To Integrate or Not to Integrate – That is the Question

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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
  o Acute Care
  o Behavioral Health (BH)
  o Long Term Care Services and Supports
    ▪ Direct Care Services
    ▪ Assisted Living
    ▪ Skilled Nursing Facility

• IDD
  o Acute Care/LTSS
  o BH effective 10/1/19

Reaching across Arizona to provide comprehensive quality health care for those in need
ALTCS EPD Trend in HCBS Utilization [1989 – June 2019]

Reaching across Arizona to provide comprehensive quality health care for those in need
## 2019 Membership

<table>
<thead>
<tr>
<th>Setting</th>
<th>EPD&lt;sup&gt;1&lt;/sup&gt;</th>
<th>DDD&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Tribal&lt;sup&gt;2&lt;/sup&gt;</th>
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<tbody>
<tr>
<td>Own Home</td>
<td>50.3%</td>
<td>86.0%</td>
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<td>Alternative Residential</td>
<td>26.2%</td>
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<td>HCBS Total</td>
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<td>99.6%</td>
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<td>Institution</td>
<td>23.5%</td>
<td>0.4%</td>
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<td>Total</td>
<td>28,126</td>
<td>34,071</td>
<td>2,655</td>
<td>64,852</td>
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<sup>1</sup> As of June 30, 2019  
<sup>2</sup> 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
  o “…process through which appropriate and cost effective medical and medically related social and behavioral health services and supports are identified…”
  o “…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
  o Includes access to non-Medicaid services (e.g. housing) like all other members living with SMI
  o Includes heightened grievance and appeal rights like all other members living with SMI
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?
To Integrate or not to Integrate

That is the Question
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.
### Populations we serve

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<th>California</th>
<th>Florida</th>
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*Includes Dual Demonstration Medicare/Medicaid Plans as well as Dual-Special Needs Plans
Integrated support of members in their community

- LTSS and Behavioral Health Networks
- Non-covered Community Resources
- Pharmacy
- Grievances & Appeals
- Local Case Manager
- Member
- Families/Caregivers
- Medical Networks
- Quality Management
- Transition & Diversion Programs
- Network and Provider Services
Our System of Care

Trauma-Informed Services & Supports

Recovery & Resiliency

Cultural Sensitivity

Social and Community Resources

Healthcare Services

Circles of Support/Family

Member

Community Supports

Educate, Navigate and Advocate

Government Agencies

Health and Wellness

Social Determinants of Health

Government Agencies
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 West Virginia has scored 100% on state External Quality Review audits the past three consecutive years.

Aetna Better Health of New York has been recognized for three consecutive years by NYS for implementing initiatives that drove positive health outcomes.
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
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
Whole Person Care – A Value Based Purchasing Option
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
| Integrate | \n|---|---|---|
| Provide community activity of choice | | |
| Monitor | \n|---|---|---|
| Monitor medication compliance | | |
| Increase | \n|---|---|---|
| Increase compliance with appointments and instruction | | |
| Identify | \n|---|---|---|
| Identify caregiver and agency escalation procedures | | |
| Train | \n|---|---|---|
| Train caregivers to physical and behavioral needs | | |
| Decrease | \n|---|---|---|
| Redundant service provision, ER visits and hospitalization | | |
| Schedule | \n|---|---|---|
| Caregiver Assignment/Right time | | |
| Provide | \n|---|---|---|
| Provide Health/Management/Care Coordination | | |
| Obtain | \n|---|---|---|
| Obtain complete care plan | | |
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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