To Integrate or Not to Integrate – That is the Question

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August 28, 2019

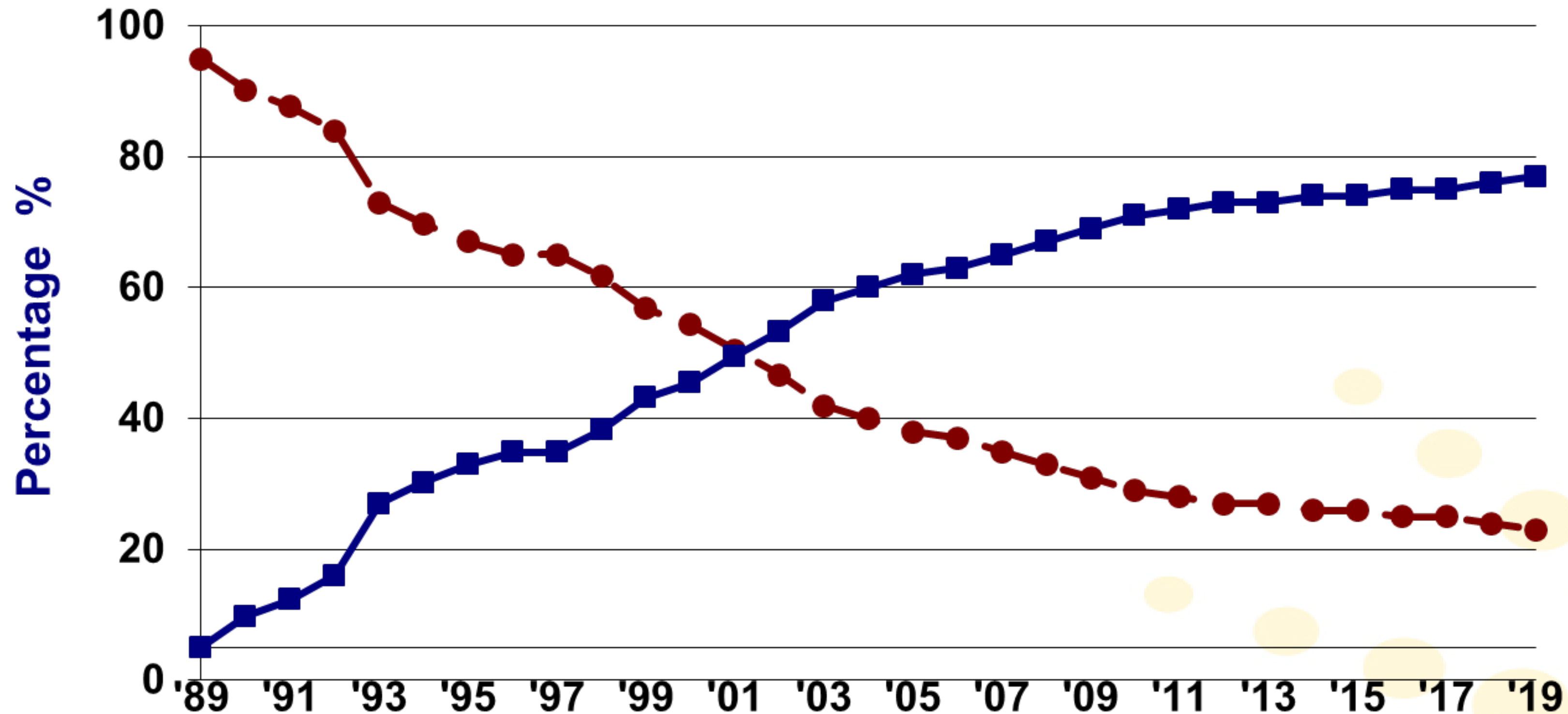
Arizona Health Care Cost Containment System (AHCCCS)

- Established in 1982 – Acute Care/Behavioral Health (last state)
- Managed care model since inception (first state)
- Arizona Long Term Care System (ALTCS) established 1989
- AHCCCS: 1.9m members; 64,900 are ALTCS
- Elderly & Physically Disabled (EPD)
  - 28,100 Managed Care; 2,700 American Indian FFS
- Intellectually & Developmentally Disabled (IDD)
  - 34,100 Managed Care

ALTCS Program Design

- EPD - Integrated model since inception
  - Acute Care
  - Behavioral Health (BH)
  - Long Term Care Services and Supports
    - Direct Care Services
    - Assisted Living
    - Skilled Nursing Facility
- IDD
  - Acute Care/LTSS
  - BH effective 10/1/19

ALTCS EPD Trend in HCBS Utilization [1989 – June 2019]



2019 Membership

Setting	EPD[1]	DDD[1]	Tribal[2]	Total
Own Home	50.3%	86.0%	73.2%	70.0%
Alternative Residential	26.2%	13.6%	3.7%	18.7%
HCBS Total	**76.5%**	**99.6%**	**76.9%**	**88.7%**
Institution	23.5%	0.4%	23.1%	11.3%
Total	**28,126**	**34,071**	**2,655**	**64,852**

[1] As of June 30, 2019
[2] As of May 31, 2019

Integration In Practice

- Direct Care providers (Attendant Care, Personal Care, Homemaker) required by policy to report to DCW Agency and/or case manager about members who exhibit a need for additional medical or psychosocial support
- Long-standing strength of case management
  - "…process through which appropriate and cost effective medical and medically related social and behavioral health services and supports are identified…"
  - "…shall also consider and integrate non-ALTCS covered community resources/services…"
- Case managers historically balanced caseload ratios based on setting, and physical/behavioral health acuity

Integration Enhancements

- For EPD, beginning 10/1/17, established case management caseload ratios specific to members living with a serious mental illness (SMI)
- Coincided with new contract awards that included, for first time in EPD program, assessments and determinations for SMI
  - Includes access to non-Medicaid services (e.g. housing) like all other members living with SMI
  - Includes heightened grievance and appeal rights like all other members living with SMI

The North Carolina Experience

Tara Larson, Vice President

Cansler Collaborative Resources, Inc

HCBS Conference

August 28, 2019

The NC Environment

- For the last several years, NC has operated in a 1915 b/c waiver for MH, SU and IDD services.
- There was a primary care case management (PCCM) model that served as the health home for most all of the Medicaid population including behavioral health/IDD.
  - Most all of the Medicaid benefit, excluding most MH/SU/IDD, operated under a fee for services (FFS) arrangement.
- Between both these managed care models, the process began on how to merge or integrate primary care and behavioral health/HCBS IDD Waiver.
  - There were some pilots of across the state of some value based purchasing arrangements or pay for performance but for the most part the incentives
- Fast forward to today – moving to a 1115 waiver where most of the Medicaid population will be in full managed care – standard plan or tailored plan

NC Points of Discussion for LTSS

Accomplish:

- Developing new service options to better meet the needs of individuals and families in a truly person-centered way, including allowing for more self-direction of services;
- Creating a specialized managed care system that recognizes the unique needs of people with disabilities, and is focused on a long term model of services and supports;
- Ensuring that people live in the most integrated community settings;
- Increasing the number of individuals who are competitively employed;
- Focusing on a quality system that values personal outcome goals for people, such as an improved life options or access to meaningful activities; and
- Working to make funding in the system sustainable and transparent.

- Measurement challenge is translating these values into tangible quality indicators while also capturing the important role that high quality traditional healthcare services play in the lives of individuals

Measures and Outcomes

- The Theme in Health is where we live, learn, work, play and age. Medicaid funding is a means to help accomplish a quality of life in LTSS. What are the measures that move the needle?
- Understanding Process Measures versus Clinical/Programmatic Outcomes
  - Most HCBS measures were process measures
  - Decide if the focus is rewards/consequences
  - Example of CHURN measure
- Value Based Purchasing Arrangements
  - Reporting in a FFS arrangement under Managed care
  - Examples of Prevention Outcomes in behavioral health/IDD, Use of Bright Futures
- Risk Based Arrangements
  - Use of Evidence Based Practice and higher rate equated to ability to "guarantee" a level of success

Outcomes in the Integrated Models

- Intervention or Supports resulted in an improvement in quality of life:
  - Employment - % who maintained/obtained employment or higher education status
  - Participation in community activities
  - Meaningful day activities
  - Integrated Housing - % with maintenance of stable or improved housing status
- People choosing where and with whom they live
- People choose where they work or that they actually retire
- Participate in the life of the Community
- Perform different Social Roles
- Health Outcomes are the HEIDS measures

Important Assumptions and Considerations

- **Long term services and supports are a part of the mainstream Medicaid benefit, not stand alone programs .**
  - People now demand or want to have options that are not just facility based such as group homes, nursing homes, etc.
- There will need to be significant discussions about values and goals of implementing managed care in LTSS
  - The policies and requirements of managed care and the financing must then be aligned to promote the goals and visions.
- LTSS services are not going to be 6 months or a year and they're not going to be inexpensive
  - The values of LTSS can't be just about cost savings.
  - By integrating services and programs, there will be efficiencies and effectiveness that will reduce cost at the provider level and at the population level but there will be "double cost" to move the system during roll out/ramp up
- LTSS providers "probably" are going to require infrastructure support such as analytics and electronic health records and training to understand and apply manage care concepts, cross disability program requirements, health outcomes or measures
  - Examples: What are HEDIS measures? How do they interface with the quality measures required in HCBS waivers? What does diabetes have to do with a habilitation goal?

CCR
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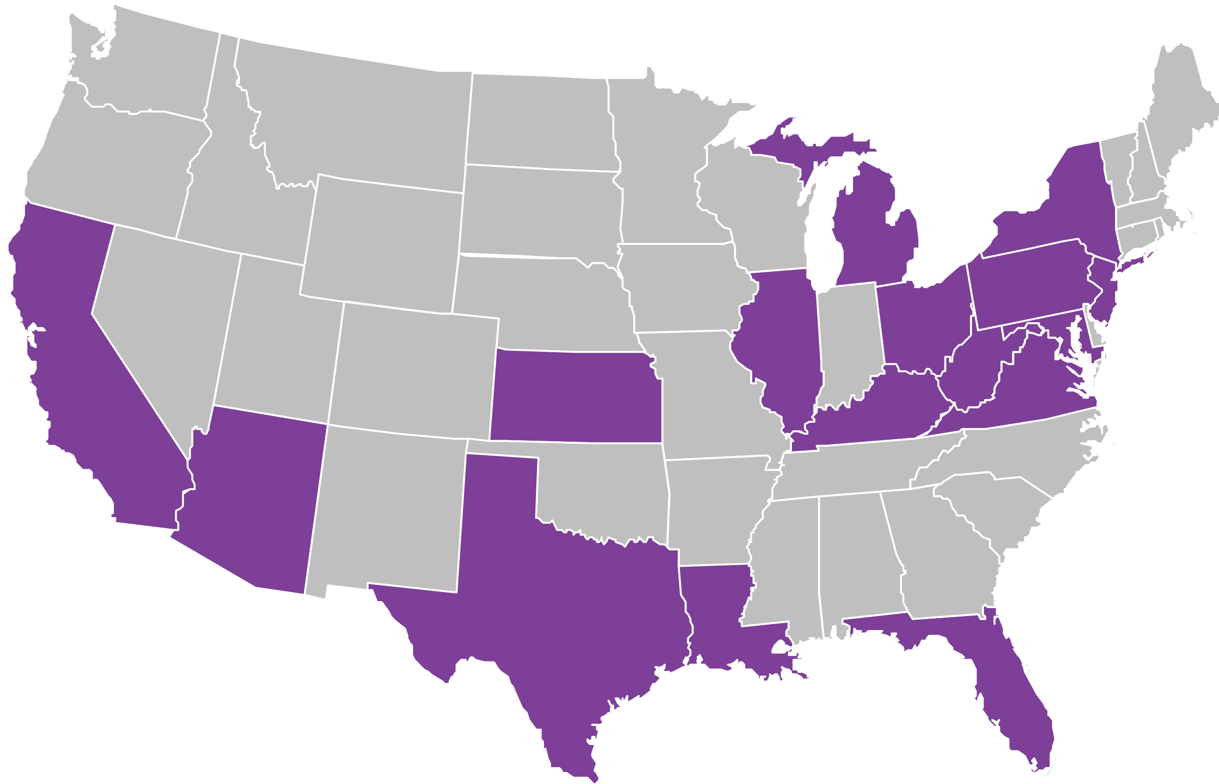
Alan Schafer

August 28, 2019

Aetna Medicaid: national presence, local impact



37 contracts across 16 states

Administer Medicaid programs in 16 states across the nation with a varying number of contracts per state managing distinct populations and regions within each state

30 plus years experience

Across all populations including managing the care of complex, high-risk populations; Best-In-Class winner of the 2017-18 Medicaid Health Plan Association Award

2M Medicaid members

In Aetna Medicaid Administrators and ABH health plans across the nation

6.7k employees

In Aetna Medicaid Administrators and ABH health plans across the nation

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Populations we serve

	Arizona	California	Florida	Illinois	Kansas	Kentucky	Louisiana	Maryland	Michigan	New Jersey	New York	Ohio	Pennsylvania	Texas	Virginia	West Virginia
ABD/SSI	■	■	■		■	■	■	■	■	■	■		■	■	■	■
ACA Expansion	■	■				■	■	■	■	■			■			■
BH Carve-In	■	■	■		■	■	■		■	■		■		■	■	■
CHIP	■	■	■		■	■	■	■	■	■			■	■	■	
Duals*	■	■	■	■	■	■	■		■	■	■	■	■	■	■	
LTSS	■	■	■	■	■				■	■	■	■		■	■	
TANF	■	■	■		■	■	■	■	■	■			■	■	■	■
Foster Children	■	■			■	■	■	■	■	■			■		■	
SPD / I/DD	■	■	■		■				■	■				■	■	

*Includes Dual Demonstration Medicare/Medicaid Plans as well as Dual-Special Needs Plans

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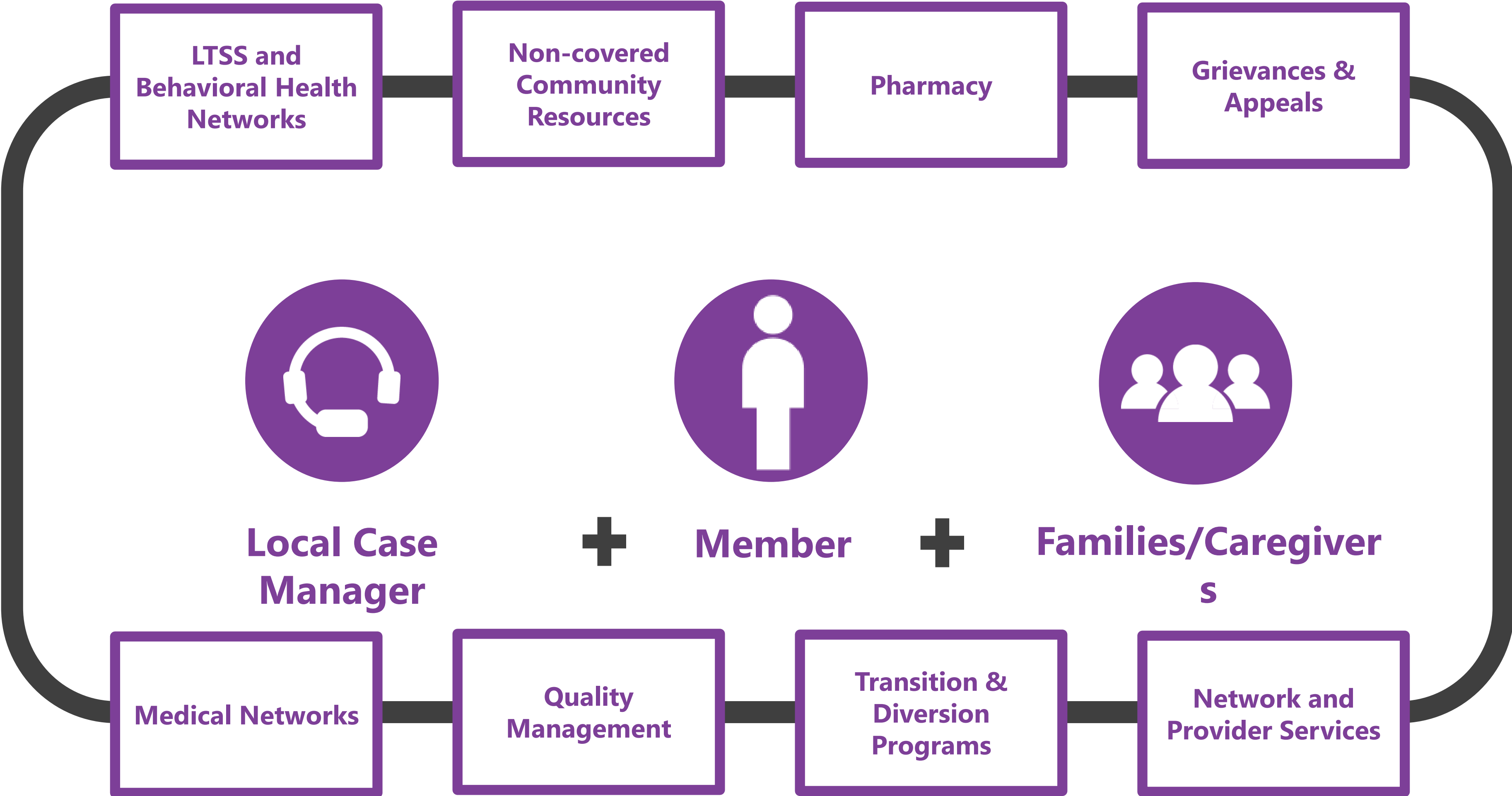
Integrated support of members in their community



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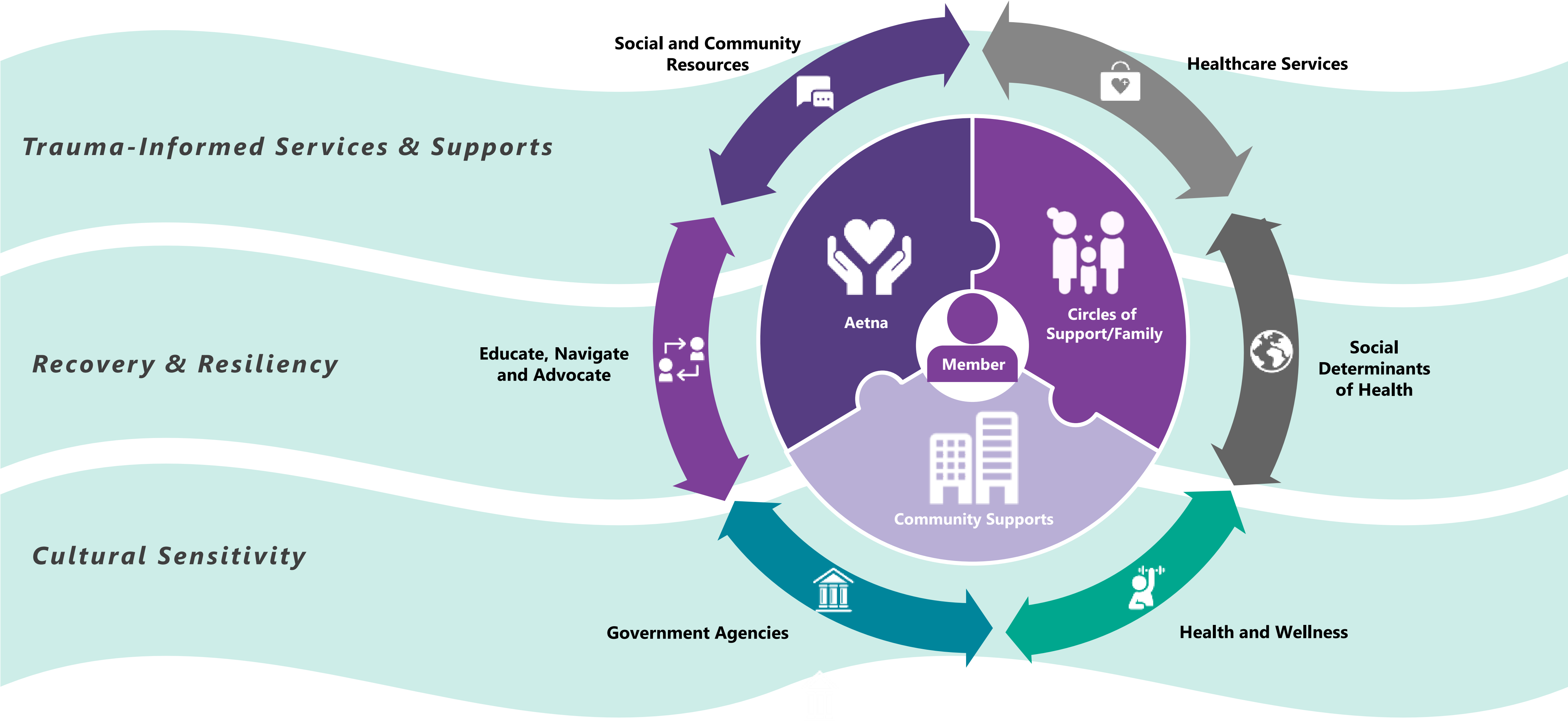
Our System of Care



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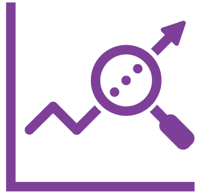
Focusing on quality and outcomes

We have high member and provider satisfaction rates and are proud to show our strong commitment to quality and transforming care for members:



The National Committee for Quality Assurance (NCQA) has **accredited 11 Aetna Medicaid plans**, three of which are at the Commendable level

Medicaid Health Plans of America honored three Aetna plans with inclusion in the **Medicaid Managed Care Best Practices 2017-2018 Compendium,** including awarding Mercy Maricopa with **"Most Innovative Best Practice"** and **"Innovation in Behavioral Health"**

Aetna Better Health of Florida is the **#1 ranked Medicaid plan** in Florida by the NCQA and consistently above **90% for customer satisfaction**

Aetna Better Health of New York has been recognized for three consecutive years by NYS for implementing initiatives that **drove positive health outcomes**

Aetna Better Health of West Virginia has **scored 100% on state External Quality Review audits** the past three consecutive years

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Value Based Purchasing (VBP) Program - HCBS

- State VBP strategies have been primarily focused on HP MLTSS outcomes
- HCBS in-home agencies
- Spend is primarily personal care services

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Solutions to the Challenges

— Focus on largest agencies (but limits opportunities for all)

— Individual agencies can propose risk-based contracting to the MCO

— Electronic Visit Verification (EVV) is real-time
  - Use of EVV or health plan member apps
  - Allows satisfaction questions to be sent same or next day
  - Potential for adequate response rates by provider

— State/Health Plan/Provider collaboration to reduce burden on providers

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Whole Person Care – A Value Based Purchasing Option

outreachhealth.com

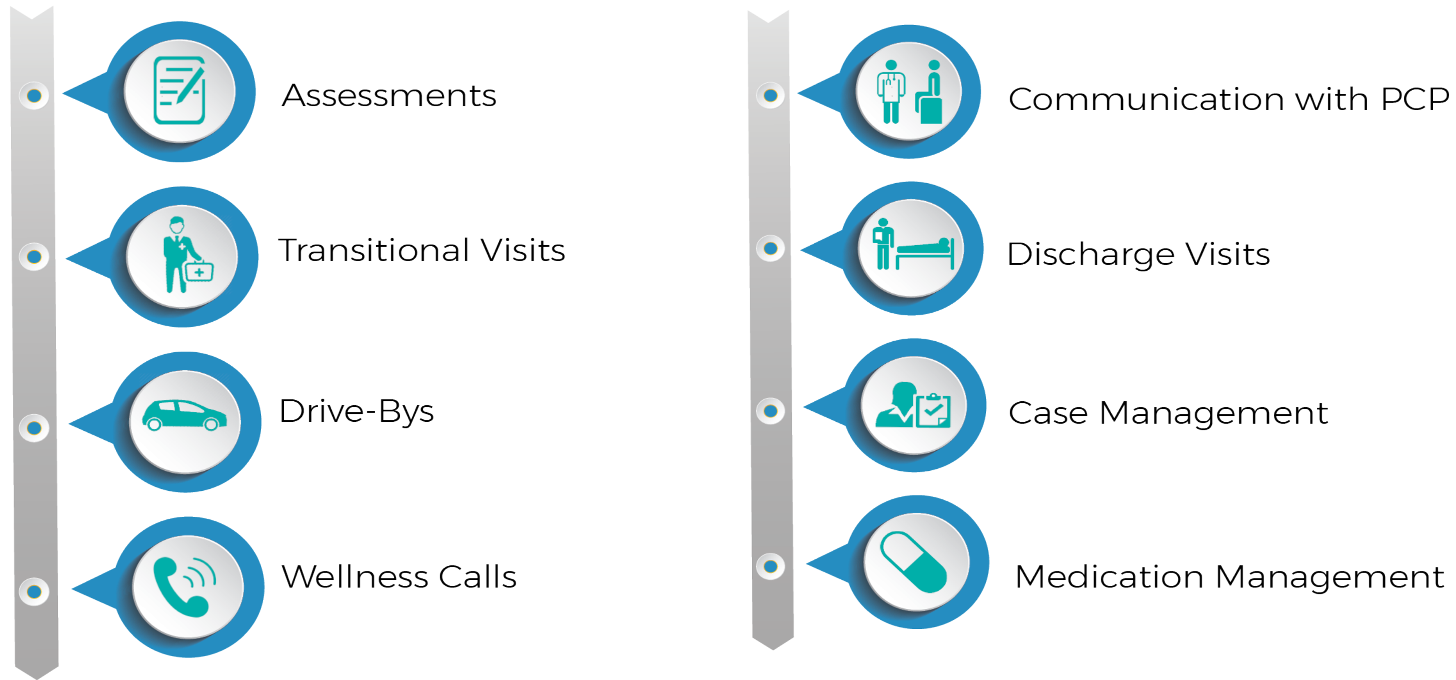
Behavioral Health Curriculum

Signs and Symptoms of Depression
Signs and Symptoms of Anxiety
Managing Schizophrenia
Communication Techniques for Dementia
Identifying Substance Abuse and Dependence
Active Listening Skills
Cognitive Behavioral Techniques
Support Strategies

Right care, Right Time

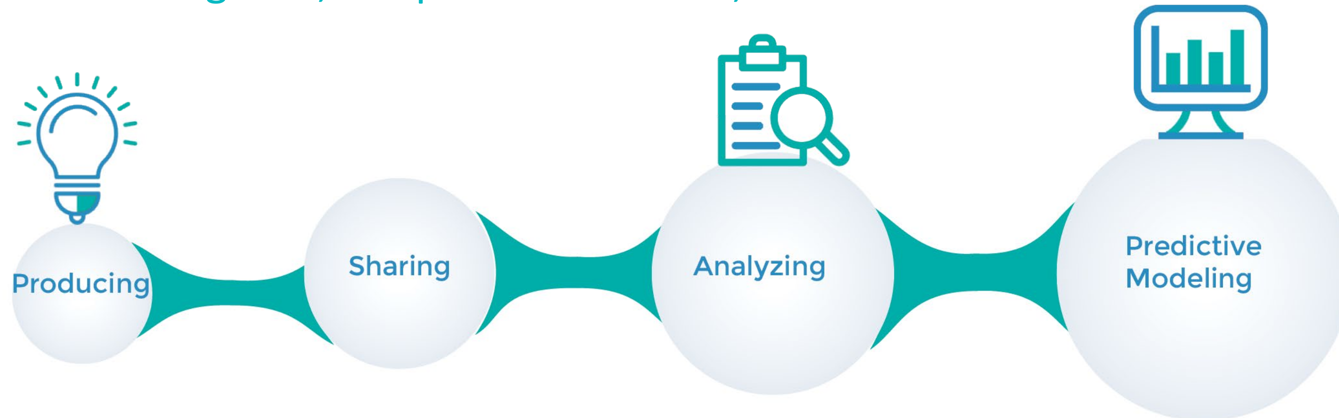
Step	Description
Obtain	Obtain complete care plan
Analyze	Analyze claims data/touchpoints
Provide	Provide Health/Management/Care Coordination
Schedule	Caregiver Assignment/Right time
Decrease	Redundant service provision, ER visits and hospitalization
Train	Train caregivers to physical and behavioral needs
Identify	Identify caregiver and agency escalation procedures
Increase	Increase compliance with appointments and instruction
Monitor	Monitor medication compliance
Integrate	Provide community activity of choice

Outreach Outcomes



Actionable Intelligence

Utilizing PCA, telephone check-ins, risk identification and social determinants for predictive analytics



Purchasing Options

Pay for Performance

Full Risk

Barriers

- Buy in from MCOs
- Number of participants in competitive market place
- Deciding on meaningful data and how to use
- Setting up payment structures
- Defining allowable service delivery
- Inclusion and use of self-direction
- Employee retention

Applying Payment

Caregivers for training time

Caregivers for specialized services – hourly rate or bonus

Outreach Outcomes

Increased Oversight

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