



Adult Care Home Legislation Stakeholder Meeting

Long-Term Services and Supports

August 19, 2020

Welcome & Introductions

Meeting Objectives

- **Share information on the Adult Care Home (ACH) payment methodology legislation**

- **Engage in collaborative discussions regarding Value-Based Purchasing, Medicaid beneficiary data, The Joint Commission and Finance**

- **Integrate the NC Medicaid Managed Care Prepaid Health Plans to understand their service delivery for adult care homes and personal care services in other states.**

Agenda

- NC Medicaid Perspectives
- Value-Based Purchasing
- Stakeholder Presentation
  - Data Summary
- Stakeholder Presentation
  - Joint Commission
- Cost Report / Rate Structure
- Report Out & Next Steps

NC Medicaid Perspectives

Dave Richard
Deputy Secretary
Division of Health Benefits

Paying for Value in NC Medicaid

Julia Lerche
Chief Strategy & Chief Actuary
Division of Health Benefits

Vision for Buying Health and Promoting Value

The Department is committed to "buying health," meaning that it aims to align financial incentives to better achieve whole-person health and wellbeing.

- **Alternative payment models allow the Department to buy "health," rather than discrete health care services.** They also allow the Department to be good stewards of public dollars.
- **Prior to the COVID-19 pandemic, the Department outlined its plans to transition Medicaid payments from fee-for-service to value.**
  - PHPS held accountable for increasing targets on the percentage of payments made under value-based arrangements, with 90% of all payments tied to VBP, and 45% tied to shared savings or risk-based models by Contract Year 5 of Medicaid Managed Care.
- **The Department aims to encourage independent providers, physician-led organizations, Federally-Qualified Health Centers (FQHCs), and rural practices to move to value – not just large health systems.**
- **The Department aims to ease provider administrative burden and align across payers in moving to value.**
  - To reduce administrative burden, the Department's VBP strategy aims to allow providers to align with existing Medicare and commercial VBP arrangements. The Department also aims to allow flexibility in administrative requirements when downside risk is taken early.

Vision for Buying Health and Promoting Value, cont.

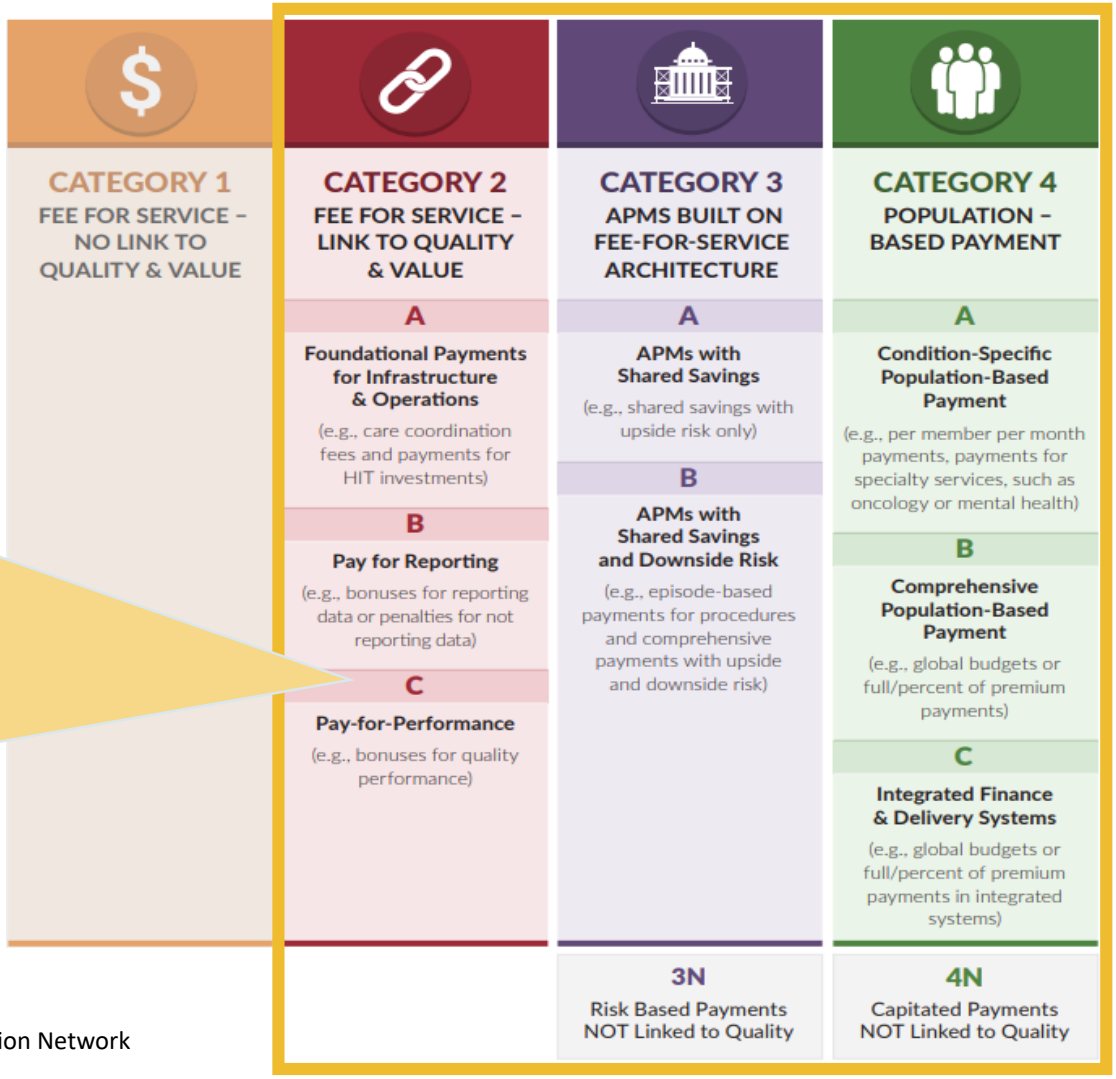
The Department is committed to "buying health," meaning that we want to align financial incentives to better achieve whole-person health and wellbeing.

- **The Department aims to recognize different levels of provider readiness for value-based arrangements and allow flexibility for PHPs and providers to develop payment arrangements tailored to their specific populations and needs.**
  - PHPs and providers can enter into any arrangements that align with the populations they serve, the services they provide, or specific health outcomes they aim to improve that align with NC Medicaid's quality strategy.
  - The Department encourages providers to build on state programs, such as the Pregnancy Management Program and local health department care management programs to reach VBP goals.
  - The State is also proposing optional value-based models and delivery systems that PHPs and providers may adopt to meet VBP targets, **including Advanced Medical Homes, an optional Medicaid Accountable Care Organization (ACO) program, and Healthy Opportunities initiatives**.
- **In March 2018, the Department released a concept paper on its care management strategy and Advanced Medical Homes for managed care.**
- **In January 2020, the Department recently released two policy papers that outline its proposed Value-Based Payment Strategy and Medicaid ACO Program.**
- **The Department is currently evaluating what, if any, changes to make to its value-based payment and ACO strategies in light of COVID-19.**

NC Medicaid's Definition of Value-Based Payment

In the first two contract years of managed care, the Department will define value-based payments (VBP) as payments to providers that fall in HCP-LAN Category 2A and above.

Beginning in managed care Contract Year 3, the Department will define VBP as **payments to providers in Category 2C and above**.

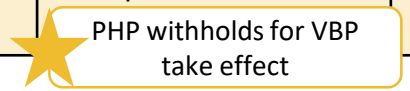


For more information on the Health Care Payment-Learning & Action Network (HCP-LAN) Framework, please see: https://hcp-lan.org/

Target Levels for Value-Based Payments

PHPs will be required to meet targets for the percentage of medical expenditures in value-based arrangements each year. The Department is currently assessing whether any changes are needed for these targets that were defined prior to COVID-19.

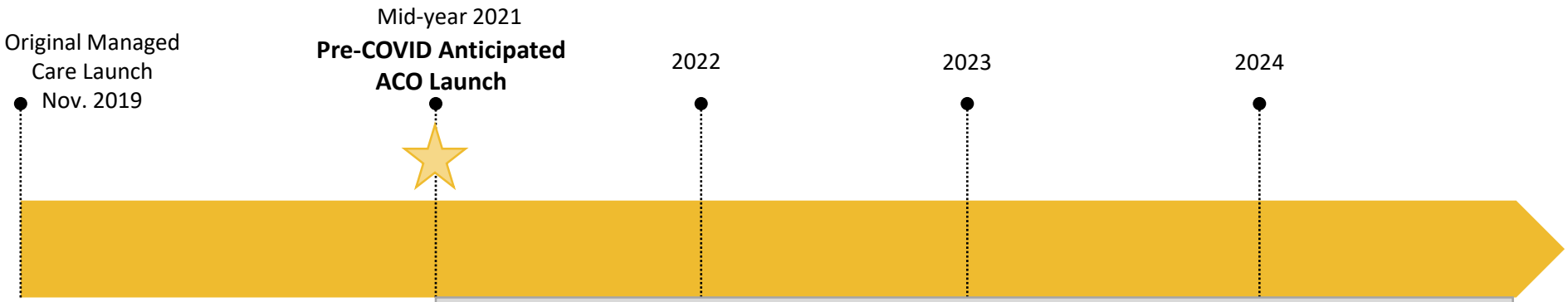
Year	Year 1	Year 2	Year 3	Year 4	Year 5
Target Level	*PHP submits a VBP Assessment to establish baseline at the end of Contract Year 1.*	**Overall** (HCP-LAN Category 2A+): • Increase by 20 percentage points or • 50% of total medical expenditures	**Overall** (Category 2C+) • 60% of total medical expenditures **Category 3A+** • At least 15% of total medical expenditures	**Overall** (Category 2C+) • 75% of total medical expenditures **Category 3A+** • At least 30% of total medical expenditures	**Overall** (Category 2C+) • 90% of total medical expenditures **Category 3A+** • At least 30% of total medical expenditures **Category 3B+** • At least 15% of total medical expenditures



In meeting these targets, PHPs and providers will **have flexibility to enter into any type of arrangement that meets the Department's definition of VBP**. PHPs and providers may leverage Department-led VBP initiatives, such as AMH Tier 3, the Medicaid ACO program, or develop their own, innovative arrangements.

Proposed Medicaid ACO Program

Prior to COVID-19, ACOs were envisioned to launch mid-year 2021, but the Department is assessing a new timeline for ACO launch.



Track 1: Lower Risk	
Track 1 arrangements would have minimal or no downside risk during this time period, but would be expected to take on some level of downside risk in later years	
Track 2: Higher Risk	
Track 2 ACOs would be allowed to operate low-risk arrangements similar to Track 1 for first two years	After initial glide path, Track 2 ACOs would be required to take on minimum levels of downside risk

Note: Providers may form ACOs that align with this model at any time after program launch.

Key Questions for ACH Legislation

- **How can we pay for Adult Care Homes in a way that promotes value?**
- **What research exists on the best ways to pay for Adult Care Homes?**
- **How do other states pay for Adult Care Homes?**

Stakeholder Presentation: Data Summary

Jeff Horton
Executive Director
North Carolina Senior Living Association

Jeff Horton

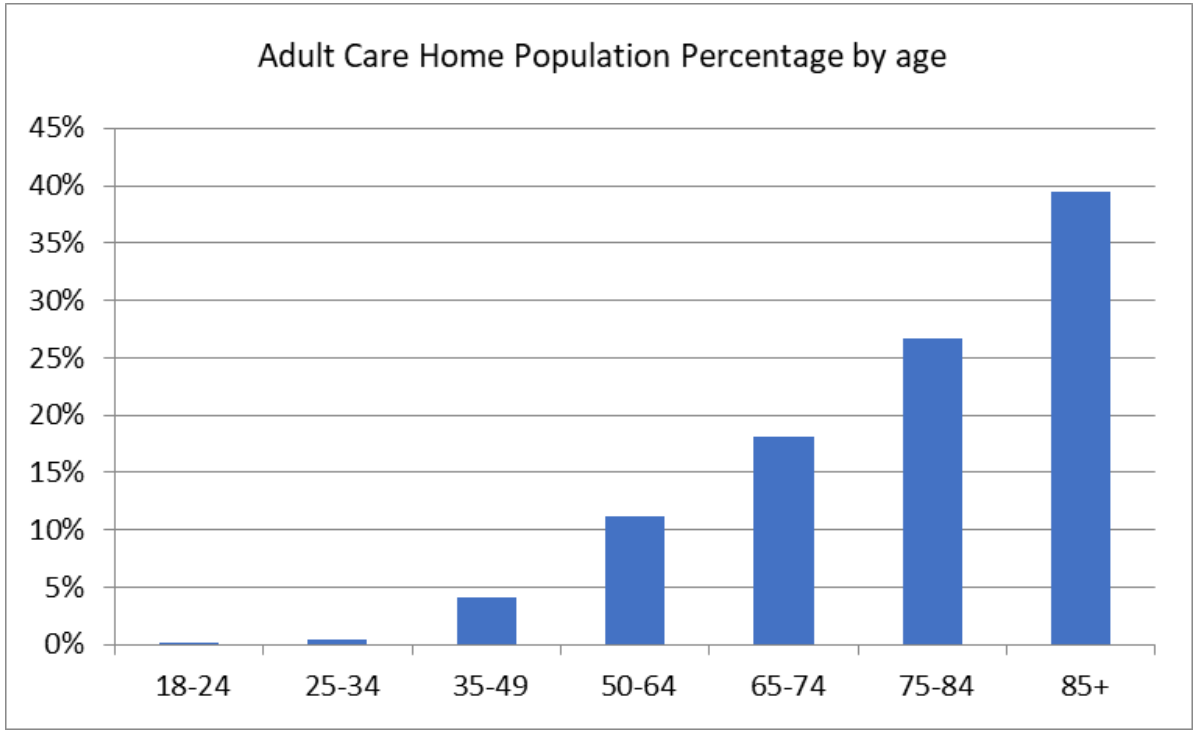
Executive Director

North Carolina's Assisted Living Residences - types

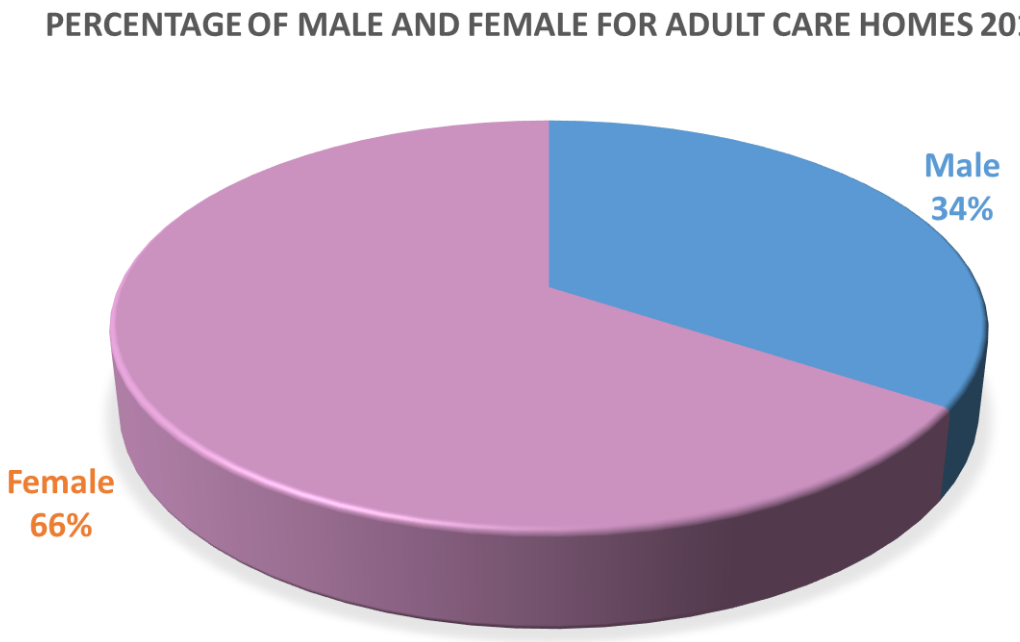
G.S. 131D-2 defines 3 types of assisted living settings

- Adult care homes (what we will be discussing today)
  - Adult care homes with 7 beds and up, 590 facilities with ~38,400 beds with ~26,000 occupied with 41% of residents with memory disorders
  - Family care homes (2-6 beds), 595 homes with ~3,400 beds with ~2,700 occupied
- Adult care homes for elderly person (55 years and older)
- Multi-unit assisted housing with services – unlicensed with minimal regulatory oversight by NC DHHS

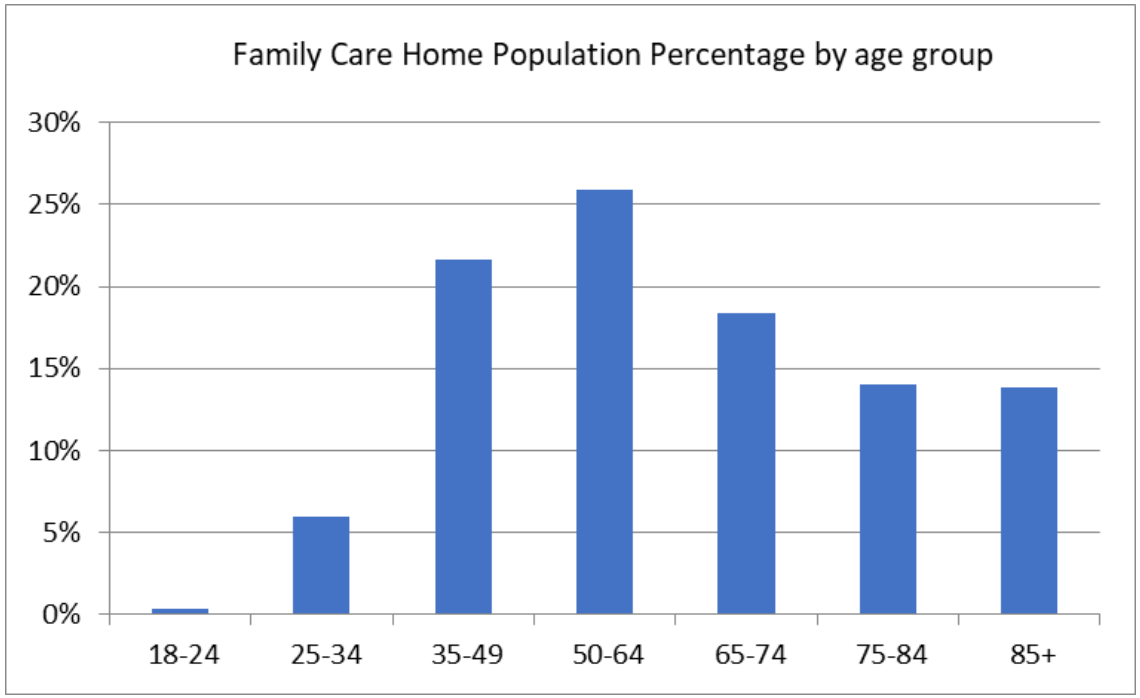
Adult care home characteristics
(DHSR licensure data)



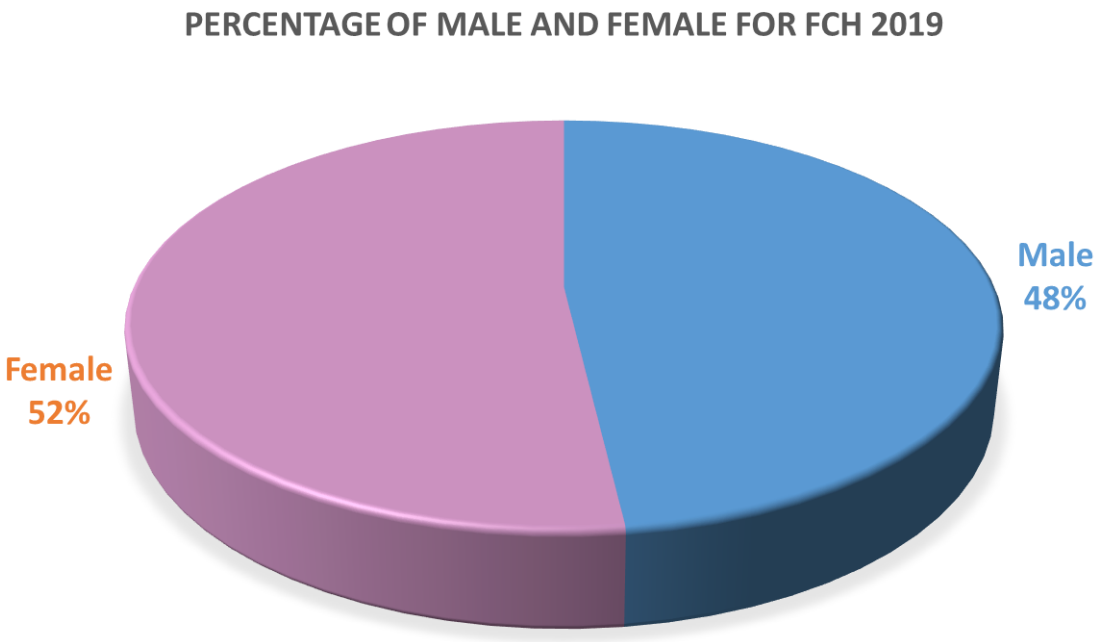
Adult care home characteristics



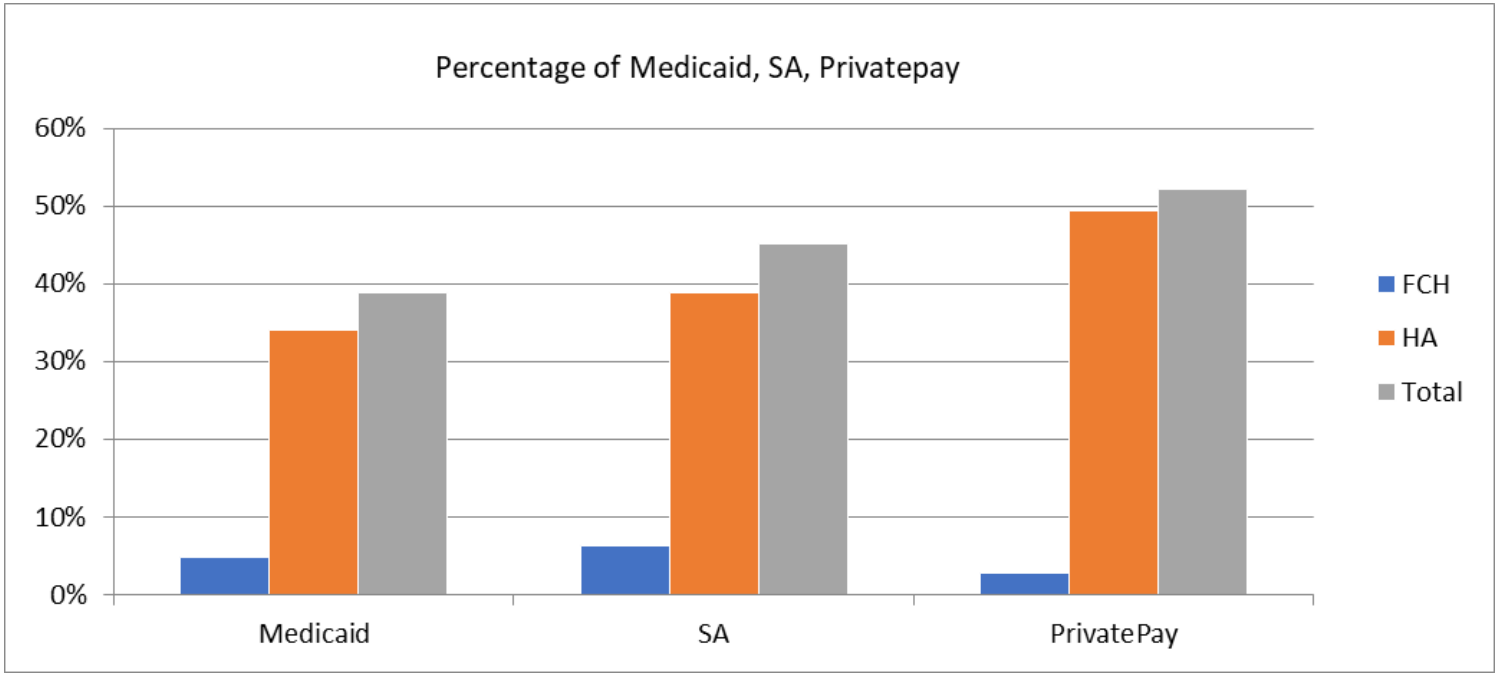
Family care home characteristics



Family care home characteristics



Payment types



Adult Care Home Methodology

- Data supplied by DHHS showed analysis of claims for 8889 unique residents of ACH communities, totaling $109 million. $73 million – over 67% - of that money went to support residents with an Alzheimer's or dementia related diagnosis.

- Among this cohort of 8889 residents, 5227 (58%) individually had an Alzheimer's or dementia related diagnosis.

- In addition, there were 731 residents of these communities, with schizophrenia, major depression and unspecified intellectual disabilities.

Adult Care Home Methodology

There are 11,011 PCS recipient residents in the communities represented in the data. Of these, 7,902 (72%) are over 65, 2930 (27%) are between 41 and 64, and a few are 40 years of age or below. In addition, State/County Special Assistance (SA) pays for the room and board for many of the PCS residents. SA is a combination of the resident's income and a 50/50 portion of state/county funds.

Average Monthly SA Payment (state/county funds)

JUNE	ACH	SCU
2015	$432	$580
2016	$412	$547
2017	$405	$516
2018	$393	$513
2019	$377	$496

Adult Care Home Methodology

As the previous slide shows:

- The average State and County Special Assistance (SA) payment made by the state for the residents in these communities has gone down in unadjusted terms every year in the DHHS reporting data. This is the result of increases in outside "countable income" such as Social Security, which is subtracted under state law from the maximum allowable SA.

- The maximum allowable SA has been essentially fixed at $1,182 per month for ACH community residents ($1,515 for Special Care units) for over ten years.

Adult Care Home Methodology

- The net effect of this is that PCS residents in these communities have had zero inflation adjustments to the room and board allowed. While the General Assembly had a program to pay $34 additional per month, that ceased when last year's budget authority ended June 30 2019, a planned increase in that number to $70 was not implemented.

- This year a special one-time payment of $1,325 was authorized in Session Law 2020-4. But special or catch-up payments are not a solution to the obvious structural issue presented by our current system – which is that we have effectively frozen room and board reimbursement for over a decade.

Adult Care Home Methodology

- The data also reflect that annually a significant number of residents are considered for termination from Medicaid in ACH communities due to outside income increases – such as Social Security – which push them a tiny amount over an income threshold.

- DAAS identified 280 such events for 2018 and 365 such events in 2019, indicating the issue is becoming more serious. Some, but certainly not all, were saved from losing Medicaid eligibility by the so called pass-along provisions: the data showed post COLA drops of 84, 138 and 58, respectively for the 2017 to 2019 Medicaid eligible populations.

North Carolina Senior Living Association

Adult Care Home Methodology

- Individuals in nursing facilities generally do not have to meet a deductible to be eligible for Medicaid. However, they must pay all of their monthly income, less a $30 personal needs allowance and the cost of medical expenses not covered by Medicaid or other insurance to the nursing facility. Medicaid pays the remainder of their cost of care.

- In some cases this results in residents electing to move to Skilled Nursing facilities to retain Medicaid reimbursement for their care, when they would otherwise be able to remain in their ACH community.

Adult Care Home Methodology

- The data show that the resident population in ACH communities requires a high level of assistance with Activities of Daily Living (ADLs) such as Bathing, Dressing, Toileting, Eating and Mobility. The minimum allowed to receive PCS money is two. Of the 11,011, 4531 (41 %) require help with all 5 ADLs, and 3759 (34 %) require help with four of the five ADLs.

- These residents suffer, on average, not just one or two but from 5 to 6 so-called exacerbating conditions affecting their ability to get on with life, like problems with balance, incontinence of bowel and bladder, shortness of breath, tremors, pain, amputations, and of course cognitive impairment.

- The medication regimens of the residents are extensive. The average resident has 9 medicines, requiring 27 to 30 medication administrations daily. In the counties of Alexander, Columbus, Dare, Iredell, Northampton, Person, Scotland, and Wilkes, the average is 40 or higher.

North Carolina Senior Living Association

Adult Care Home Methodology

Average # of Medication administrations performed/day per ACH/SCU Beneficiary

Gender	**# Medication administrations/day**
Male	27
Female	30
Age Range	
21-40 years	24
41-64 years	29
65+ years	29

Adult Care Home Methodology

Average Hours awarded on assessments per 2020 PCS Reports				ACH	SCU
2020	ACH	SCU	In Home	How Much Higher than In Home	
Jan	86	118	70	23%	69%
Feb	86	119	69	25%	72%
March	86	119	69	25%	72%
Apr	75	99	67	12%	48%
May	86	119	72	19%	65%
Jun	88	122	71	24%	72%
Jul	87	121	71	23%	70%
Averages	**85**	**117**	**70**	**21%**	**67%**

April was the mini- assessment time frame.

North Carolina Senior Living Association

Adult Care Home Methodology

How is assisted living funded by Medicaid in other states?

- Washington State pays for Medicaid PCS as a Medicaid State Plan service in both the in-home setting as well as residential settings including assisted living facilities and "adult family homes," which are similar to NC's family care homes.

- However, whereas North Carolina pays for both in-home and residential PCS based on approved hours and billed as units, Washington allows payment for residential-based services at a daily rate or per diem.

- Specifically, the Washington State Plan states:
  - "Payment for agency and Individual provider *(personal care)* services are reimbursed at an hourly unit rate, and payment for residential-based services is reimbursed at a daily rate."

Adult Care Home Methodology

Summary

- North Carolina's adult care homes take care of more complex PCS beneficiaries (including memory disorders) than other settings that provide PCS services.

- Whereas other settings are limited in terms of their contact with PCS beneficiaries due to the nature of intermittent care, i.e. in-home PCS, adult care homes are responsible for the beneficiary 24 hours/day, 7 days a week, which results in these homes providing more care than is captured with the current PCS assessment and allocation of hours model.

North Carolina Senior Living Association

Adult Care Home Methodology

Summary

- The current payment model does not capture all of the care provided to Medicaid beneficiaries by adult care homes.
- The PCS assessment accounts for additional hours due to the number of administered medications, as many as 30 hours per month, which is a significant amount and part of the reason ACH residents tend to get more hours than in-home care.
- However, individuals not requiring as much medication administration interactions receive considerably less on their assessed hours. The real expense to adult care homes not covered by the current PCS model is care coordination. Adult care homes are held to an intense level of scrutiny in this area and are not reimbursed for it.

North Carolina Senior Living Association

Adult Care Home Methodology

Summary (continued)

- Whereas North Carolina Medicaid previously was told by CMS that PCS services in residential and in-home settings had to be comparable and eventually led to the current independent assessment and allocation of hours model, there is now precedent with Washington state's Medicaid State Plan that allows residential settings to be reimbursed with a daily or per diem payment under the same PCS program umbrella.

- A per diem payment for PCS services in North Carolina's adult care homes is the most reasonable way to pay for services due to the fact that providers provide much more care for Medicaid beneficiaries than they are being paid.

Questions?

Stakeholder Presentation: The Joint Commission

Kimberly Clawson
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Payor Relations
The Joint Commission

The Joint Commission

Joint Commission Accreditation and North Carolina Adult Care Homes Reimbursement Options and Alternative Payment Model (APM)

Presentation to the Adult Care Home Legislation Stakeholders Meeting

August 2020

The Joint Commission - Overview

- Largest full continuum accreditor of healthcare organizations and services
- Nearly 23,000 accredited and certified locations in U.S.
- Accreditation/Certification is achieved by completion of a successful survey which demonstrates organizational compliance to our standards
- Private, non-governmental, non-profit – founded in 1951
- Accreditation voluntary
- Increasingly used in Alternative Payment Models (APMs)
- New accreditation - Assisted Living, launch 2021

The Joint Commission

North Carolina Accreditation Statistics

Accreditation:

11 - Skilled Nursing Facilities

45 - Ambulatory Care

107 - Behavioral Health

114 - Home Care Services

105 - Hospitals

15 - Critical Access Hospitals

Deeming Authority:

Hospital

Ambulatory Surgi Centers

Home Health

Hospice

Critical Access Hospital

Psychiatric Hospital

The Joint Commission

Joint Commission Assisted Living Community Accreditation (ALC)

- New accreditation to meet market need –starting January 2021
- Focus on person-centered care
- Eligible ALCs may provide a range of housing, personal care services and health care
- Select standards focus on persons with Alzheimer's disease – if applicable to the organization

The Joint Commission

Joint Commission Standards Chapters

Patient-Focused Functions

Care Treatment and Services

Infection Prevention and Control

Medication Management

National Patient Safety Goals

Rights of the Individual

Organization Functions

Environment of Care

Emergency Management

Human Resources

Information Management

Leadership

Life Safety

Performance Improvement

Record of Care

The Survey Process

The **tracer methodology** — the cornerstone of The Joint Commission's on-site survey process. Literally "traces" the experience of care

The objectives of the tracer methodology include:

- Following the experience of care through the entire continuum
- Identifying performance issues in one or more steps of the process or in the interfaces between processes
- Validating compliance with the standards through interviews and observations

Benefits of Using Joint Commission

Our standards…

- are the basis of an objective evaluation process that can help organizations measure, assess and improve performance and safety
- are reviewed for updates twice a year; changes based on the latest literature reviews, scientific research and stakeholder input
- many of our accreditations have received deemed status from CMS and meet and exceed most state licensure requirements

In addition….

- National Patient Safety Goals (NPSGs) – Each year The Joint Commission determines the highest priority patient safety issues and requires organizations to meet these goals
- Surveyors have professional experience in the type of organization they survey; minimum of a Masters degree in a clinical engineering field

Examples: Use of Accreditation in Alternative Payment Models (APMs)

The Joint Commission

Florida: Nursing Home Prospective Payment

- Accreditation is part of a Medicaid quality incentive
- Goal to balance financial incentives for high quality care with incentives for efficiency
- Organizational performance is evaluated on select metrics – higher payment is given for high performing organizations
- Accreditation is one of the metrics called a “structural metric” focusing on improvements in organizational process, performance and efficiency

The Joint Commission

Tennessee: Quality Improvement in Long-Term Services and Supports (QuILTSS) (nursing home program)

- LTSS program - Value-based purchasing initiative
- Rewards providers that improve care and focus on person centered care delivery
- Select Quality Measures are scored: satisfaction, staffing and staff competency, resident choice, etc.
- Accreditation is a bonus quality measure

Alternative Payment Model Framework

- Quality metrics are selected based on stakeholder input and areas where improvement is desired

- Accreditation is seen as a quality measure - helps organizations establish robust processes for improvement

- Individual metrics (quality measures) are “scored” using a point system points correlate with tiered ranking or specific payment amount. Example 1 point = .50 cents ppd.

The Joint Commission

Conclusion and Questions

- Joint Commission accreditation and standards focus organizational process improvement and safety
- New Assisted Living Community (ALC) accreditation – 1/2021
- ALC standards address a range of services provided by organizations assisted living organizations
- Select standards will address Alzheimer's where applicable to the organization
- Joint Commission has been used in similar LTSS and Medicaid program redesign

Cost Report / Rate Structure

Reggie Little
Associate Director
Provider Reimbursement (FFS)
Division of Health Benefits

Report Out and Next Steps

Linda Rascoe
Sr. Policy Analyst
Long Term Services & Supports
Division of Health Benefits

ACH Stakeholder Survey:
https://medicaid.ncdhhs.gov/providers/programs-and-services/long-term-care/adult-care-homes/ach-stakeholder-survey

ACH Webpage:
https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/adult-care-homes