, there is a great deal of opportunity for us to collaborate, depending on the state and the extent to which MCOs are administering a robust scope of benefits for populations who use long-term care.

As MCOs, we do not have the facility or personnel infrastructure to provide long-term services and supports directly to members. We have to work together with you to ensure that our members receive this care. MCOs need and want to work with you.

Part IV

Encouraging Collaboration Opportunities with Academia

The Commission meeting concluded with informal presentations by Commissioners from three universities. The Commissioners described their technology-related research and development programs and discussed collaboration opportunities for providers and technology companies. Following is a summary of the informal presentations and a report of the discussions that followed.

Debi Sampsel

Chief Officer of Innovation and Entrepreneurship
University of Cincinnati
Cincinnati, Ohio

As Chief Officer of Innovation and Entrepreneurship at the University of Cincinnati, my job is to bring together the University's College of Medicine, College of Engineering, and College of Nursing to work on an innovative Smart House.

The Innovation Collaboratory House is located at Maple Knoll Village, a continuing care retirement community (CCRC) and LeadingAge member in Springdale, OH. We work there to incubate innovation, including new technology inventions. Then we ask residents to evaluate the technologies that we are planning to bring to market. We also work with industrial partners to see if we can take the products they already have on the market to the next level.

You need a strategic plan for this kind of collaboration and a formal, written agreement outlining how the partners are going to work together. Our Memorandum of Understanding includes how we were going to deploy our assets and how we are going to share our intellectual property.

Jim Osborn

Executive Director and Co-Founder
Quality of Life Technology Center
Carnegie Mellon University
Pittsburgh, Pennsylvania

Carnegie Mellon University (CMU) and the University of Pittsburgh jointly run the Quality of Life Technology (QoLT) Center. This National Science Foundation-funded Engineering Research Center focuses on the development of intelligent systems that improve quality of life for everyone while enabling older adults and people with disabilities.

The QoLT Center addresses the needs and activities of everyday living by prototyping:

- Personal and assistive robots.
- Cognitive and behavioral virtual coaches.
- Safe mobility and driver assistance technologies.
- Human health and wellness monitoring awareness and assistance solutions for home or community.

In addition to research and development, the Center offers educational programs, commercialization initiatives and unique partnership opportunities.

The partnership between CMU and the University of Pittsburgh brings together a cross-disciplinary team of technologists, clinicians, industry partners, end users and other stakeholders to create revolutionary technologies that will improve and sustain the quality of life for all people.

Jon Sanford, M. Arch

Director
Center for Assistive Technology and Environmental Access
Associate Professor of Industrial Design
Georgia Institute of Technology
Atlanta, Georgia

The Center for Assistive Technology and Environmental Access (CATEA) at the Georgia Institute of Technology is a multidisciplinary research center devoted to enhancing the lives of people with all levels of ability and functional limitations through the development and application of assistive and universally designed technologies.

Rather than focusing on disability, we believe that the limitations of current technologies and the design of the built environment account for the difference between any individual's potential and his or her ability to perform activities and participate in society. We seek to minimize those limitations by bringing together the diverse talents of many different types of engineers, scientists, clinicians and other professionals.

Several years ago, we created a consortium in Atlanta called Designing Technology for Healthy Aging. This initiative brings together local aging services providers, technology developers, contractors, occupational therapists—pretty much anybody who is doing anything related to design

of technology, home modifications, and aging in place. Before the collaboration began, many of these people didn't know each other. But our work groups and monthly meetings, which feature interactive presentations, have helped build new relationships that have led to new collaborations.

For example, Georgia Tech now has a strong relationship with Wesley Woods, a LeadingAge member and CCRC in Atlanta. We recently worked with the Center for Health in Aging, a joint project of Wesley Woods and Emory University, to launch a Small Business Innovation Research project with a small technology firm.

CATEA has also developed a mutually beneficial relationship with a long-term care provider in the Netherlands. The program brings students to the Netherlands for six weeks to conduct research while living in a long-term care setting.

The provider specifically requested that we send a design student from Georgia Tech, a nursing student from Emory University and a gerontology student from the University of Georgia. All three students travel to the Netherlands at the same time. They work on projects that are related to a thesis or a dissertation and that are relevant to the technology needs of the provider.

Through this project, we have developed a relationship with the University of Twente in the Netherlands. We are now working together to procure a grant to develop some technologies that can be implemented by the long-term care provider. This is a unique situation in which the provider sought us out for a student-focused program that led to the faculties of two universities working together.

Joint Discussion about Funders and Champions

Funding for research is the most difficult challenge facing academic institutions, and each presenter shared different strategies for meeting this challenge.

Sanford reported that Georgia Tech invites students to work on its technology projects while completing their master's degrees or working on their dissertations.

"They are our champions because they want to do this work," he said. "But if you don't have students, the work becomes more difficult."

Funding from the State of Ohio and from Maple Knoll Village helped launch two smart homes at the University of Cincinnati.

"In our first living laboratory smart house, we identified the technologies that we wanted to incubate further because we thought they would benefit the aging-in-place platform," she said. "And then all of the partners—the health care providers, academics and businesses—went to the State of Ohio and received a line item in the state budget to help us finance the technology that went into the house."

The University created its second smart house with help from Maple Knoll Village, which donated the house and its furnishings. The university is also supporting the project financially and is currently looking for additional funding.

Osborn underscored the need to get policy makers to take the field of aging services technologies more seriously.

"I'd like to be able to approach the State of Pennsylvania and offer to turn out technology that

could reduce its Medicaid costs," he said. "But, in return, I would ask for a cut of the savings that we produce so we can sustain our research and development efforts."

A Need for Champions

Sempsel and Osborn emphasized the need for a university-based research program to have a strong champion. Sempsel suggested that this champion should be a full-time faculty member.

"Find someone who can champion the whole project, because it takes a dedicated, full-time person to lead the program and keep the stakeholders engaged," she said.

Osborn agreed, but emphasized the need to have champions on both the university and the provider sides.

"It may be even more important to have champions on the provider side because their engagement and energy permeates everything," he said. "Many of our projects were successful because they got a lot of people excited, and that has helped the technology go from nothing into something."

Appendix A:

Major CAST Accomplishments for March 2014 – October 2014

Updated CAST's EHR and Telehealth Selection Tools, and released a new CAST Medication Management Selection Tool. To view these tools, visit CAST Technology Selection Tools.

- Published *STEPS ON THE ROAD TO LONG-TERM CHANGE: Strategies for Creating a Person-Centered Health Care System*, the Proceedings of the CAST Commission Meeting held on March 16, 2014, in Washington, DC.
- Identified and updated the new CAST Technology Policy Priorities, based on Commissioners' discussion. The technology policy priorities are now published on the Federal Policy page of the CAST website. The new priorities are shaping technology policy-related public comments and advocacy efforts by LeadingAge and CAST. Examples include:
    - Public comments on the use of EHRs by hospice in the Proposed 2015 Hospice Rule from the Centers for Medicare and Medicaid Services (CMS).
    - Response to a request from the office of Sen. Ron Wyden (D-OR) and the Senate Finance Committee for LeadingAge's input on advancing the availability and utility of health care data.
    - Created a CAST Technology Professionals Network that aims to provide peer-to-peer networking,

education, shared learning and active participation in CAST activities for technology professionals working for LeadingAge member organizations.

- Continued to advocate for the inclusion of long-term and post-acute care providers as active participants in health Information exchange (HIE) initiatives and other activities funded by the American Recovery and Reinvestment Act (ARRA) of 2009. These initiatives include state-designated HIE entities and Beacon Communities.
- Continued to provide guidance and successfully influence LeadingAge state affiliates and members to become actively engaged in state initiatives authorized by the Health Information Technology for Economic and Clinical Health （HITECH) Act.
- Continued to support LeadingAge state affiliates on technology education, technology surveys aimed at gauging technology adoption, and other technology-related activities, including technology policy and advocacy efforts.
- Raised the visibility of CAST and its members in leading media outlets, including newspapers, magazines, and trade and industry publications.

CAST Research Update - October 2014

CAST continues its efforts to encourage and actively engage in outcomes-oriented evaluations of aging services technologies as an essential element to more informed decision-making and wider adoption. Here is an overview of the new opportunities and ongoing research initiatives:

- **EHR Initiative:** CAST updated its electronic health record (EHR) portfolio of tools. The portfolio includes several components. A whitepaper walks providers through the most important planning steps they should take before selecting and implementing an EHR. It also covers the most important features and functionalities to look for in an EHR. A selection matrix compares 32 EHR products for long-term and post-acute care across over 225 functionalities and features. An easy-to-use online EHR Selection Tool helps providers select products that meet their business needs and include their must-have features. Finally, a companion set of case studies focuses on the impact of using advanced EHR features like clinical decision support systems and health information exchange.
- **Telehealth Initiative:** CAST updated its telehealth and remote patient monitoring (RPM) portfolio of tools. The portfolio includes several components. A whitepaper explains the different types of telehealth technologies available; their uses, benefits and potential revenue streams; and business models

that support these technologies. It also provides the most important planning steps an organization should take before selecting and implementing a telehealth solution. A selection matrix compares 26 products from 21 vendors across more than 220 different functionalities and features. An easy-to-use online Telehealth and RPM Selection Tool helps providers select products that meet their business needs and include their must-have features. Finally, a companion set of case studies focuses on the impact of using telehealth on care quality and outcomes.

- **Medication Management Initiative:** CAST released a new medication management portfolio of tools. The portfolio includes several components. A whitepaper explains the different types of medication management technologies available; their applicability to different phases of medication management, settings, benefits and potential revenue streams; and business models that support these technologies. It also provides the most important planning steps an organization should take before selecting and implementing a medication management solution. A selection matrix compares 15 products from 14 vendors across more than 305 different functionalities and features. An easy-to-use online Medication Management Technology Selection Tool helps providers select products that meet their business needs and include their must-have features. Finally, a companion set of case studies focuses on the impact of using medication management technologies on care quality and outcomes.

LeadingAge Legislative Update: October 2014

Executive Summary

Congress was in recess until after Labor Day. It was in session relatively little in September and adjourned in early October for the election season. Congress will return in November for a lame-duck session.

Because of polarization between the two parties in both houses, we do not expect much in the way of legislation to be passed and signed into law for the remainder of this Congress. In particular, Congress has failed to pass even one of the 12 regular appropriations bills for fiscal year 2015, which began on Oct. 1.

Federal programs will be funded for the first part of fiscal 2015 under a continuing resolution (CR). That CR will last until after the elections. The timeframe to be covered by subsequent continuing resolutions has yet to be determined.

Senior Housing

Senior housing could benefit from the inability of Congress to finalize a 2015 spending bill for the Department of Housing and Urban Development (HUD). Early versions of the appropriations bill severely underfunded senior housing programs and would have made it difficult for HUD to continue the housing with services demonstration program.

A CR will continue the fiscal 2014 funding levels for these programs. We are working to maximize funding for Section 202 and Section 8, and to keep the demonstration moving forward.

Medicare

It is unclear right now whether the lame-duck Congress will take up any new Medicare legislation. Outstanding issues for long-term services and supports include:

- **Observation days:** We continue working hard for passage of H.R. 1179/S. 569 to require that all time a Medicare beneficiary spends in the hospital will be counted toward the three-day stay requirement.
- **Therapy caps:** The exceptions process is set through March 31, 2015. It is possible, although not likely, that Congress will attempt a permanent solution to the flawed physician payment system later this year. We will continue working to ensure that reform or removal of therapy caps continues to be part of permanent "doc fix" efforts.
- **Post-acute payment reform:** The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (H.R. 4994), also introduced in the Senate as S. 2553, was passed by both houses. The legislation calls for the development of standardized patient assessment data and quality measures reporting across the spectrum of long-term services and supports. (Note: The President signed The IMPACT Act on Oct 6, 2014.)
- **Adult day services:** We support H.R. 3334, the Adult Day Services Act, which would authorize that providers of adult day services be certified to provide Medicare-covered home health services.
- **Technology in home health:** We support S. 596, the Fostering Independence Through Technology (FITT) Act, which would provide incentives for home health agencies to use technology to remotely monitor the Medicare beneficiaries they serve.
- **Medicare Telemedicine Parity Act:** H.R. 5380 is a bipartisan bill introduced by Rep. Mike Thompson (D-CA), Rep. Greg Harper (R-MS) and Rep. Peter Welch (D-VT) to amend Title XVIII of the Social Security Act. It would provide for a phased-in expansion of telehealth coverage under the Medicare program over four years, and would remove arbitrary barriers that limit access to services for Medicare beneficiaries. Included in these provisions are the gradual removal of geographic restrictions to patient care, and the addition of coverage for health care services that take place in other locations, such as the home and walk-in retail health clinics. The bill also proposes improvements for covered services, such as services provided by diabetes educators, remote patient monitoring for chronic disease management, outpatient therapies, home telehealth, hospice, and home dialysis. The proposal authorizes the Government Accountability Office to

study the cost and clinical effectiveness of these changes.

Medicaid

We don't foresee any changes in Medicaid at the federal level for the remainder of this year. We strongly oppose reductions in federal Medicaid funding.

Long-Term Services and Supports Financing

We continue advocating, both directly and in coalition with other stakeholders, to develop a more effective financing structure for the services LeadingAge members provide. Our Financing Task Force report, *Pathways to Coverage*, is the foundation of our advocacy work.

Older Americans Act – Home and Community-Based Services

We support S. 1562/H.R. 4122 to reauthorize the Older Americans Act (OAA). Dissension over formulas for allocating funding among the states has stalled the reauthorization legislation. It appears less and less likely that the Older Americans Act will be reauthorized in this Congress.

Because funding for OAA programs was severely cut back in recent years, we are pushing for increased funding for fiscal year 2015. However, we expect the OAA will receive level funding, for at least the beginning of fiscal 2015, under a continuing resolution.

Tax Reform

Despite much activity in the House Ways and Means and Senate Finance committees in 2013, it now appears unlikely that this Congress will achieve major tax reform legislation. We continue to monitor developments that could affect not-for-profit organizations.

Regulatory Issues

ICD-10: The ICD-10 compliance deadline is Oct. 1, 2015, according to the final rule CMS published Aug. 4.

Medicare payment update: The Medicare skilled nursing facility payment update for 2015 will average two percent, according to the final rule that was published on Aug. 5, 2014 and took effect on Oct. 1, 2014. Payment updates for individual facilities may vary according to their geographic location and case mix.

Hospice payment rule: The Centers for Medicare and Medicaid Services (CMS) published the hospice final payment rule for 2015 on Aug. 4. It took effect on Oct. 1, 2014. CMS estimates that payment rates will increase an average of 1.4 percent in 2015 over current payment rates.

Advocacy Efforts

LeadingAge and CAST used the CAST Technology Policy Priorities developed by CAST Commissioners to shape several sets of public comments submitted by LeadingAge.

These include:

1. Public Comments on the use of EHRs by hospice in the CMS Proposed 2015 Hospice Rule.

2. Response to a request from the office of Sen. Ron Wyden (D-OR) and the Senate Finance Committee for LeadingAge's input on advancing the availability and utility of health care data.

CAST State Technology Update – October 2014

State-Level Technology Activities

In its continuing effort to track technology activities in the states, CAST held two conference calls prior to preparing this update.

The first call included a presentation by Candy Hanson, program manager at Stratis Health, on the Minnesota Health Information Technology for Post-Acute Care Project.

The second conference call featured a presentation entitled "Health Information Exchange Improves Care Coordination" by Dusanka Delovska-Trajkova, chief information officer at Westminster Ingleside, a LeadingAge member in Washington, DC.

State Updates

- **North Dakota, New Jersey and New York:** North Dakota and New Jersey—the states with the nation's highest and lowest electronic health record (EHR) adoption rates—have both launched statewide health information exchanges (HIE). In addition, New York is taking steps to expand its ability to increase doctor and patient participation in its statewide network.
- **Florida:** The board of LeadingAge Florida had embraced technology as a policy issue. LeadingAge Florida hosted its first technology conference in September and thanks CAST for its input and support. CAST Commissioner Peter Kress was the keynote speaker for the conference.
- **New York:** Selfhelp Community Services submitted three proposals to New York's Balance Incentive Program. All of the proposals were funded. The Balance Incentive Program has been encouraging participation in HIE. The program's scaled-down version of an enterprise data system will enable Selfhelp to connect with some of its local HIEs. This will be a year-long project that will study how well Selfhelp's connections with HIEs work in conjunction with the Medicaid redesign project and how it can be used in other states.

CAST Standards Update

LTPAC HIT Summit & Roadmap

The annual Long-Term and Post-Acute Care (LTPAC) Health Information Technology (HIT) Summit convened in Baltimore June 23-24. Speakers, board room discussions, and showcase demonstrations focused on the themes featured in a Draft Roadmap that the LTPAC HIT Collaborative is developing.

These themes include:

- Connected worker.
- Connected patient.
- Connected provider.
- Health intelligence and quality.
- Evolving business imperative.

The Summit emphasized the importance of extending beyond back-end systems that have often dominated the interoperability discussion. The new mobile, cloud, connected device/sensor reality—and the fact every member of the provider workforce, virtual care team, patient and family social ecosystem is becoming connected in real-time—is changing the interoperability discussion.

Meaningful Use and Regulatory HIT

The broader regulatory framework around interoperability is increasingly focused on transitions of care, and hospital readmissions continue to be a priority. Standards have been adapted to support transitions, with greater consideration of the full set of clinical, person-centered, and quality concerns recognized in LTPAC and particularly expressed in Release 2 of the Consolidated Clinical Document Architecture (C-CDA) Transitions in Care dataset.

There is intensifying interest, within both executive and legislative sectors, to drive significant standardization across care sectors building on the Continuity Assessment Record and Evaluation (CARE) work. This CMS initiative aimed to develop and test CARE as a standardized data collection tool for use in acute care hospitals and post-acute care settings including long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies. The CMS-funded demonstration involved 140 general acute hospitals and post-acute providers in 11 markets.

The Office of the National Coordinator for Health Information Technology recently published *A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure*. This concept paper provides a useful overview of priorities and strategies to advance the impact of health IT.

Real Opportunities for Interoperability

Real opportunities for LPTAC provider engagement in health information exchange (HIE) continue to be most promising in ad-hoc arrangements. For example:

- LTPAC HIT vendors, pharmacies and lab vendors are increasingly supporting direct system exchange of pharmacy (full circle), labs and other ancillaries.
- Physician/clinician portals and mobile apps are providing richer physician/provider interaction.
- Increasing adoption of E-interact processes are opening up hospital/LTPAC provider transitions initiatives, but still on an ad-hoc basis.
- Affordable Direct encrypted mailboxes are increasingly being leveraged as communication vehicles for ad-hoc interactions. Mailboxes are being made readily available to LTPAC providers

and professionals by vendors, including Cerner and others, and state HIEs like the Florida Health Information Exchange.

ICD-10 Delayed but NCPDP is Not

ICD-10 standards implementation deadlines were delayed from October 2014 until October 2015. However, the LTPAC e-prescribing exclusion expiration has not been extended. Therefore, all electronic pharmacy integrations must leverage NCPDP standards, effective Nov. 1, 2014.

Appendix B

Principles for Managed Long-Term Supports and Services 2014

LeadingAge represents over 6000 non-profit organizational members who provide services across the aging span of long-term services and supports (LTSS). We recognize the importance of creating population health strategies, and know that, for many with chronic care needs, this includes the full continuum of LTSS. We realize the myriad of environmental pressures driving the States to explore and implement managed LTSS programs. We are concerned that many of these programs are being developed without adequate stakeholder input, thus impacting large numbers of vulnerable and high risk beneficiaries, for whom many of these managed care health plans have had little or no experience. The statements below represent LeadingAge members' core set of principles that are elemental to effective, efficient and equitable delivery of managed LTSS that will ultimately lead to sustainable programs for the States, the providers of these services and the individuals they serve. LeadingAge member organizations believe that managed long-term supports and services must adhere to the following core principles:

Access

- Individuals have access to the services that they need and, whenever possible, in the setting they choose, and effective uniform assessment tools are utilized.
- Services are coordinated across settings and based on individual assessment-based needs.

- Enrollment is expanded only when there is evidence of success and adequate capacity of services to meet the needs of the population enrolled in Managed LTSS.
- Person-centered programs are in place and adequately funded to ensure the core functions of individual advocacy, systemic monitoring, early intervention, and consumer education.

Quality

- Managed LTSS programs develop consistent quality measures that apply to long-term services and supports, including measures that address consumer experience, measures of direct workforce, integration of services, and quality of life measures.
- Enrollment should include "opt-out" provisions when services or networks are not adequate for individual needs or do not include current provider or services that individuals find essential to their care.

Transparency

- Managed LTSS contracts are developed through an open and transparent process with the managed care health plans, the state Medicaid offices, providers and consumers.

Finance

- Medicaid and Medicare, alone and when combined (as in a capitated system for dually eligible individuals), meet the same standard for adequate payment.
- Uniform standards for payment are accompanied by streamlining conditions of participation, forms, codes and other administrative issues.
- Payments are adequate for innovative, efficient care: Recognizing Medicaid must change to promote greater efficiency without compromising quality.