Long-Term Services and Supports Evaluation of Rebalancing Strategies

Submitted to: Rhode Island Executive Office of Health and Human Services

Submitted by: The Lewin Group

Organization of the Presentation

Rhode Island's current long-term services and supports (LTSS) delivery system is weighted heavily toward institutional services; it is the state's intention to rebalance toward home- and community-based services (HCBS).

The aim of this presentation is to:

- Provide background on the current delivery system
- Describe the qualitative and quantitative methods used by the Lewin team to identify policy solutions
- Present key recommendations to improve the LTSS system based on the qualitative and quantitative tasks
- Discuss timeline considerations for key activities
- Present suggestions for next steps

STATE OF THE STATE: RHODE ISLAND'S CURRENT LTSS POPULATION, SPENDING, AND DELIVERY SYSTEM CHARACTERISTICS

State of the State: Population and Service Spending

- RI is an aging state – 15.1% of the state is age 65+ vs. 13.7% nationally; the 85+ population is also larger – 2.7% of the state population vs.1.9% nationally.

- By 2030, the 65+ population is projected to be 24.7% of the state's population, compared to 19.7% nationally.

- The 2014 AARP State Scorecard of LTSS ranks RI 38th among all states overall and in the third quartile on 4 out of the 5 measures of a high-performing LTSS system.

- Only 21.4% of total LTSS spending goes to HCBS for older adults and people with disabilities.

- 7,760 individuals age 65+ in RI accessing Medicaid-funded HCBS (including duals in Rhody Health Options).

LTC/LTSS spending in RI is heavily weighted toward institutional care

**Percent of Medicaid and state-funded LTSS spending going to HCBS
for older people and adults with physical disabilities (FY2014)**
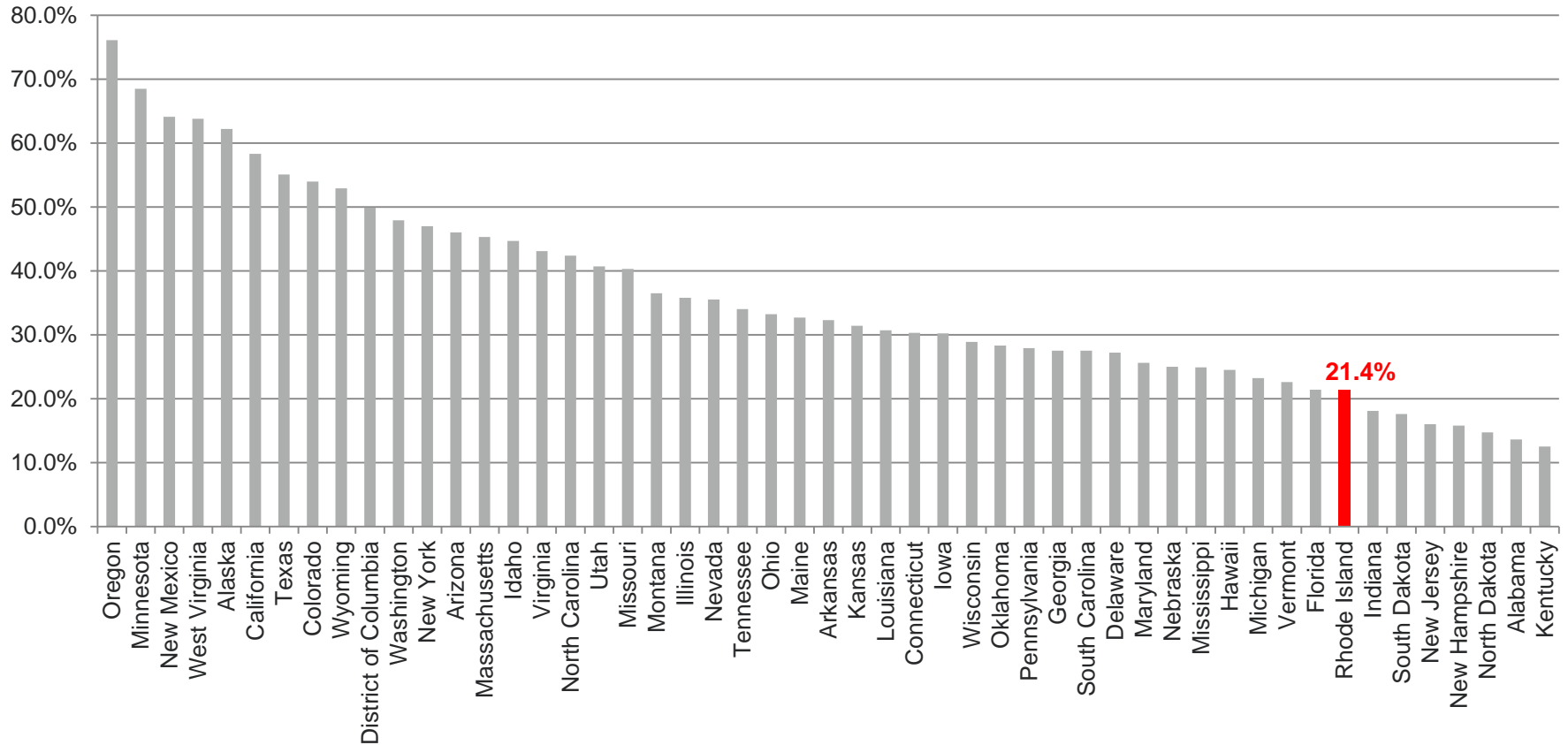
Source: Truven Health Analytics (2016). Medicaid Expenditures for LTSS in FY 2014.

State Ranking on LTSS System Performance by Dimension

Overall Rank*	State	Affordability & Access Rank	Choice of Setting and Provider Rank	Quality of Life & Quality of Care Rank	Support for Family Caregivers Rank	Effective Transitions Rank
26	Montana	41	18	11	49	10
20	Nebraska	37	25	10	18	25
41	Nevada	32	40	40	24	32
32	New Hampshire	29	39	13	38	19
26	New Jersey	13	37	21	22	36
14	New Mexico	12	6	38	37	17
25	New York	22	20	34	6	45
28	North Carolina	24	19	35	31	21
33	North Dakota	48	34	3	27	29
44	Ohio	42	32	39	39	27
45	Oklahoma	45	27	51	9	48
3	Oregon	20	5	13	14	1
42	Pennsylvania	46	25	37	36	28
38	Rhode Island	36	38	31	19	31
34	South Carolina	29	35	29	34	16
24	South Dakota	40	43	5	13	24
48	Tennessee	43	49	31	48	44
30	Texas	10	16	49	11	47
39	Utah	34	46	25	50	2
6	Vermont	15	8	17	12	5
19	Virginia	8	17	22	45	23
2	Washington	7	4	19	7	4
46	West Virginia	50	30	48	43	41
8	Wisconsin	18	7	7	14	13
16	Wyoming	16	33	12	21	30

* Final rank for overall LTSS system performance across five dimensions.
Source: State Long-Term Services and Supports Scorecard, 2014.

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Project Goals

Overall Project Goals and Tasks

- The goal of this four-and-a-half month project was to identify recommended actions, activities, and policies to reform and rebalance the LTSS through the following activities:
  - Environmental scan to understand Rhode Island's current policies and activities around rebalancing the system and other states' mechanisms for change, activities, and impact
  - Focused data analyses to identify precipitating factors for individuals in need of or receiving LTSS in Rhode Island (including the "Pre-Medicaid" population and those already enrolled in Medicaid) and to provide data related to the recommendations
  - Engagement of stakeholders (e.g., consumers, advocates, providers, policymakers) as key contributors to the development of the initial and refined actions, activities, and policies
  - **Final reports summarizing strategies to rebalance LTSS in Rhode Island**

Policy Focus Areas

Based on feedback from EOHHS, the following four focus areas are within the scope of this final deliverable *(priority activities or initiatives currently in progress or planned in RI are identified by **bold blue text**)*:

1. Building Age Friendly Communities
2. Strengthen Internal/Medicaid Interventions
3. Enhance Industry Partnerships and Financial Incentives
4. Cross-Cutting Commitment to LTSS Transformation

Policy focus areas were cross-walked to the *Framework for Rebalancing*, which was developed by the Lewin team.

– Initiatives and key activities selected for final presentation are those for which there was significant stakeholder agreement across the project's activities.
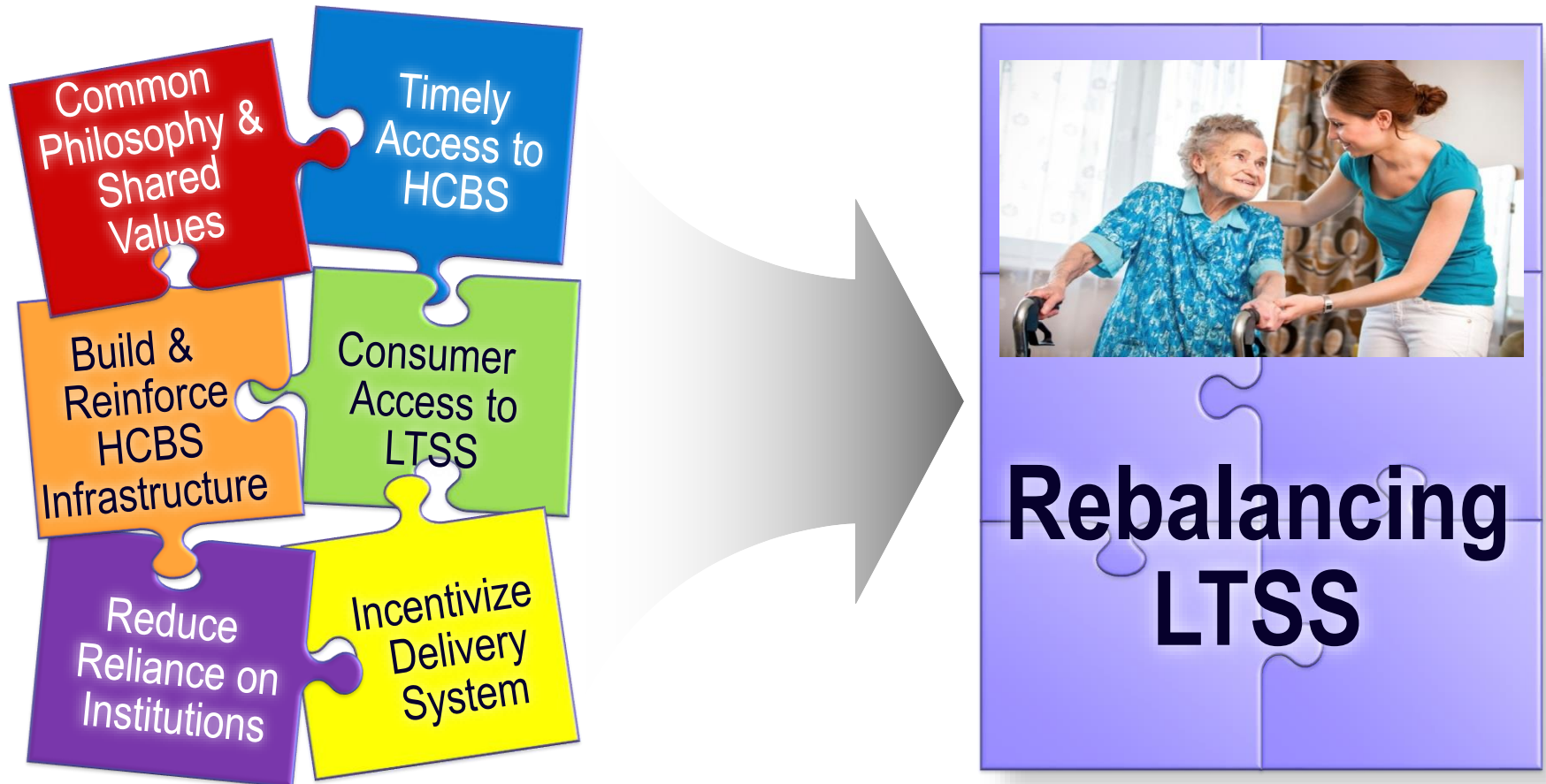
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Methods

Environmental Scan

- Based on feedback from EOHHS, nine focus areas were the subject of the environmental scan

- The team conducted deep dives into the pre-selected nine focus areas, including discussion of:

  - Background on our understanding of the issues in RI and facts on the ground (current status) – determined based on reports shared by EOHHS, discussions with subject matter experts, and literature search results

  - Best practices from other states that might address delivery system issues – identified through rankings on the LTSS Scorecard, subject matter expert recommendations, and literature search results

  - Preliminary recommendations for RI – developed from the Lewin's team internal expertise and are initial recommendations that need to be further honed and expanded through additional inquiry

Qualitative Inquiry

- Two phases of qualitative inquiry were conducted:
  - Key Informant Interviews
  - Focus Groups
- Key Informant Interviews
  - 7 stakeholders identified through consultation with EOHHS to discuss issues in 3 areas: Communication, Awareness, and Access to Information; Eligibility Process; and Nursing Home Partnerships
  - One-on-one topic-specific interviews were conducted by telephone during the week of September 12, 2016 by UConn, Brown, and Lewin; each lasted approximately 60 minutes each.
- Focus Groups
  - 4 focus groups conducted across same topics as interviews with one additional topic requested by EOHHS – Delivery System, Provider, and Process Transformation
  - 90-minute FGs held in Warwick, RI between September 26 and October 7, 2016. Each session was were moderated by UConn
- Analytic approach
  - Extensive notes and focus group transcripts were analyzed and compiled into the report numerating recommendations and additional considerations (i.e., barriers, potential partners, strategies).

Quantitative Analysis

- Two data sources were analyzed to understand LTSS experience for three populations:
  - Pre-Medicaid population (No Medicaid prior to LTSS use)
  - Medicaid-eligible prior to LTSS use
  - Nursing home transitions
- APCD Analyses
  - Described the population using LTSS in CY 2013
  - Examined service utilization immediately prior to LTSS entry to help understand patterns of care (overall and by type of LTSS used)
  - Used regression techniques, examining predictors of nursing facility (NF) entry relative to HCBS
- MFP/NHTP Analyses
  - Described individual characteristics associated with referrals to NF transition to the community
  - Described characteristics and key outcomes associated with transitions from the NF to the community
  - Evaluated quality of life data available in the MFP/NHTP database

Final Deliverables

- Three deliverables are submitted to EOHHS:
  - Report detailing Qualitative Inquiry
  - Report examining Quantitative Analyses
  - This PowerPoint outlining our recommendations for activities to be prioritized in Rhode Island, with a separate table documenting all activities across the four policy areas included in the qualitative inquiry

- This PowerPoint integrates learnings from environmental scan, qualitative inquiry, and quantitative analysis. Recommendations are included organized by the *Framework for Rebalancing LTSS*.
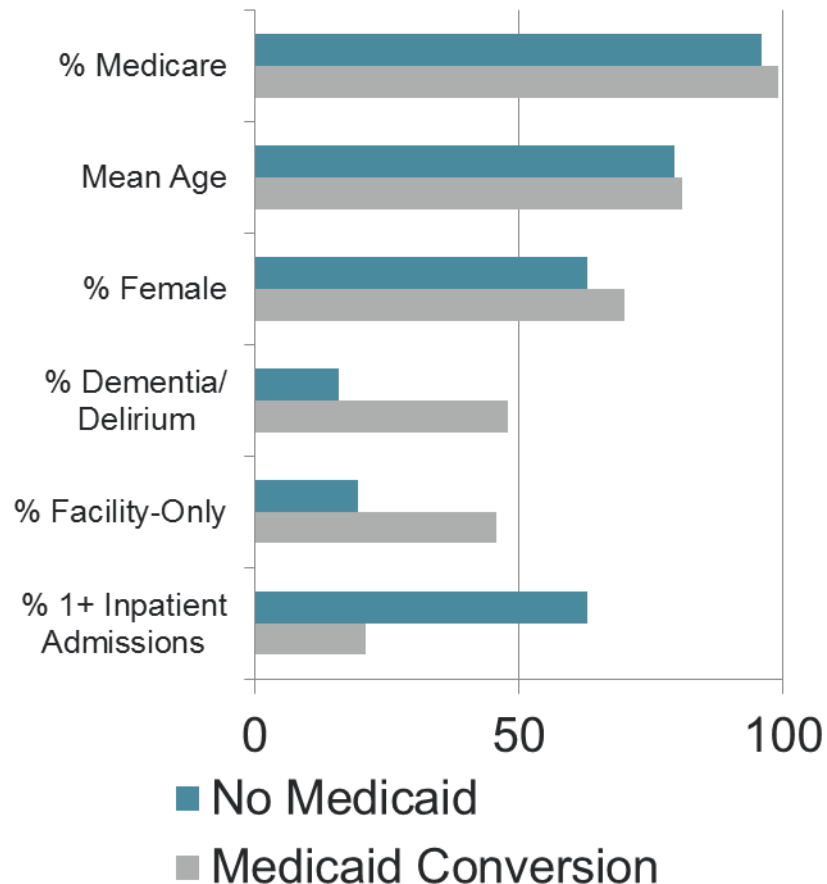
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Key Findings from the Quantitative Analyses

All-Payer Claims Database (APCD)

Enrollment Status	Medicare Only	Medicaid Only	Medicare and Medicaid	Commercial Only	Total
Total Unique Members in APCD	155,637	82,656	36,805	329,573	604,671
Percent of Total (%)	25.7%	13.7%	6.1%	54.5%	100.0%
Total Unique LTSS Users	23,923	7,323	5,371	12,206	48,823
Percent of Total (%)	15.4%	8.9%	14.6%	3.7%	8.1%

- Predictors of LTSS: Facility vs. HCBS
  - Older, Medicare eligible, cognitive impairment – NF use
  - Inpatient use drives NF use
  - Specialty provider spending also positively associated with NF use
  - Patterns of predictors similar for Medicaid and non-Medicaid populations
- Most Facility-Only LTSS users have no acute episode prior to entry
  - Older, more likely to be female, cognitively impaired, over half are Medicare-only

Medicaid Enrollment Post-LTSS Initiation

Chart legend:
- No Medicaid (teal)
- Medicaid Conversion (gray)

Categories (x-axis 0 to 100):
- % Medicare
- Mean Age
- % Female
- % Dementia/Delirium
- % Facility-Only
- % 1+ Inpatient Admissions

- 1,199 NF users (first or only) with no Medicaid enrollment for 12 months prior to NF admission
- 10.9% of NF users enrolled in Medicaid following admission
- Most are Medicare beneficiaries
- Demographic profile similar
- Medicaid enrollees more cognitively impaired
- Medicaid enrollees more likely to use NF only; less likely to have had inpatient admission in 30 days prior

Money Follows the Person/Nursing Home Transition Program (MFP/NHTP)

2,749 Total Referrals

Referral Status	Percentage
Referrals resulting in transition	24.9%
Referrals not resulting in transition	68.7%
Referrals still in process	4.9%
Ambiguous	1.5%

- Most referrals do not result in transition

- Demographic profile similar between referrals from MFP & NHTP

- Total transitions between 1/2010-7/2016: 684 (220-MFP; 464 NHTP)

- Median days from NH admission to referral: 190 days (MFP), 38 days (NHTP)

- Median days from referral assessment to transition to community: 72 days (MFP), 40 days (NHTP)

MFP/NHTP, cont'd.

Characteristic	MFP (N=220)
Successfully Discharged After 365 Days (%)	54.1%
Still Enrolled in the Program (%)*	11.9%
Discharged Before 365 Days, by Reason (%)	
Discharged Due to Death (%)	12.4%
Voluntary Withdrawal (%)	5.2%
Other (%)	16.5%
Median Days from Transition to Discharge Before 365 Days	141 Days
1+ Suspensions from Program (%)**	51.0%
Reasons for Suspension**	
Admitted to Hospital (%)	59.6%
Hospitalization Followed by Long-Term Rehab (%)	19.2%
Other (%)	21.2%
Re-Activated After Suspension (%)**	51.5%

3x

more housing supplements received through MFP transitions than NHTP

Characteristic	NHTP (N=215)
NHTP Transfer to Case Management Agency (%)*	52.1%
Median Days from Transition to Case Management Agency	81 Days

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#1: Create a common philosophy and shared values around rebalancing

#2: Ensure timely access to Medicaid HCBS

#3: Develop HCBS infrastructure to meet community needs

#4: Create easy and seamless consumer access to LTSS

#5: Reduce reliance on institutional services

#6: Incentivize delivery system to support community-based care

#1: Create a common philosophy and shared values around rebalancing

Common Philosophy & Shared Values

- Legislative and administration commitment to rebalancing
  - Identify legislators to sponsor and draft legislation to support LTSS rebalancing; for example:
    - Connecticut: Included language giving State Medicaid Agency Director authority to develop a strategic plan to rebalance Medicaid LTSS (refer to Connecticut CGS Section 17b-369 (c) (2006))
    - Vermont: Included language giving State Medicaid Agency Director authority to reduce the supply of nursing homes (refer to Vermont Act 160 (1986))
  - Pass and sign legislation
  - **Budget implication**: Minimal

#1: Create a common philosophy and shared values around rebalancing (cont.)

Common Philosophy & Shared Values

- Establish scorecard to create transparency and track progress toward rebalancing
  - Capture a common set of measures across providers/regions and a standard process for data collection identified on the scorecard
  - Build reporting structure
    - Create an electronic tool for reporting data to the state
    - Designate state agency to maintain reporting infrastructure
  - Develop a report card or quality measures/data book
    - Summarize submitted data in a report card
    - Make the report card available to consumers and providers on provider and payor performance
    - Formalize a feedback loop for input from consumers and providers to the state
    - Regularly update data
  - **Budget implication**: Unknown; costs depend on existing infrastructure, available data, staff capacity

#1: Create a common philosophy and shared values around rebalancing (cont.)

Common Philosophy & Shared Values

- Engage stakeholders regularly
  - Garner support from stakeholders and gather input on priorities for strategy to rebalance
    - Specific request for engagement from industry partners
  - Engage stakeholders to identify a common set of measures for scorecard
    - Identify existing national measures and focus on integrating providers
    - Include more quality measures and "standards of responsiveness" in contracts with providers
  - **Budget implication**: Unknown; primarily state staff time

#2: Ensure timely access to Medicaid HCBS

Timely Access to HCBS

- **Implement presumptive financial eligibility for Medicaid for all HCBS waiver programs, and provide services while application is pending**
  - Implement opportunity under 1115 waiver authority to accept self-attestation of financial eligibility for up to 90 days
  - Expand policy to all Medicaid-funded HCBS programs
  - Monitor impact of presumptive eligibility policy on key outcomes, including beneficiary ability to remain in the community and avoid Nursing Facility admission
  - **Budget implication**: <$100,000 per annum; potential cost savings from NF avoidance

#2: Ensure timely access to Medicaid HCBS

Timely Access to HCBS

- **Develop and maintain an online waiver benefit and financial eligibility platform**
  - Support process from application to determination through online application process that allows for documentation to be uploaded
  - Streamline and standardize the financial eligibility process to reduce the number of necessary steps and hand offs required, redesign the application form to be more user-friendly, and standardize the form and process used across all populations
    - Reduce any burdensome or unnecessary documentation and paperwork and clarify necessary timelines for documentation (e.g., reduce timelines for bank statements from six to three months)
  - **Budget implication**: Unknown

#2: Ensure timely access to Medicaid HCBS (cont.)

- Improve assessment process
  - Adopt and use standardized assessment tool for functional eligibility
    - interRAI-Home Care is a widely used assessment tool for HCBS across state Medicaid programs; offers turn-key assessment solution
      - Eliminate PCP sign-off requirement for functional eligibility, instead build in clear level of care criteria to new standardized assessment
      - Eliminate SSDI disability determination requirement for <65 consumers
    - **Budget implication**: Costs of adopting a new assessment tool based on experience in other states range from $1.4-$4.8 million for development and implementation (some $ may be eligible for federal match)
  - Increase assessor capacity
    - Increase assessor capacity to prevent delays in receiving a functional assessment
      - Expand the types of medical and other professionals that can complete assessments
      - Co-locate functional assessors in hospitals or other settings
    - **Budget implication**: Unknown; need to evaluate current workload to estimate number of FTEs needed

#3: Develop HCBS infrastructure to meet community needs

Build & Reinforce HCBS Infrastructure

- **Repurpose facilities – whole or part**
  - Develop grant opportunities/pilots to incentivize nursing facility providers to change/expand their business models to include HCBS (i.e., repurpose empty wings or entire facility to assisted living, independent living, other housing models, adult day programs, institutional respite beds)
    - The Connecticut Rightsizing Initiative (2014-15) – evaluation currently underway
      - Connecticut made 2 rounds of "rightsizing" grants (planning and project grants) to 11 nursing facilities in 2014-15, aimed at helping the nursing facility industry diversify services and develop alternative business models.
      - Nursing facilities required to work with community organizations to develop projects
      - Each grantee is also obligated to either decrease licensed beds in their facility or increase discharges directly to the community from partner hospitals (if the project includes any)
  - **Budget implication**: Unknown; total funding for CT Rightsizing Initiative was approximately $12 million in rounds 1 and 2; a third round expected (between $1-2 million per grant)

#3: Develop HCBS infrastructure to meet community needs (cont.)

Build & Reinforce HCBS Infrastructure

- Explore housing supports
  - **Implement RI EOHHS proposed program for home financing and tax credits for home modifications, "Aging in Place Safe and Accessible Homes Program"**
    - Increase tax relief credit to match MA and CT (their property tax credits are more generous – $1,000 vs. $500 in RI)
    - Develop home modification loan/grant programs
    - Livable Homes Tax Credit (VA model allows credits up to $5,000 for home mods)
  - Replicate and promote the SASH (Support and Services at Home) model
    - St. Elizabeth's has a grant to pilot the SASH model
  - **Revisit Supportive Care Residence Act of 2009**
    - Stakeholders perceived regulations to be too restrictive; identify potential improvements that would support innovative housing models
  - **Budget implication**: Housing supports: ~$225k per annum; unknown impact from tax credits/grants or revising Supportive Care Residence Act

#4: Create easy and seamless consumer access to LTSS

Consumer Access to LTSS

- Create a true No Wrong Door (NWD) system in Rhode Island
  - **Invest in The POINT as the state's NWD vehicle (obtain matching funds where available)**
  - **Develop a single comprehensive source of information on LTSS options and eligibility**
    - Ensure a neutral, impartial resource, independent of the state, regardless of income level
    - Explore possibility of securing federal 90/10 matching funds for the website, since it will serve Medicaid clients
  - Implement an electronic system to capture intake information, facilitate referrals, and triage cases (e.g., MN Linkage Line)
  - Create a *Community Navigator Team* (e.g., CT Rightsizing Initiative) to provide enhanced, personalized assistance to walk the family/consumer through the whole process of obtaining community services
  - Build portal for access to information and publicize it widely
  - Reinforce and fund The POINT as hub for community information on LTSS and NWD – make The POINT "a household word"
  - **Budget implication:** State estimate of $735,000 (may not account for all costs associated with NWD)

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#4: Create easy and seamless consumer access to LTSS (cont.)

- Align information from multiple agencies
  - **Review and capture existing LTSS resources; revise for consistency and completeness**
    - Include information on all LTSS options, both publicly financed and private pay (e.g., private case management, reverse mortgages, elder law attorneys, life insurance, dementia care, adult day programs)
    - Standardize messaging about LTSS statewide (e.g., relevant state agencies, marketing materials from MCOs)
    - Post clear information on each specific HCBS program's eligibility and benefits on one central website (e.g., The POINT)
    - Identify entities responsible for updating centrally located LTSS information on a timely basis
  - **Budget implication**: Unknown; some of these costs may be included in estimates of the ADRC/website/The POINT enhancements

#4: Create easy and seamless consumer access to LTSS (cont.)

- Conduct community outreach
    - Conduct community education campaign to reach individuals well in advance of a crisis using high-quality information resources
    - Promote The POINT/ADRC as a resource for hospital discharge planners, case managers, community social workers, and family caregivers (e.g., warm transfers between service providers)
    - Coordinate with Division of Elderly Affairs to distribute information about HCBS to persons already receiving Older Americans Act services who may be pre-Medicaid and at risk of institutionalization
    - **Budget implication**: Unknown; need to consider costs of materials development, translation, marketing campaign development, execution, evaluation

#5: Reduce reliance on institutional services

- **Continue moratorium on nursing facility beds**
- NH bed buyback and facility buyback programs
  - As of 2014, RI had 8,020 certified beds with 92% occupancy; RI was ranked #43 for the number of certified beds per 1000 65+ (52.5 compared to 35.5 nationally)
  - Minnesota reduced their bed supply by approximately 28% from 2000-2014 (first bed buyback program implemented in 2000). In 2014, Minnesota had 37.9 certified beds per 1,000 65+ (ranked #29).
  - Reducing overall bed supply by approximately 8% will bring occupancy statewide to 95%; create incentives for bed conversions/facility closure to reduce bed supply by 645 beds, targeting over-bedded regions of the state over the next 5 years through these strategies:
    - General bed buyback
    - Conversion of double rooms to single rooms: This strategy had the most buy-in, and would reduce beds and increase QOL at same time. It might involve an increase in the Medicaid bed rate
    - Whole facility buyback
  - Engage industry stakeholders including both providers and state associations directly to discuss options
  - **Budget implication**: Costs of bed buyback in other states range from $10k-$45k; a quality assurance fee or IGT used in IN & ND to finance bed buyback programs; these investments would save the state $174 or more per day for a Medicaid bed

#5: Reduce reliance on institutional services (cont.)

- Develop "Next Generation" Nursing Home transition program
  - MFP Program sunsets December 2018
  - Engage stakeholders to determine post-MFP transition strategy
  - Improve quality oversight and management of MFP/NHTP programs
    - Develop and maintain real-time, web-based system for tracking and monitoring participants' outcomes in real time (MO has model web-based system)
  - Examine reasons for why MFP has not achieved transition targets; why referrals do not lead to transition
  - Explore role of housing supplements in MFP/NHTP in transition success
  - Identify additional housing supply/incentivize growth of affordable, accessible housing in Rhode Island
  - **Budget implication**: Unknown; transition costs to RI going forward will depend on form of "next generation" program

#5: Reduce reliance on institutional services (cont.)

- **Create incentives through Accountable Entities for hospitals to work with community-based organizations as part of the discharge planning process**
  - Promote evidence-based care transition models to support transition home after hospitalization (e.g., GRACE model or Coleman Care Transitions model) - model after Community-based Care Transitions Program (CCTP)
  - Provide recurring training to hospital staff about referrals to community-based settings based on level of care and what is available at home
  - Work with health care providers who are caring for patients with a planned hospital admission to develop plans in advance of admission to support community discharge
  - **Budget implication:** Unknown; some costs associated with Medicaid Prevention Pilot, others with expansion of Accountable Entity Program to include LTSS
- **Enhance Pre-Medicaid CNOM DEA Co-Pay Program**
  - Obtain necessary statutory approval for required regulatory changes necessary to expand eligibility
    - Increase upper income limit for eligibility to 250% of FPL
    - Extend eligibility to those age 19-64 with Alzheimer's Disease or related dementia
  - Pursue federal match funds claiming under 1115 waiver
  - **Budget implication**: Costs to expand co-pay program ~$2.4 million; some costs offset by savings to Medicaid from enrollment delay/avoidance

#5: Reduce reliance on institutional services (cont.)

- Personal Needs Allowance (PNA)
  - Increase community Medicaid personal needs allowance to better support people continuing to live in the community versus going into a nursing facility
    - RI monthly personal needs allowance for HCBS of $923 in 2015 ranks 35th. The median amount was $1,962 per month in 2015, ranged from a low of $77 per month in Maryland to a high of $2,199 per month (300% of SSI) in 19 states.
    - To bring RI's personal needs allowance for community-based individuals in line with the national median, the allowance would need to increase by 112%.
  - **Budget implication**: Unknown; increasing PNA can offset some Medicaid NF costs

#6: Incentivize delivery system to support community-based care

- **Promote PACE program**
  - Identify, in partnership with providers, high-acuity consumers who may be candidates for PACE; establish mechanisms to make referrals where PACE is available
  - **Work collaboratively with PACE on marketing strategy to promote PACE and provide ongoing education to community/referral sources**
  - **Identify ways to improve retention of PACE enrollees**
  - **Leverage new federal flexibility to expand PACE to those who do not require a nursing home level of care**
  - **Work with CMS to develop a pilot to expand eligibility for PACE**
  - **Budget implication**: Unknown; dependent on selected activities, expansion of eligible population, and leveraging of CMS to pilot

#6: Incentivize delivery system to support community-based care (cont.)

Incentivize Delivery System

- Capitalize on existing programs
  - PACE, Dual Eligibles Demonstration
  - Integrate LTSS into SIM Grant activities
  - Take advantage of CMS opportunities forthcoming
  - **Budget implication**: Unknown; dependent on programs' activities able to be leveraged
- Accountable Entities for the "pre-Medicaid" population
  - **Partner with high-volume Medicare Accountable Entities (AEs), an ACO model, to incentivize care transitions and NF avoidance among Medicare beneficiaries at risk of NF admission ("pre-Medicaid")**
  - **Budget implication**: Costs estimated ~$500k

#6: Incentivize delivery system to support community-based care (cont.)

- Accountable NF pilot program
  - **Implement Accountable Nursing Facility Pilot Program proposed by RI EOHHS**
    - Establish standards for "Accountable NFs"
    - Certify a small number (<10) of "Accountable NFs" who meet specific standards and are willing to participate in a new payment model
    - Certified Accountable NF Pilot Participants eligible to participate in innovative payment model through participating MMCOs. Payment model guidance to MMCOs to include 4 primary dimensions:
      - New Admission Rate: Differential rate for first 30 days in NF
      - Quality Multiplier: Modify rate adjustments for quality achievement
      - Single Bed Room Incentive: Increase daily rate to adjust for decreased number of beds
      - All payor performance bonus based on performance in avoidable ED use, average length of stay, and NH transition
    - MCO Contract Commitments
      - Require MCOs to contract with Certified Accountable NF Pilot Participants (number to be determined)
  - Obtain stakeholder input and buy-in into the design of this program/system through a transparent, collaborative process
  - **Budget implication**: Costs estimated at $1.25 million

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Recommendations and Next Steps

Near-Term Activities

- Create unified vision of – and commitment to – LTSS rebalancing in the Legislature and Administration

- Stakeholder engagement – increase transparency
  - Potentially re-engage the LTCCC
  - Support prioritizing efforts
  - Industry partnerships
  - Scorecard development

- Maximize federal match where possible (CNOM DEA Co-Pay)

- Evaluate IT capacity – NWD, unified information infrastructure, NH transition, HCBS assessment

- Engage best practice states directly to learn from their experiences

- Examine MFP/NHTP – begin designing "next generation" program

- Continue analysis of APCD; link with other data sources to develop more complete picture of LTSS trajectories

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Next Steps

- Establish priorities
  - Review recommendations and prioritize based on state resources and objectives
- Need to start somewhere – all roads lead to rebalancing
  - Rebalancing is a long-term investment – 3 decades of policy and program investments to date
  - Most initiatives will not produce an immediate return on investment

Rebalancing LTSS