Successful Integration of Managed LTC and Dual Demonstration plans.

Speaker: Randall Klein, President, ComplexCare Solutions

July 29, 2014
CCS Overview

- National company specializing in face-to-face assessment and care management services for Medicare Advantage (MA), MA Special Needs Plans (SNP), Medicaid – Medicare Plans (MMP, MLTC, Dual Demonstration) and Commercial members

- Care management and assessment services approached from comprehensive health perspective, oriented towards integrated pillars of clinical, social and financial responsibility

- Management team with deep plan-side knowledge and with experience in MLTC, duals, behavioral health

- Integrated solutions that complement and enhance existing resources:
  - Assessment Services: > 120,000/year
  - Care Management: > Average daily census ~6,000
  - Quality & Compliance: Increases in STARS/HEDIS
Dual Eligibles:

Overview: Dual Demonstrations
Who are Dual Eligibles?

- 9 million beneficiaries are “dual eligible”- constitute one of the nation’s most vulnerable and costly populations
- Account for 15% of Medicaid enrollees but 40% of Medicaid cost
- 2/3 of dual eligibles are older than 65 and roughly 1/3 are younger than 65 with disabilities
- 55% have annual incomes below $10,000
- Half are in fair or poor health, more than twice the rate of other on Medicare enrollees
- More likely to have mental health needs and to live in nursing homes

Eligibility Standards

- Enrolled/Eligible for both Medicare and Medicaid programs
- Must navigate both Medicare and Medicaid to access services, use Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover (long term care)
Duals Require Substantial Acute and Long Term Care

Distribution of Medicare Spending for Dual Eligibles, By Service

- **Inpatient Hospital**: 27%
- **Medicare Advantage**: 18%
- **Providers**: 16%
- **Drug Subsidies**: 15%
- **Outpatient**: 10%
- **SNF**: 6%
- **Home Health**: 5%
- **Hospice**: 3%

Spending is related

Medicare Spending: $132B

Distribution of Medicaid Spending For Dual Eligibles, By Service

- **Long Term Care**: 69%
  - Nursing Facility: 41.1%
  - ICF-ID: 11.1%
  - Home Health and Personal Care: 45%
  - Mental Health: 2.8%
- **Acute Care Not Covered by Medicare**: 56%
- **Prescription Drugs**: 1%
- **Medicare Premiums**: 9%
- **Medicare Acute Care Cost Sharing**: 16%

Medicaid Spending: $129B

KFF Medicare’s Role for Dual Eligible Beneficiaries.
Distribution of Medicare Spending for Duals and other beneficiaries

The distribution of spending by type of service for dual eligibles

- Inpatient Hospital: 29%
- Medicare Advantage: 20%
- Providers: 17%
- LIS/Drug Subsidies: 16%
- Outpatient: 11%
- SNF: 7%

Distribution of spending for other beneficiaries

- Inpatient Hospital: 28%
- Medicare Advantage: 25%
- Providers: 23%
- LIS/Drug Subsidies: 5%
- Outpatient: 9%
- SNF: 4%
- Home Health: 4%
- Hospice: 2%

More SNF; Rx; less providers: managed
Approved dual demonstrations expected to account for over 1.2M members by 2017

DUAL DEMONSTRATIONS CURRENTLY APPROVED IN 12 STATES

- Arizona
- Hawaii
- Idaho
- New Mexico
- Oregon
- Tennessee
- Vermont
- Wisconsin

Dual demonstrations approved by CMS
Dual demonstrations pending CMS approval
## States payment model & Duals Eligible for Demo

<table>
<thead>
<tr>
<th>State</th>
<th>Model</th>
<th>Enrollment</th>
<th>Passive Enrollment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Capitated</td>
<td>350,000</td>
<td>5/1/14 7/1/14</td>
</tr>
<tr>
<td>Colorado</td>
<td>MFFS</td>
<td>62,982</td>
<td>7/1/2014</td>
</tr>
<tr>
<td>Illinois</td>
<td>Capitated</td>
<td>136,000</td>
<td>6/1/2014</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Capitated</td>
<td>90,000</td>
<td>1/1/2014</td>
</tr>
<tr>
<td>Michigan</td>
<td>Capitated</td>
<td>105,000</td>
<td>4/1/2014</td>
</tr>
<tr>
<td>New York</td>
<td>Capitated</td>
<td>178,000</td>
<td>1/1/2015</td>
</tr>
<tr>
<td>Ohio</td>
<td>Capitated</td>
<td>114,000</td>
<td>1/1/2015</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Capitated</td>
<td>93,165</td>
<td>Passive enrollment not included</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Model</th>
<th>Enrollment</th>
<th>Passive Enrollment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Carolina</td>
<td>Capitated</td>
<td>53,000</td>
<td>1/1/2015</td>
</tr>
<tr>
<td>Texas</td>
<td>Capitated</td>
<td>168,000</td>
<td>4/1/2015</td>
</tr>
<tr>
<td>Virginia</td>
<td>Capitated</td>
<td>78,596</td>
<td>5/1/2014</td>
</tr>
<tr>
<td>Washington</td>
<td>Capitated MFFS</td>
<td>48,500 66,500</td>
<td>1/1/2015 10/1/2013</td>
</tr>
</tbody>
</table>

**MOU Pending:**
- Connecticut
- Rhode Island
- Iowa
- Missouri
- North Carolina
- Oklahoma

Health Management Associates. 2014.
Services Included

**Medicare**

*Part A:*
- Inpatient hospital
- Inpatient SNF
- Hospice
- Home health

*Part B*
- Outpatient services
- Physician services
- Lab
- PT/OT
- Medical supplies

*Part D*
- Prescription drugs

**Medicare Advantage**
- Replaces A & B

**SNP**
- Additional Services

**Medicaid Traditional**
- IP/Op hospital services
- Physician services
- EPSDT
- Rural health clinic services
- FQHC services
- Lab & X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric & Family Nurse

**LTSS**
- Nursing Facility Services
- Home Health Services

69 % of Medicaid Spending
LTSS Service Details

Health Services at your Home:
- Nurses
- Home health aid
- Physical Therapists

Personal Care:
- Bathing
- Dressing
- Grocery shopping

Adult Day Health Care

Nursing Home Care

Specialty Health:
- Audiology
- Dental
- Optometry
- Podiatry
- PT

Other services:
- Home-delivered meals
- Personal emergency
- Transportation to medical appointments
Programmatic Challenges and Risks of MLTC & Duals Demonstration
Slow State Enrollments

- CMS enrollment data across CA, IL, MA, and VA shows 55,800 Dual Eligibles enrolled in a fully integrated Medicare-Medicaid Plan (MMP) as of June 2014.
- Enrollment rates should elevate after states migrate from voluntary to passive enrollments.

<table>
<thead>
<tr>
<th>State</th>
<th>Opt Out Percentage</th>
<th>Total Anticipated Enrollment as of June 2014</th>
<th>Expected Enrollment</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>22.3%</td>
<td>7%</td>
<td>456,000</td>
<td>Anecdotes</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>22.5%</td>
<td>19.5%</td>
<td>90,000</td>
<td>• Provider Networks</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• PCPs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• LTSS Providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Difficulty reaching members</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Churn</td>
</tr>
<tr>
<td>Illinois</td>
<td>25%</td>
<td>20%</td>
<td>135,825</td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td>25%</td>
<td>10%</td>
<td>166,076</td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>25%</td>
<td>2%</td>
<td>78,596</td>
<td></td>
</tr>
</tbody>
</table>

Dual Eligibles: Churn

Health Plan Costs and Infrastructure to retain members

- 15.6% Duals lost Medicaid benefit 2009-2011.
- 43% of which lost Medicaid coverage 13-35 months
- State to State movement
- Did not properly reenroll

<table>
<thead>
<tr>
<th></th>
<th>Full Benefits</th>
<th>Partial Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td># of dual eligible</td>
<td>292,242</td>
<td>91,020</td>
</tr>
<tr>
<td># losing Medicaid benefits in next 36 months</td>
<td>45,493</td>
<td>21,154</td>
</tr>
<tr>
<td>% losing Medicaid benefits in next 36 months</td>
<td>15.6</td>
<td>23.2</td>
</tr>
<tr>
<td>% of those losing Medicaid benefits who regained them</td>
<td>51.3</td>
<td>57.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of times benefits lost</th>
<th>Full Benefits</th>
<th>Partial Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>83.8</td>
<td>87.1</td>
</tr>
<tr>
<td>2</td>
<td>11.1</td>
<td>10.7</td>
</tr>
<tr>
<td>3 or more</td>
<td>5.0</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Health Affairs, 33, no.1 (2014): 147-152
## Fragmentation of LTSS Services

### IN-HOME MEDICAL SERVICES
- **Health risk assessments**
  - Clinical in-home assessments conducted by licensed nurse
  - Used for care plan
- **Medication management and reconciliation**
  - Identifying proper medication regimen and ensuring its implementation
- **Ongoing in-home medical care**
  - Nursing services to provide in-home clinical services such as wound treatment
- **Development of care plan**
  - Design of care plan in coordination with physicians, social workers, and care givers

### IN-HOME NON-MEDICAL SERVICES
- **Activities of daily living** (i.e. bathing, hygiene, etc.)
  - Home health aids to provide basic living tasks aimed at providing adequate living standards
- **Behavioral health services**
  - High-touch services tailored for members with behavioral or complex health conditions
- **Transportation to and from medical appointments**
  - Scheduled transportation for members who cannot transport themselves
- **“Fall-proofing” of residence**
  - Analysis of home environment to ensure physical safety of members

### ADMIN SERVICES
- **Claims processing**
  - Reporting and filing of claims to ensure proper health reimbursements
- **Identification of highest-risk members**
  - Analytics to determine members most in need of care management services
- **Scheduling coordination of PCP appointments**
  - Coordinating with providers to ensure timely and appropriate care is provided

### Social and community services
- Social services such as adult day health care and wellness programs
Key Execution Issue: Managing Assessments

- Comprehensive Assessment is foundational element of successful Care Management
- Need common platform for managing assessments and connecting members with the appropriate model of care efficiently.
  - Face-to-Face assessments allow health plans to better analyze situation and extract pivotal information not obtainable over the phone.
  - Encourages high level of engagement through assessments with patients
  - Encourages active communication and patient observation (physical and social determinants)
  - Required for many demonstrations
- Populated database before assessment will allow for question customization pre-assessment- more effectively direct care plan
- Schedule Medicare & Medicaid Assessments at the same time
- Be mindful of visit length
- Timeliness is critically important
Key Issue: Assessment Differences

- **Differences:**
  - Telephonic and Field assessment or Field assessment only
  - Telephonic versus Field Assessment.
  - State mandated form versus state approved form
  - Degree top which drives service authorization
  - Self reporting or validated by clinician

- **In common:** medical history, functional status, cognition, disease diagnoses, nutritional status, housing status, medication, past treatments and procedures, home environmental assessment, mental health indicators, substance abuse, legal guardian, advance directives, social support
Key Issue: Evaluate Need for Home and Community Based Services

- Unique opportunity to evaluate home-based risks and barriers to care (e.g. caregiver needs)

- Especially important for Dual Eligibles, frail individuals and those with complex medical needs.

- Can be incorporated as part of an NCQA “Chronic Complex” care management program

- Can be a input to Medicare-Medicaid Plan Interdisciplinary Care Teams and Duals Eligible models of care

- Critical Driver of program success
Key Issue: Stratification

- Dual members have complex conditions that require high level of coordination and preventive measures to reduce hospitalization costs.

- Pay attention to setting - SNF: Homecare drive re-hospitalization and require different interventions.

- Attributes driven by claims analysis and at home assessments use to synthesized stratification and appropriate levels of care management:

  Stratification Example:
  
  - Low – will receive basic wellness oriented intervention, education and materials
  - Medium – will receive telephone outreach for HRA completion and technology driven care planning with on-going telephonic intervention.
  - High – will receive in-home visit and full assessment for on-going care management engagement, maybe short term based on scenario

- Even within MOC, likely enough flexibility to tailor level of engagement to appropriate level of support.
Care Management Differences

- Population prevalence of specific health conditions
- Health plan’s targeted disease states and resources
- State legal environment – delivery of medicine by a corporation
- Availability of community resources: i.e. transportation, meal delivery, adult day care
Successful Integration
Successful Integration: Dual Demo perspective

Expansive Communication
- Member
- Provider
- Market

Enhanced Coordination
- Network
- ICT

Transition to Integrated CM
- Tools

Financing
- Reporting
- Risk Adjustment

Medicaid Institute at United Hospital Fund. March 2014
## Execution

<table>
<thead>
<tr>
<th>Requirement</th>
<th>How to Execute</th>
</tr>
</thead>
</table>
| **Expansive Communication**       | • Analytics: member analytics  
• Analytics: provider profiling and access  
• Member Engagement                   |
| 1. Population Overview            |                                                                                                                                          |
| 2. Identification of Vulnerable Populations |                                                                                                                                         |
| **Enhanced Coordination**         | • Medicare & Medicaid Access requirements  
• Value based vs. FFS  
• Build vs. partner  
• Establish internal benchmarks      |
| 1. Network Development: contracting strategy |                                                                                                                                          |
| 2. Engagement of non traditional providers |                                                                                                                                          |
| 3. Engagement of home & community based supports |                                                                                                                                          |
| 4. Caregiver supports             |                                                                                                                                          |
| 5. Quality Measures               |                                                                                                                                          |
| **Transition to Integrated CM**   | • Stratify level of need care management (claims & HRA)  
• Face-to-face, high touch care management, where appropriate  
• Effective Network Management  
• Clear and collaborative aim to stakeholders  
• Member & Caregiver engagement  
• Integrate with existing CM         |
| 1. Interdisciplinary Care Team (ICT) |                                                                                                                                          |
| 2. Assessment Tool                |                                                                                                                                          |
| 3. Individualized Care Plan (ICP) |                                                                                                                                          |
| 4. Interdisciplinary Care Team     |                                                                                                                                          |
| 5. Care Transition Protocols      |                                                                                                                                          |
| **Financing**                     | • Revenue optimization program  
• Value based contracting  
• Member stratification  
• SNF Utilization  
• Non-traditional solutions  
• High hour cases                  |
| 1. Proper Risk Adjustment         |                                                                                                                                          |
| 2. Accurate reporting             |                                                                                                                                          |
| 3. Cost Containment               |                                                                                                                                          |
CM Alternatives to Integrate LTSS

Why providers
- Deepest clinical capabilities and may be willing to share risk in certain situations
- Existing relationship with members
- But, only in few select geos

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Why large vendors
- Expertise in care management, especially complex care
- Scale networks of case mangers and nurses in most geos

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Why in house
- CM core capability of many plans
- Lower cost
- Control over care delivery costs

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Why HHAs
- Feet-on-the-ground
- Already in members homes
- May not have full clinical capabilities
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Why AAAs
- Strong players, but only in a few select geos
- Existing relationship with members
- Required to offer to AAAs in some states*

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*Many Plans will use more than one solution
Case Studies
Case Study: Mandatory NYS MLTC

- Applied mandatory managed care enrollment for dual eligibles that require 120 days of long-term service care
- Shift away from fee-for-service Medicaid Home and Community Based Service (HCBS) into managed care from December 2010 to October 2013
- State envisions managed care model would help
- Partial-capitation MLTC plans are not financially at risk for acute and behavioral health care services or prescription drugs

Changes in Long-Term care:

December 2010:
79% of Medicaid HCBS users statewide received services on Fee-for-service basis

October 2013:
71% of HCBS beneficiaries were enrolled in MLTC plan
Lessons learned: NYS

• Clear communication between beneficiaries regarding key eligibility standards to prevent unintended disenrollment & mitigate confusion
  • Guidance on how enrollees can maintain Medicaid eligibility during annual renewal process
  • Low health literacy for beneficiaries about plan options can be mitigated by enrollment brokers and consumer advocates
• State education for providers and local departments of social services (LDSS) for preparation of enrollment processing
Thank you.

For any questions, please contact:

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RKlein@complexcaresolutions.com