

Centers for Medicare and Medicaid Services
Long Term Services and Support
Open Door Forum
Moderator: Jill Darling
Tuesday, July 17, 2018

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. At the end of today's presentation, we will conduct a question and answer session. To ask a question, please press Star 1.

Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over to (Felicia Verit). You may begin.

(Felicia Verrett): Thank you (Brandon). Good afternoon and good morning. Welcome to the CMS Long Term Services and Support Open Door Forum. My name is (Felicia Verit). I will be your moderator for this forum. This open-door forum is not intended for the press and remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov. Thank you.

And now I'll turn the call over to (Jean Close).

(Jean Close): Thank you (Felicia). On behalf of the Center for Medicaid and Chip Services and the Disabled and Elderly Health Programs Group, welcome. Thank you for joining us to hear about the latest trends and expenditures for long term services and supports and new research on how early use of home and community-based services leads to less use of institutional services.

Also we will hear from Washington State who has launched a demonstration to provide early access to services. And finally, we'll hear about assistance that's available to provide information and early access to home-based services through No Wrong Door Systems.

Joining me in welcoming you is our good federal partner from the Administration for Community Living, (Lori Gerhard). (Lori) is Director of the Office of Consumer Access and Self Determination. (Lori).

(Lori Gerhard): Thank you (Jean) and welcome everyone. And good afternoon and good morning. The Administration for Community Living funds a nationwide network of more than 1,200 aging and disability agencies that are staffed and run by people that live in the local communities they serve. Aging and disability agencies include state units on aging, area agencies in aging, aging and disability resource centers; centers for independent living.

Each day this network helps people seeking long term services and support access the support they need. The Administration for Community Living, the Centers for Medicare and Medicaid Services and the Veteran's Health Administration have a long-standing partnership working with states to transform our nation's long-term service and support access system.

In 2003, we studied innovated states like Wisconsin and Washington and over the years worked with all states and territories in developing aging and disability resource centers that have evolved into the No Wrong Door System. Through programs like the No Wrong Door System, we are transforming the community services access system to center on the people served. Listening to them and facilitating processes to help all people in need of long term

services and supports find the care they are seeking and streamlining the enrollment process for publicly funded programs.

In 2009, we worked collaboratively with 20 states and the Veteran's Administration Medical Centers to explore self-direction and develop the Veteran directed home and community-based series program now called Veteran Directed Care. Veterans are using a flexible service budget to purchase the care and services they need including hiring families, friends and neighbors to provide the care they need when they need it. Veterans design their care to fit their life. Today 64 VA medical centers offer the program in 34 states, the District of Columbia and Puerto Rico through 2012 aging and disability network agencies.

Over 7,000 veterans have received services through Veteran Directed Care. Through chronic disease self-management programs, fall prevention programs and other evidence-based programs, we've empowered people to take control of their health through individual choices. We've had a hypothesis that if we reach people early when they are in need of long term services and supports, and provide the support they need, we may be able to reduce the rate of institutionalization. People may be able to keep their independence and engage in community life. And we may be able to serve more people with the same investment or less.

We value the long-standing partnership with the Centers for Medicare and Medicaid Services and the Veteran's Administration. And are excited to hear the results of this study. I'll hand the microphone back to you (Jean).

(Jean Close): Great, thanks (Lori). Every year we publish the CMS long term services and supports expenditures report. We want to recognize the researcher behind this work (Steve Eiken) and his excellent team at IBM Watson Health for writing

this and many reports that are used far and wide the planning of long term services and supports. Today we have with us Dr. (Effie George) who will share with us highlights from the report. (Effie)?

Dr. (Effie George): Yes, thank you (Jean). My name is (Effie George) and I in the Division of Community Systems transformation and I'm very happy to present to you main findings of the 2016 LTSS, long term services and supports, expenditure report. These reports - this report and other reports are posted on Medicaid.gov and available publicly.

There are four main findings that I'd like to discuss for a few moments with you today. They are one, the resumption of Medicaid long term services and supports expenditure increases, two, continued increase spending for home and community-based services. We refer to them as HCBS. Third, variation HCBS utilization by age group. And fourth and finally the increased role of managed care in long term services and supports.

There's been the resumption of Medicaid LTSS expenditure increases. And we've also seen a slowdown in expenditure in the growth that is picking back up. The continued increase spending for home and community-based services varies by target population and age group. So people tend to look at long term care differently and also, we really noticed that striking increase in the role of managed care.

So first, the LTSS spending has resumed. It had slowed earlier in the decade. When we first started collecting data, through our partners at IBM Watson, this was in the 1980s and 1990s, increases were very rapid. We were seeing about 10% a year thereabouts. Gross spending in the late 1990s into 2000 decade and into 2011, when there was a challenging fiscal environment, things in spending started slowing down. And now since 2014, growth has

picked up again. It's up to about 4.5% and it's about at its usual pace that we had seen in the 2000 decade. So a little slower, but it is getting back to what is perhaps and will be normal.

We are seeing institutional LTSS spending. We see a divide in LTSS between institutional spending and HCBS that home community-based services spending. Institutional spending has been relatively flat. And you can see these general trends still hold true. There were rapid increases in institutional spending early on. Perhaps with more stability in actual negative growth. And that's not controlling for inflation. That's just less dollars going out. About .7% per year less than the first three years of this decade and about .5% more but not quite enough to balance it out. Generally, there's a flat pattern that we're seeing for institutional spending on LTSS during this decade.

Now on the other hand, HCBS spending, we're seeing it increase. Any increase that we see in LTSS is coming from that continued growth in home and community-based spending. We've seen this is a pretty consistent pattern over the years especially when HCBS was a really small, when the spending increases were very small, we're still seeing rapid growth.

So when you go from say two states having waivers to ten states having waivers. You'll see that the 20% growth rate per year. And that's what's declined over the time. We've historically seen low spending early in this decade, 4% per year and then 8 spending growth for the last three years dated 2014 to 2016. So a little bit less than we saw in the 2000s, but again continued growth in HCBS as opposed to institutional LTSS spending.

The balance has shifted over time. You can see significant shifting since our first year of data in 1981. This is increasing from less than 10% in the 1980s on HCBS to now 57% using 2016 data in terms of HCBS spending.

Especially the more recent years, we've seen a steady 2% per year increase in that percentage. The percentage of LTSS spending going towards having community based and it really hits the theme that HCBS is actually really the norm now. Medicaid LTSS and I think it's true for the broader community as well, has transformed for mostly at one point in time institutional services for LTSS to where now the majority of services for LTSS are happening and occurring in being providing in the community.

It used to be that nursing homes, state centers and state hospitals as you know had more for lack of a better word, weight and more emphasis for the system. And that's where the money was going. But now it's tilted towards home and community-based services. This is really relevant to what our other speakers are going to share with you today. This is more about the norm. And they're going to have more to say about how early use of HCBS as well leads to reduce utilization of institutional services later on.

Of course, how people experience LTSS will vary by state and this shows that each state, again, is in a different place in terms of their balance between institution and community-based spending. But you would certainly - anyone on the call today would benefit from going to the report directly because in the LTSS report in the appendices, you can find state by state data in terms of how much you spent on institutional services and community services and by which authority. For example, how much is being spend in nursing homes in Colorado versus how much is being spent in 1915C waivers in Colorado. You can find all this information in the back of that report. And again, posted publicly.

So 30 states spent more than 50% of Medicaid LTSS in home and community-based services in 2016. So there's still some states that aren't

quite there yet. And their expenditures are organized differently. So go check out that report.

I want to briefly look at person level data as well. The most recent data we have; however is 2013. But what's interesting about that report in 2013 is that 2/3 of the Medicaid LTSS beneficiaries were receiving HCBS. This is over the course of the entire calendar year 2013. For some people over the course of the year, they would have received both.

Thanks to programs such as the Money Follows the Person program also under (Jean Close)'s leadership, and similar initiatives, people are recovering and getting better so that they can move from institutional services back in the community. And sometimes the opposite happens as well. But we do get data on how often one accrues relative to the other. So people use both HCBS services during the year and some only use institutional services.

A little bit about the age breakouts. People under age 21 and people under age 65, about 80% received only HCBS compared to people who were elderly. It was more 50/50. So for people that were elderly, you'll see only 48% of them using HCBS where 6% were using both HCBS and institutional and with more transitions with the younger age group. Forty-six percent were receiving institutional services. So there is variation by age. We have a beneficiary report posted and that will delve much deeper into this issue. But again, the caveat is 2013 data.

And we continue to see the rapid growth of managed care. There are trends that we've seen, how these services are delivered. Expenditures for LTSS delivered through managed care have increased rapidly since 2012. This is the first year that we had data specific to managed care. Our first year actually was 2008. We had - it was slow growth, but it's been rapid and more; steady

of the years. Probably 20% per year until 2012, and then it's been 20% per year since then from \$10 billion being spent on managed LTSS in 2012 to \$39 billion. That's a huge jump in 2016.

We also have a managed LTSS report posted publicly for everybody on our Medicaid.gov webpage as well. We do have a couple other upcoming reports coming out for everyone. These are all available again, publicly. I hope you make good use of them. If you have any questions, please let us know. With that, let me turn it back to my Deputy Director (Jean Close). Thank you.

(Jean Close): Thank you (Effie). It's clear that we're at the point where for Medicaid covered population more and more options are available for states to furnish home and community-based services to their participants. It's a pleasure to be with you today. I'm (Jean Close), Deputy Director of the Division of Community Systems Transformation within CMS' disabled and elderly health programs group.

Our Division is focused on identifying and disseminating trends in Medicaid home and community-based services. We also seek to promote access in continuous quality improvement in the furnishings of these services.

Today we want to share the findings of our study that mathematic policy research undertook for us. We are hopeful that his research can provide evidence to support your efforts to improve access to expand the scope of home and community-based services furnished through Medicaid.

Some background, since 2007, we have been administering the money follows the person demonstration which included more than 44 states. MFP is a major federal initiative to give people needing home and community-based services more choice about where they live and receive care. For over 10 years, the

program has been increasing the capacity of state Medicaid programs to serve people in the community as opposed to institutions.

In 2016, we issued the final evaluation of the 10-year program. The evaluators MPR found that one, community-based services were less costly than institutional care. And two, participants in MFP reported better quality of life and higher satisfaction after transitioning from an institution to the community.

For those of you listening into this webinar who work in home and community-based services, I doubt these findings are surprising to you. You may also find it not surprising that most people prefer to reside in their own homes rather than receive long term care services in an institution.

The MFP evaluation and the vast data accumulated over the years on certain Medicaid eligible populations, gave us the opportunity to find out more about the Medicaid population and their use of HCBS. We commissioned very smart researchers (Kate Stewart) and (Carol Irvin) at MPR to help us find out. The study can be found through our website, Medicaid.gov in the LTSS section. We're also going to sending post webinar, a link to a couple of these reports that we mentioned today.

So we asked MPR to find out if early use of home and community-based services is associated with less downstream use of institutional care. Who is most likely to use institutional care? We asked, do individuals with long stays tend to remain in the institution and not transition? And finally if a state seeks to reduce use of institutional care, how and to whom should these efforts be directed?

Here are some of the key points about the study's design. First of all who did the study include? All were Medicaid eligible participants. All were new users of Medicaid home and community-based services or Medicaid institutional services. Three populations were considered. Individuals with intellectual or developmental disabilities, adults with physical disabilities, and older adults age 65 and older.

This group was then divided into two categories, institutional initiators and community-based initiators. Institutional initiators were those who first were furnished services in institution. For example, a person who fractured a hip and received services in a hospital and then entered a nursing facility. The other group was community-based initiators. Those whose first use of services was home and community-based services, for example, a person with dementia who began using personal care services through a 1915C waiver program.

Then the study looked at their trajectory of service use over time. They looked at the pattern of individuals as they moved from setting to setting and back again. The researchers captured whether someone had an institutional stay. They considered the length of stay in the institution, transitions back to the community, and recurring institutional stays.

So we asked the researchers to find out: Do the characteristics of new users of home and community-based services differ from new users of institutional services? Do new users of HCBS have fewer long institutional stays compared with those whose first use was the institution? When a long institutional stay occurs, does previous use of HCBS increase the likelihood of transitioning back to the community? And for those who transition to the community from an institution, who is readmitted to an institution?

Let's explore the findings. First question, do the characteristics of new users of home and community-based services differ from new users of institutional services? Yes. We found that older adults were most likely to initiate institutional services. Few in the population with intellectual or developmental disabilities initiated first use in an institution. Further, even for the other groups considered, older age was significantly associated with institutional initiations within each of the study populations. In addition, Asians and Hispanics were less likely than whites and blacks to initiate institutional care no matter what the study population.

Let's move onto our second question. Do new users of HCBS have fewer long institutional stays compared to those whose first use was the institution? Now within this is our most exciting finding. Few individuals who initiated home and community-based services, had a long institutional stay, defined as 91 days or more.

Our third study question looked at transitions from an institution to the community. When a long institutional stay occurs, this previous use of HCBS increased the likelihood of transitioning to the community we found. While most individuals with a long stay of 91 days or greater remained in the institution, home and community-based services initiated was associated with a higher rate of transition as well as use of home and community-based services after transition.

And our last question, for those who transition to the community from an institution, who is readmitted back to the institution? Again, older adults were most likely to be re-institutionalized. Adults with physical disabilities, there was no association between community-based service initiation and re-institutionalization. Blacks and Asians were less likely than whites to be re-institutionalized.

So in some, few community initiators had a long institutional stay. For those with a long institutional stay, transition rates were higher for those who had previously used home and community-based services. Older adults who were community initiators who subsequently had a long institutional stay and returned to the community, were less likely to be re-institutionalized. And racial and ethnic minorities generally used less institutional care than white groups.

As all studies do, this study had several limitations. Keep in mind the results were descriptive of patterns of use. The findings do not imply a causal relationship. Data is missing on a number of characteristics that may have had an impact on individuals use of institutional or HCBS. For example, we did not look at individuals' functional limitations, social supports or local policies.

MPR noted that for data for race and ethnicity, may be unreliable for some stays. This data was captured for individuals who were ever eligible for Medicare or for Medicaid. So to conclude, there are two significant takeaways messages here. For Medicaid programs seeking to reduce overall use of high cost institutional care. Consider guiding individuals toward home and community-based services provided in a state plan or through waiver programs. Also seek to reduce the association between age and the use of institutional services.

So with us today is (Kathy Morgan) who can tell us how Washington State is doing just this. (Kathy) will provide information regarding how Washington State provides access to early interventions that lead to decreases in avoidable nursing home admissions. What authority Washington accomplishes this through and the infrastructure necessary in the community make it happen. (Kathy) is Deputy Director of the home and community-based services

division within the aging and long-term support administration with the Washington State Department of Social and Health Services. (Kathy)?

(Kathy Morgan): Thank you (Jean). I'm pleased to be here today to provide a state's perspective on the importance of offering early access to long term services and support. And one of the things I always find helpful when hearing another state present on their long-term services and support system is to gain a high-level overview of the authorities they use. And how services are organized in purchased. So that's where I will begin today.

In Washington Aging and Long Term Support Administration is responsible for operating and managing the state's Medicaid funded long term service and support system as well as programs for older adults and care givers. One of the strengths of Washington's LTSS system is that many of our services are entitlements. Washington has had a state plan personal care program since 1989 and the functional eligibility for the program is less than nursing facility level of care.

What this means is if someone meets eligibility criteria, they can access services in their own home or community-based setting. One of the federal requirements of state plan services that there are no caps on the number of people we can serve, and these services cannot be targeted to particular populations based upon diagnosis or age.

Eighty-three percent of our budget in Washington is spent in these state plan programs which include our nursing homes, community first choice, Medicaid personal care and pace. We also offer services through waivers. And waivers can offer more predictability to states, because you can target specific populations and cap enrollment to a particular number of individuals based upon your budget appropriations.

Another important flexibility waivers provide for states is the ability to serve individuals with higher incomes that do not qualify financially for traditional Medicaid programs. In Washington financial eligibility under waivers is 300% of the federal benefit level. Only 2% of our budget is spent in waivers. However, this number was much larger in the past because we used to provide personal care services through the (cokes) waiver. However when we moved personal care - personal emergency response systems and other services to the community first choice, we did that leverage a higher federal match for those services which brought us in an additional \$90 million in federal funds which led - which the legislature reinvested into community-based care for seniors and individuals with disabilities.

Four percent of our service budget is not related to Medicaid. These services are provided through grants and state and federal funds such as the Older Americans Act. These services are targeted to individuals who typically do not qualify for Medicaid. Or they have chosen not to participate in Medicaid. These programs are for services and supports designed to keep people in their own homes. And provide services such as information and assistance to help people understand how to use their own resources and learn what services are available to them things like senior nutrition, legal assistance and family caregiver support.

These funds while small have been instrumental in allowing our state to test new services and supports to determine if they do result in being able to divert or delay people from nursing homes and from accessing Medicaid funded long term services and supports.

Washington has been rebalancing our long-term service and support system since the early 1990s. Offering services to individuals in community settings

has resulted in relocating individuals from more expensive nursing home care. But has also resulted in diverting a large number of individuals from the need to enter nursing home care in the first place.

The number of people served in our long-term service and support system has increased by 78% over the past 25 years. Over this same time period we've decreased the percentage of people served in nursing homes from 47% to 15% and saved more than \$4.4 billion in state and federal funds through these rebalancing efforts. This has been done through fee for service purchasing of long term services and supports that really emphasizes the use of case managers actively working with clients around options and choices.

A focus on health and safety and active resource development to ensure we have the services and providers to meet the changing needs of the clients served in the community. And a budget forecasting system that allows to move funding save when the nursing home census is controlled into services into community. It's important to note that the rebalancing Washington is achieved has been achieved incrementally over probably the past 30 years. States, of course, have to start from where they are and understand the needs of clients who want to be served in community settings and what the community gaps are in meeting those needs.

Actively mining data and consumer and stakeholder input to understand the barriers to serving individuals in the community are key to ensuring early access to home and community-based care. The data has informed a number statutory changes that have been key in expanding the types of services that paid long term care workers can provide in our state which has been critical - which has been a critical part of building the workforce necessary to serve individuals outside of nursing homes.

Among those are the following: nurse delegation which began in a limited fashion in 1996 and has expanded over time to include additional settings and tasks including delegation of insulin injections. Statute allow paid family members to assist with skilled tasks without the need for nurse delegations and allowing individuals who are not RNs or family members to assist with medications that include opening bottles, putting pills in people's hands, crushing medication, as long as the client knows that's the medication that they're actually getting.

There's a perception that people move from one setting to another as they age or become disabled starting out at home and then moving to a residential facility then to a nursing home. In Washington we know that's no longer the case. People with significant health challenges and levels of disability are served in large numbers in all settings in Washington.

We recently completed a study looking at individuals that began the long terms services and supports between the years of 2002 and 2005. Those that began services in 2010 to 2012 and those that started in 2015. The purpose of this was to identify the differences in where people actually began receiving services. What we've learned is that people receiving their first long term service and supports in a nursing home have dramatically declined from 40% in the 2002 to 2005 cohort to 29% in the most recent cohort. At the same times, those receiving services for the first time in their own homes has significantly increased from 42% in the early cohort o 53% of the most recent cohort.

Interestingly, the percentage of people first receiving services in licensed community residential settings which in our state are adult family homes and assisted living facilities, has remained the same at 18%. We also know from this data that fewer individuals that start their services in a community setting

transition to services in a nursing facility. And for those individuals that start services in a nursing home, more of them then transition to services back to their own home.

Washington's population like the nation is aging rapidly and the number of individuals 65 and older will double over the next 20 years. The fastest growing population is individuals ages 85 and older. And we know from the national statistics that 70% of our; that are lucky enough to reach age 65 will need some form of long term services and supports during our lifetime. Although we've experienced a lot of success in our rebalancing and diverting services away from nursing homes, we also recognize the need to continue to evolve our system to meet the demands of the age wave.

A Medicaid transformation waiver under the 1115 federal authority offered us the opportunity to test and demonstrate the next innovation of our support system. The LTSS component of the waiver is modeled after a successful state funded program designed to serve individuals who are supported by unpaid family care givers.

We are offering new services and have expanded eligibility to individuals that are typically not financially eligible for Medicaid because we want to get services to them prior to spending down to Medicaid eligibility. The goals of the waiver are to offer additional choices to individuals who are eligible for transitional or traditional Medicaid long term services and supports, support our unpaid care givers, support people before they have to impoverish themselves and rely fully on Medicaid and test whether presumptive eligibility will increase our ability to offer services more quickly.

So we began enrolling individuals into the wavier service in September of 2017. So we have about nine months of data for the demonstration so far.

There are a number of key aspects to the 1115 waiver that were necessary for us to implement the type of changes we wanted to demonstrate. We have the ability to create a wait list if needed to control the number of people served by these new services. Amount and duration scope flexibility, and we also limit - have the ability to limit the number of providers. And we're finding success in testing our presumptive eligibility. Early access means able to meet an immediate need for people and they're willing to accept Medicaid much sooner or accept help, not Medicaid but accept help much sooner. And participants in the waiver are also not subject to cost of care or state recovery.

The Medicaid alternative care, MAC, otherwise known as MAC is targeted to individuals that meet current financial and functional eligibility for Medicaid funded long term services and supports. Targeted to care receivers who are 55 and older receiving categorically needy or alternative benefit plan Medicaid. It allows care receivers to choose to wrap services around their unpaid family care giver as an alternative to choosing to receive services under our traditional state plan and waiver options. Meaning they cannot access the personal care benefit if they choose to enter the demonstration waiver. However, they can disenroll from the 1115 at any time and access those services. So they're never locked in.

Tailored services for older adults allows us to offer services to individuals before they impoverish themselves to access Medicaid funded long term services and supports. This group must also be 55 or older. They can have resources that exceed the \$2,000 required under traditional Medicaid and have up to \$53,100 for a single person and up to \$108,647 for a couple. We believe that by offering a small amount of services earlier to individuals before the access personal care or before the spend down to Medicaid eligibility will allow them to use their own resources more wisely, allow them to maintain

their home, and delay them from accessing costly long-term services and supports.

The care receiving must meet eligibility criteria before the caregiver can receive any support services under the MAC and (unintelligible) programs. And benefit categories include personal assistance services, caregiver assistance, training and education, health maintenance and therapy supports, durable medical and supplies. One of the hallmarks of our system in Washington is our No Wrong Door access to services. We have a strong partnership between the state and the 13 area agencies on aging in our state and both entities play the role of the state's front door to access needed services designed to keep people in their own homes and communities.

As part of the 1115 waiver and the work that was done, we developed warm handoff protocols to ensure that no matter what door people find to enter services, they are able to navigate the eligibility process seamlessly so that we can begin services quickly prior to people ending up in institutional care settings. Making sure that individuals get the information and services they need no matter where they first place a call is key to catching individuals when they most need information and services and more likely to accept them.

By tracking and trending data over time, we've also learned that offering early access to home and community-based services does allow individuals to be served in settings that are more preferred by individuals and provide a more cost-effective way of meeting the needs for states. It also results in lower utilization of nursing homes including less individuals receiving their first service in a nursing home and more likelihood that if they do have a need to access nursing home care they are much more likely to return to the community.

I will now turn the presentation over to (Ami).

(Ami Patel): Thank you (Kathy). Hello everyone. My name is (Ami Patel) with the Administration for Community Living and I'll be elaborating a little more on what (Kathy) just mentioned on No Wrong Door. I work on the National No Wrong Door initiatives here and wanted to talk to you about some opportunities for how you can apply all of this information you've heard today. And as (Kathy) mentioned, No Wrong Door efforts are really centered, around treating coordinated access systems that best meet the needs of individuals as they navigate what might seem like a fragmented system.

And this work really supports the takeaways we just heard from Washington and CMS. And shows that there is a strong correlation between improving access early on for home and community-based services and the transformative work that states have done over the years.

So first a little more on No Wrong Door. ACL, CMS and the Veterans Health Administration worked with eight leading states early on, one of those including Washington on developing four key functions of a coordinated access system. And those are: state governance and administration, public outreach, person-centered counseling and streamlined eligibility. And these key elements are part of the benchmarks in what's called AARP's LTSS scorecard which is a survey that's conducted every three years and states complete a self-assessment. And with that scorecard, we're really able to see what these access functions look like and assess a state's progress towards a fully functional No Wrong Door system.

So you can read more about the No Wrong Door key elements and the recent LTSS scorecard by going to the resources page of our No Wrong Door website. So the real question on everyone's mind is how to sustain these

efforts? And we know that there are some real tangible efforts that states have succeed in and one of those is Medicaid administrative claiming. As we know it, access to Medicaid is a critical component to No Wrong Door systems. So with Medicaid claiming, states and local aging and disability network agencies are able to be reimbursed for activities such as outreach and intake, application assistance, person-centered counseling and even activities related to screening or triage to prevent the Medicaid spend down and to divert individuals away from costly institutional care.

We currently know of 12 states that are claiming with No Wrong Door activities and 15 that are in the planning phases. And so with talking to states, we know that they're averaging over \$2 million in reimbursements a year. So you can see the value in this work and the opportunities for sustaining this work through Medicaid claiming. And as a part of ongoing technical assistance, in 2016, CMS posted guidance specifically around No Wrong Door Medicaid claiming and launched just this year ACL worked with states to develop a workbook and toolkit to really help states navigate through the process of Medicaid claiming and how to build that infrastructure to again really have these sustainable efforts in place.

And so some of these tools include guidance for really engaging with No Wrong Door partners including Medicaid or other key partners at the state level. We also have a cost simulator, claiming code guidance, tools for estimating the claiming potential and so these are great resources, again, for states as they consider implementing Medicaid claiming as a part of their sustainable efforts and these tools can also be found on our No Wrong Door website.

And another component I wanted to mention as we wrap up today's call is ACL's efforts around building a strong business case for No Wrong Door. So

ACL will be funding up to nine states this fiscal year with as specific goal to develop a methodology and determine a return on investment for states and No Wrong Door systems. And so by developing and identifying key data elements needed to demonstrate a return on investment, we'll also be working with states to produce a business case model that truly shows the impact of No Wrong Door systems.

So with that, I will turn it over to facilitate Q&A.

Coordinator: Thank you. We will now begin the Question and Answer session. If you would like to ask a question, please press Star 1. Please unmute your phone and record your first and last name clearly when prompted. Your name is required to introduce your question. To withdraw your question you may press Star 2. Once again at this time if you would like to ask a question, please press Star 1.

It looks like I'm showing no questions at this time.

(Felicia Verrett): Thank you (Brandon). Thank you everyone for attending the CMS long term services support open door forum. At this time the meeting is ended. Thank you.

Coordinator: Thank you for participating in today's conference. All lines may disconnect at this time.

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