HEALTH MANAGEMENT ASSOCIATES

September 14, 2016

KAPP Medicaid System National Trends for Individuals with I/DD

HealthManagement.com

Introductions

- KAPP Attendees
- Health Management Associates
- Rich VandenHeuvel, Principal, HMA

KAPP Attendees

- Who is in the room?
  - Providers:
    - Local/Regional
    - Statewide
    - National
  - State Partners
  - Other Partners
    - National Organizations
    - Advocates
    - Beneficiaries/Family Members
  - Other?

About Health Management Associates

- Health Management Associates, or HMA, has a 30+ year history specializing in publicly funded health care
- We are leaders in delivery system restructuring, strategic planning, behavioral health, primary care practice transformation, long-term services and supports, managed care policy and operations, correctional health, and consultation to state and county governments and federally-qualified health centers
- Colleagues include former state Medicaid directors, CMS officials, managed care executives, physicians, clinicians, senior executives and researchers

Rich VandenHeuvel, MSW

- Began as Direct Support staff in 6 bed Group Homes
- 20+ years in publicly funded LTSS services
- Direct staff, Care Manager, Clinical Supervisor, Quality Improvement, Utilization Management, Clinical Director and CEO
- 2 years as CEO of a regional Managed Behavioral Health (including I/DD LTSS + MI and SUD) Organization
- 1+ year at HMA working with states, MCOs, providers and IT/data analysis partners

Overview for Today

Overview

- KAPP Leadership Requested HMA Provide an Intensive Introduction to:
  - Emerging National Trends in Service Design and Reimbursement for Individuals with Intellectual and Developmental Disabilities
  - Highlighting Challenges and Opportunities
  - Identifying Critical System Elements to Support Transitions
  - Begin discussion regarding Kentucky's path forward for I/DD Supports

Overview

- Structure for the Day
  - National Service Design and Reimbursement Trends
    - Facts and Figures
    - Medicaid Trends
    - Managed Care Trends
  - Critical System Elements and Challenges
    - Health Plan Roles
    - Provider Opportunities
  - Discussion of Kentucky's Path Forward

Overview

- Process for the Day
  - Frequent Opportunities for Questions
  - Close with a Future Oriented Discussion
  - Serve as a Springboard for your Conference

Overview

- A Note about Polarities
  - "Polarity: a state in which two ideas, opinions, etc., are completely opposite or very different from each other" *from Mirriam Webster*
    - Managed Care: a system of healthcare delivery to manage cost, utilization and quality *from Medicaid.gov*
    - Disability Rights Movement:
the movement to secure equal treatment, access, opportunities and rights for people with disabilities *from the Anti-Defamation League*

Overview

- A Note about Polarities (continued):
  - Managed care ranges from fully integrated (carved in), risk based managed care through commercial Managed Care Organizations (MCOs) to states applying managed care principles to fee-for-service (FFS) reimbursement
  - The pressure between providing necessary entitlement services and balancing state budgets means all states are applying methods to: "manage cost, utilization and quality"

Overview for Today

- A Note about Polarities (continued):
  - Managing cost, utilization and quality is different from assuring equal access and opportunity
  - Medicaid is a state/federal healthcare coverage program – Insurance
  - States are dependent upon Medicaid to fund services
    - Medicaid LTSS Funding for I/DD ICF and Waiver Services is roughly $ 48 billion
    - Kentucky I/DD ICF and Waiver Services is roughly $ 650 million
    - Kentucky FMAP: 70.46%

Overview for Today

- Providers are *uniquely positioned* to impact cost and quality of services
- LTSS services for people with I/DD have a different history and evolution than Physical and Behavioral Health services
- KAPP *should* leverage this history
- HMA is aware of this evolution *and*
  - While services evolved differently, the majority of financing follows a governmental insurance model
  - Insurance models follow a simple principle: "Follow the Money"

National Service Design and Reimbursement Trends

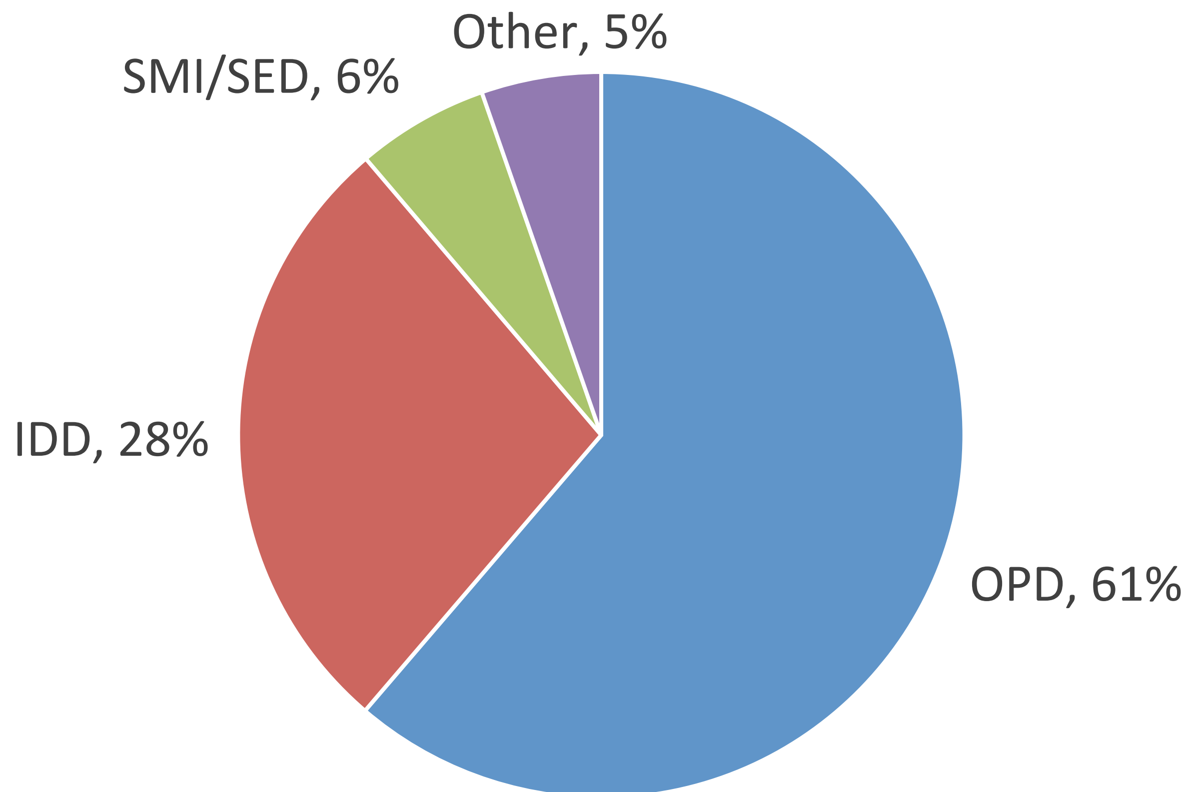
Facts and Figures:

- I/DD Spending
  - Medicaid LTSS
  - I/DD Medicaid Spending
  - Kentucky Expenditures
- Waiting Lists

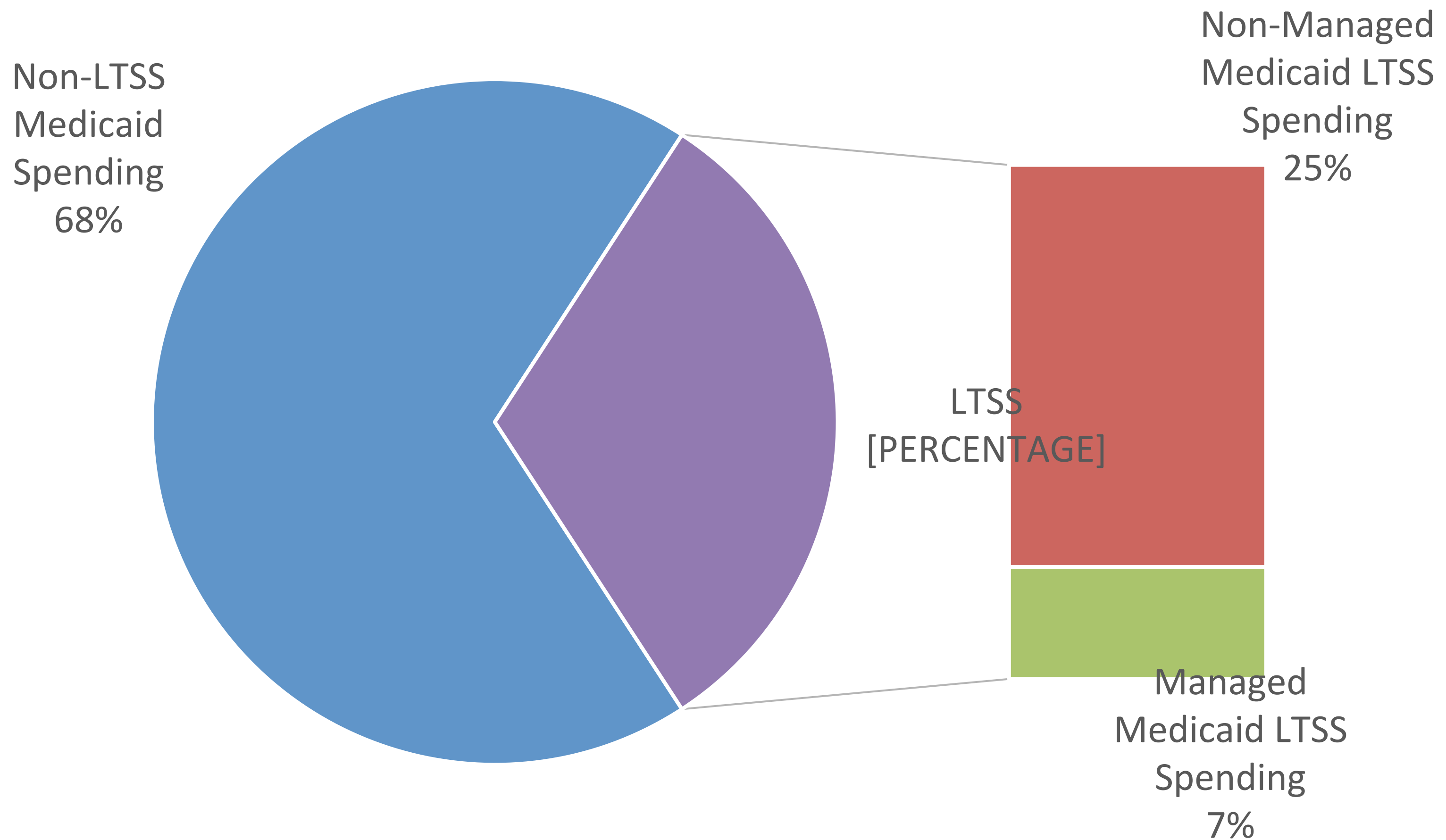
Medicaid LTSS

- There are roughly 4.3 million users of LTSS with Medicaid financing
- LTSS spending in Medicaid continues to be very substantial – currently $166 billion – but is mostly FFS
- States have set the stage to shift most of this spending to managed care
- This shift is occurring with extraordinary speed, i.e., it looks likely to be largely accomplished within the next 5-7 years

Medicaid LTSS expenditures, 2014

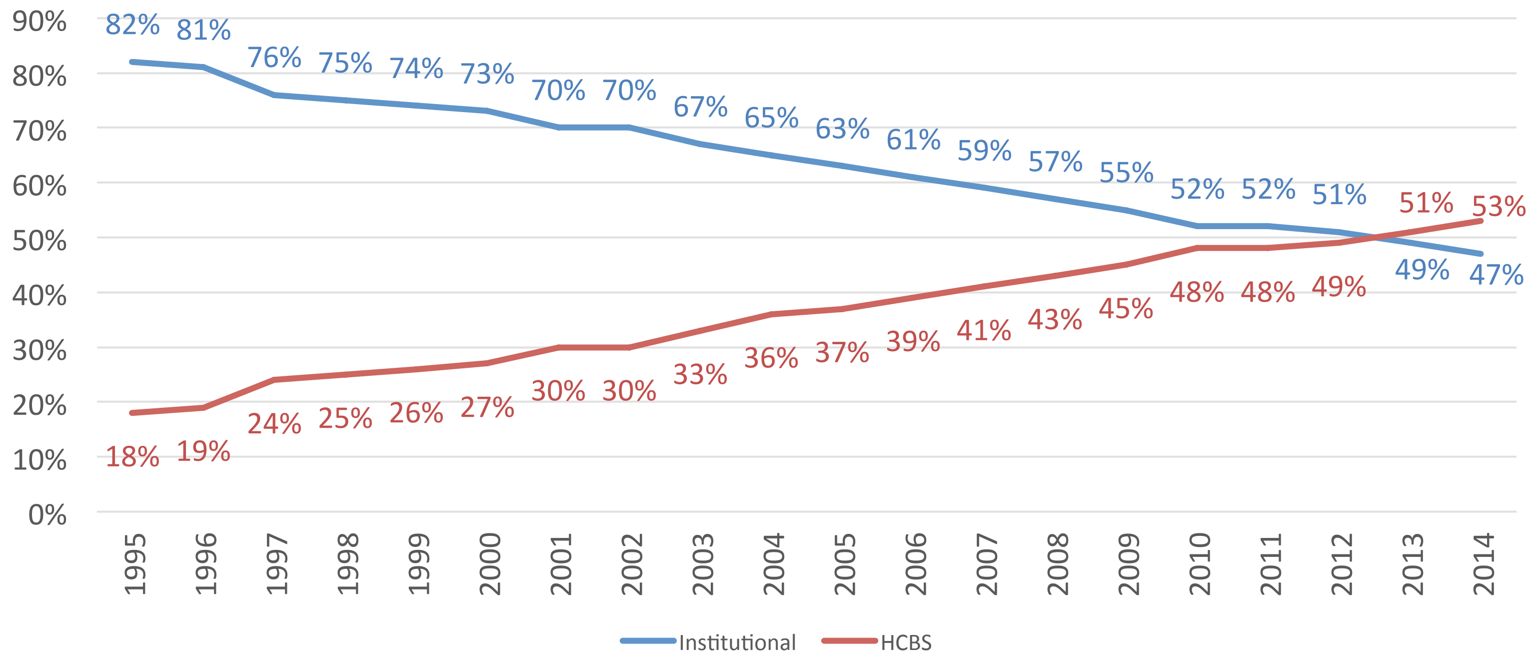


Medicaid MLTSS spending in context, 2015



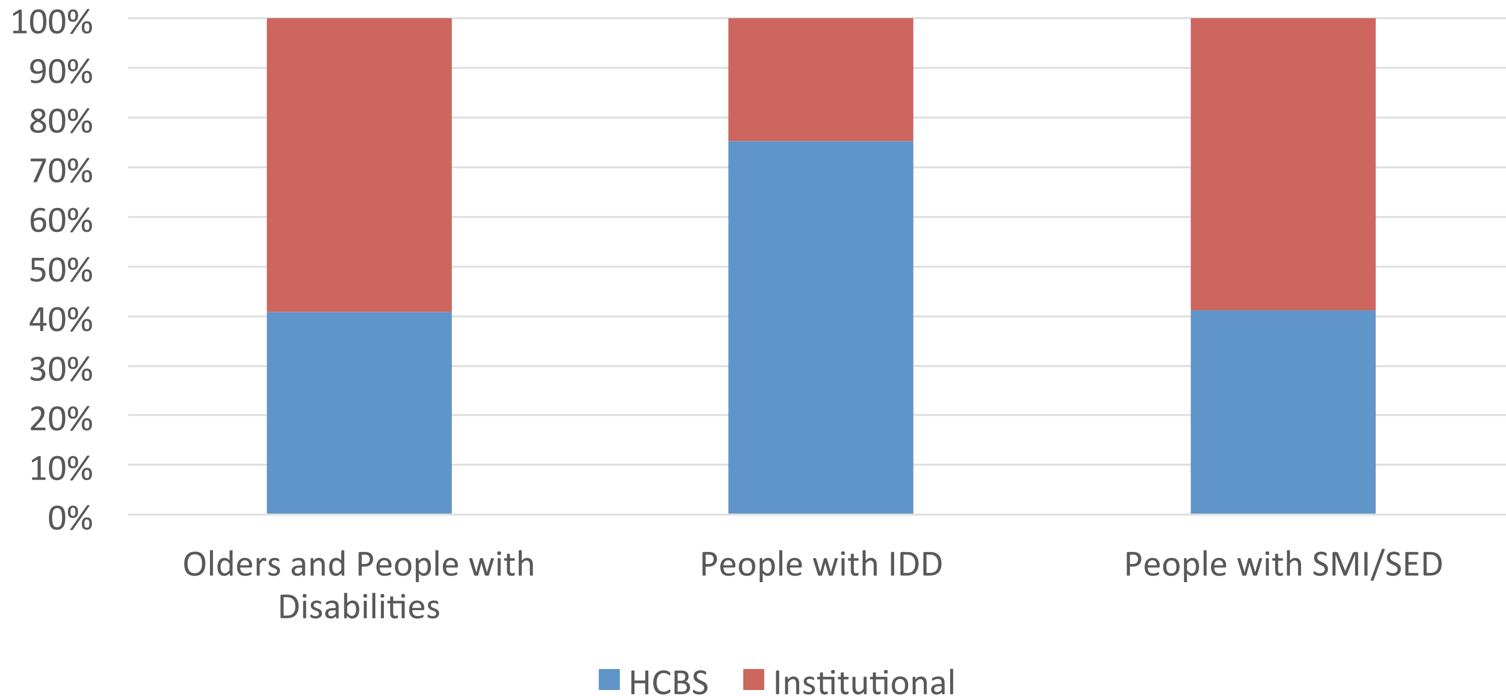
Medicaid LTSS

- Medicaid LTSS are shifting from institutional to HCBS



Medicaid LTSS

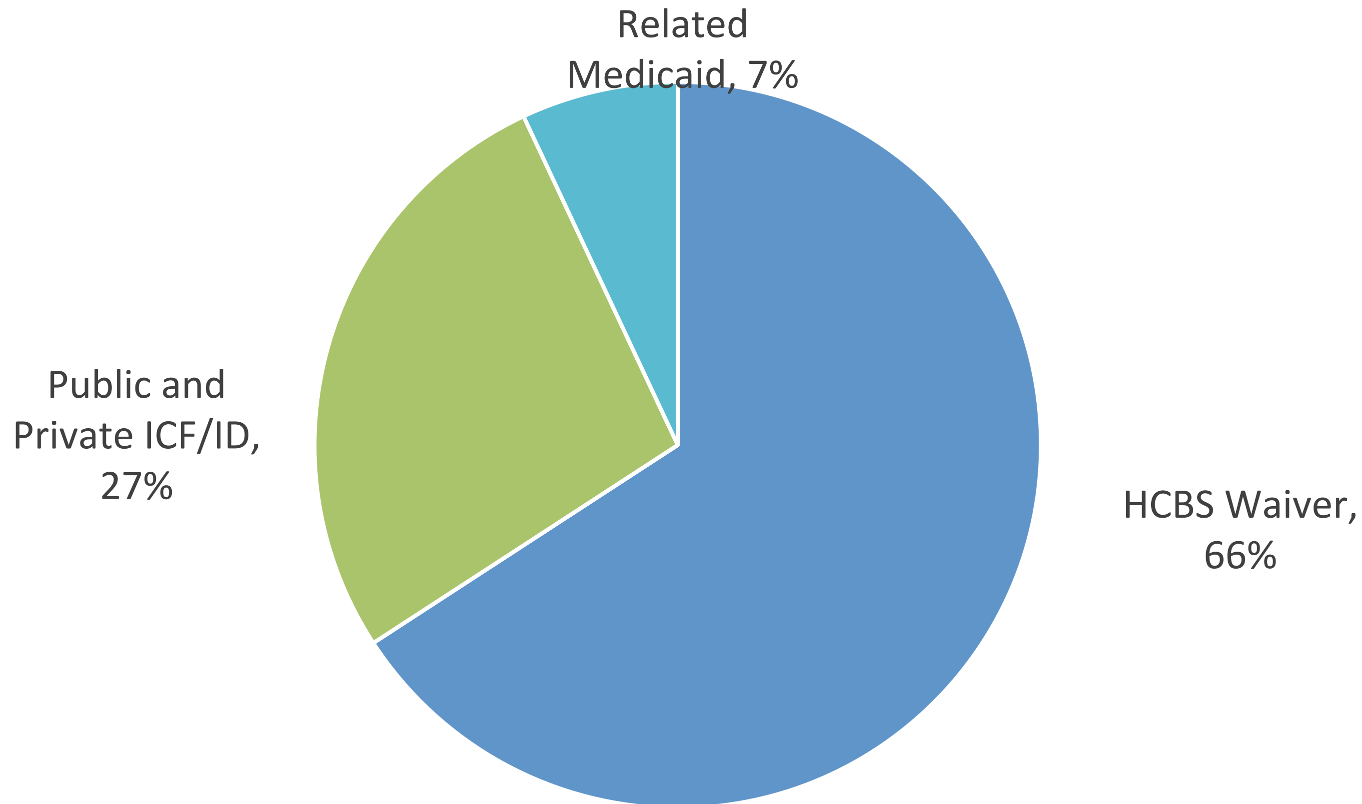
- HCBS Led by I/DD Services



I/DD Medicaid Spending

- Medicaid LTSS for persons with I/DD is a $48 billion market, 9% of total Medicaid spending
- Medicaid I/DD spending has grown at a 6.9% CAGR since 1998 and a 5.8% CAGR since 2008.
- If current trends continue, Medicaid I/DD market will reach $75B in 2023
- Growth drivers:
  - Deinstitutionalization
  - Conflict-free case management
  - Waiver wait-list reduction
  - Aging caregivers
  - Longer life spans for people with I/DD
  - **Service cost drivers (HCBS settings implementation, labor costs – min. wage, DOL, etc.)**
  - Beneficiary Expectations?

National Components of I/DD Medicaid spending, 2013



Medicaid I/DD spending on LTSS: Top 10 waiver spending states 2013

	Expenditures ($M)			Recipients			$/Recipients		
	Waiver	ICF/IID	Total	Waiver	ICF/IID	Total	Waiver	ICF/IID	Total
New York	$5,328.9	$2,710.1	$8,039.0	79,689	6,929	86,618	$66,871	$391,095	$92,809
California	$2,372.3	$674.2	$3,046.5	102,558	8,918	111,476	$23,131	$75,601	$27,328
Pennsylvania	$2,022.7	$568.5	$2,591.2	29,034	3,226	32,260	$69,667	$176,237	$80,324
Ohio	$1,320.1	$758.2	$2,078.4	32,811	6,720	39,531	$40,235	$112,830	$52,576
Michigan	$1,184.5	$0.2	$1,184.7	36,600	0	36,600	$32,363	N/A	$32,368
Minnesota	$1,160.8	$122.6	$1,283.4	18,011	1,781	19,792	$64,449	$68,830	$64,843
Texas	$1,102.1	$1,076.5	$2,178.7	30,002	8,962	38,964	$36,735	$120,125	$55,915
Wisconsin	$915.2	$162.5	$1,077.7	27,348	846	28,194	$33,466	$192,062	$38,224
Massachusetts	$842.5	$122.7	$965.1	21,430	437	21,867	$39,313	$280,496	$44,136
Florida	$840.4	$321.9	$1,162.3	28,852	2,854	31,706	$29,128	$112,801	$36,658
All other states	*$13,321.3*	*$5,033.3*	*$18,354.6*	*292,443*	*52,399*	*344,842*	*$42,968*	*$119,869*	*$50,321*
Total	**$30,410.7**	**$11,550.7**	**$41,961.5**	**698,778**	**93,072**	**791,850**	**$43,520**	**$124,105**	**$52,992**

Kentucky I/DD Spending 2013

- In 2013, Kentucky served a combined 12,409 ICF and HCBS Waiver recipients
- Estimated Total Combined Expenditures:
  - $ 622,482,267
- Recipient Percentages:
  - Waiver: 97%
  - ICF: 3%
- Expenditure Percentages:
  - Waiver: 74%
  - ICF: 26%
- Expenditures per person:
  - Waiver: $ 38,282
  - ICF: $ 412,495

Waiting Lists

- In 2013, an estimated 232,000+ people with I/DD were waiting for LTSS services
  - An estimated 42,000+ people received targeted case management while on waiting lists
- Waivers effectively provide a utilization control for states due to limited slots
- Kentucky did not report waiting list data
- What is your perception of waiting lists in KY?

Questions/Discussion

Facts and Figures

Medicaid Trends

Medicaid Trends

- What Medicaid Sees
- What Medicaid has Learned
- What Medicaid Wants
  - From Health Plans
  - From Providers
- What this Means
  - For Health Plans
  - For Providers

What Medicaid Sees

- The largest share of the Medicaid population are mothers and children; in almost all states
  - After 35 years, these beneficiaries are enrolled in health plans
- In many states, Medicaid health plans also have responsibility for the acute care services for disabled beneficiaries
- Medicaid agencies have done this because they believe that this approach will establish accountability, control costs, and improve outcomes
- Roughly $225 billion of the overall $525 billion in Medicaid spending now flows through health plans in risk based Managed Care

What Medicaid Sees

- Medicaid managed care provides for the delivery of health benefits through contracts between state Medicaid agencies and managed care organizations (MCOs)

- MCOs accept a set per member per month payment (capitation) for this service responsibility (insurance risk)

What Medicaid Sees

- Medicaid agencies are now turning their attention to more complex populations, mainly LTSS users, SMI and DD
- Spending associated with these populations is roughly $250 billion of the remaining $300 billion
- The natural path is to apply the same template for reform, i.e., to redirect this spending through health plans

What Medicaid Sees

- Medicaid agencies retaining risk for only the most complex beneficiaries is an economically poor insurance design
- The overall results of managed care are positive:
  - Health plans can be hired and fired - Accountability
  - Outcomes are up – Quality
  - Costs are reasonably well under control – Cost/Efficiency
- However, health plans mainly do what Medicaid has always done:
  - Develop vast networks of independent providers
  - Operate FFS payment systems

What Medicaid Sees

- As Medicaid agencies look to reform payment and delivery systems for complex populations, they are trying to understand how the concepts of managed care must be adapted to serve these higher need beneficiaries
- Historical definitions of success are not sufficient for complex populations
  - Serving people with I/DD requires both a Cultural and a Business Foundation

What Medicaid Sees

- The Center for Health Care Strategies (CHCS) Identified that High Quality Delivery Systems for Persons with I/DD Must Provide:
  - Access
  - Choice
  - Outcomes
  - Integration, and
  - Value

What Medicaid Sees

- CHCS also identified the following Core Elements for New Service Delivery Models:
  - Coordinated (Integrated) Array of Services and Supports
    - Primary and Acute Medical
    - Behavioral Health
    - LTSS
  - Stakeholder Engagement
    - Design and
    - Management

What Medicaid Sees

- CHCS Core Elements for New Service Delivery Models (Continued):
  - Support Networks
    - Engaging in Planning and Resource Decisions
  - Existing Provider Infrastructure
    - Honoring and Leveraging Longstanding Relationships

What Medicaid Sees

- CHCS Core Elements for New Service Delivery Models (Continued):
  - Financial Alignment
    - Integrating Funding Streams
    - Aligning Incentives
    - Reinvesting Savings
  - Risk Assessment and Resource Allocation
    - Standardized, Comprehensive Assessment
    - Used to Inform Person Centered Planning
    - Assessment and Re-assessment to Inform Resource Allocation

What Medicaid Sees

- CHCS Core Elements for New Service Delivery Models (Continued):
  - Performance Measurement
    - Outcome Measures/Data
    - Publicly Reported
  - IT Infrastructure
    - Real Time Data Available to Providers, Care Managers and People Served
    - Ability to Collect and Report Performance

What Medicaid Sees

- CHCS Core Elements for New Service Delivery Models (Continued):
  - Reimbursement Rates
    - Shift from FFS/Volume Based to Performance/Risk Models
    - Capitation Rate Sufficient to Support Access
  - Lifelong Planning
    - Transition Support
    - Caregiver Contingency Planning

What Medicaid Wants

- **From Health Plans**
  - Develop models that integrate all services to improve quality and outcomes
  - Facilitate and support the development of clinical and financial integration among providers because they believe that it will be hard for providers to do this on their own
  - Develop new payment models that shift risk to providers to stimulate efficiency and help control costs (shared risk and Value Based Purchasing)

What Medicaid Wants

- **From Providers**
  - Clinical and financial integration among providers to promote higher quality and better outcomes
    - Includes Acute and Physical Health Care and Behavioral Health Care
    - Increasingly also includes Social and Community Supports
    - Financial Integration helps track Total Cost of Care
  - Sharing of risk to support efficiency and effective use of limited resources

What This Means

- **For Plans**

- Key functions of the future are reporting and analytic activities and value-based purchasing
- Traditional functions may become less relevant or shifted to providers, move focus on oversight and delegation
- Focus on total population health, social determinants of health, and outcome measurement

What This Means

- **For Providers**
  - Clinical and financial integration will require new forms of communication and cooperation among previously independent actors
  - Sharing and managing risk will require new information and financial systems and competencies
  - Must know in real time whether succeeding or not

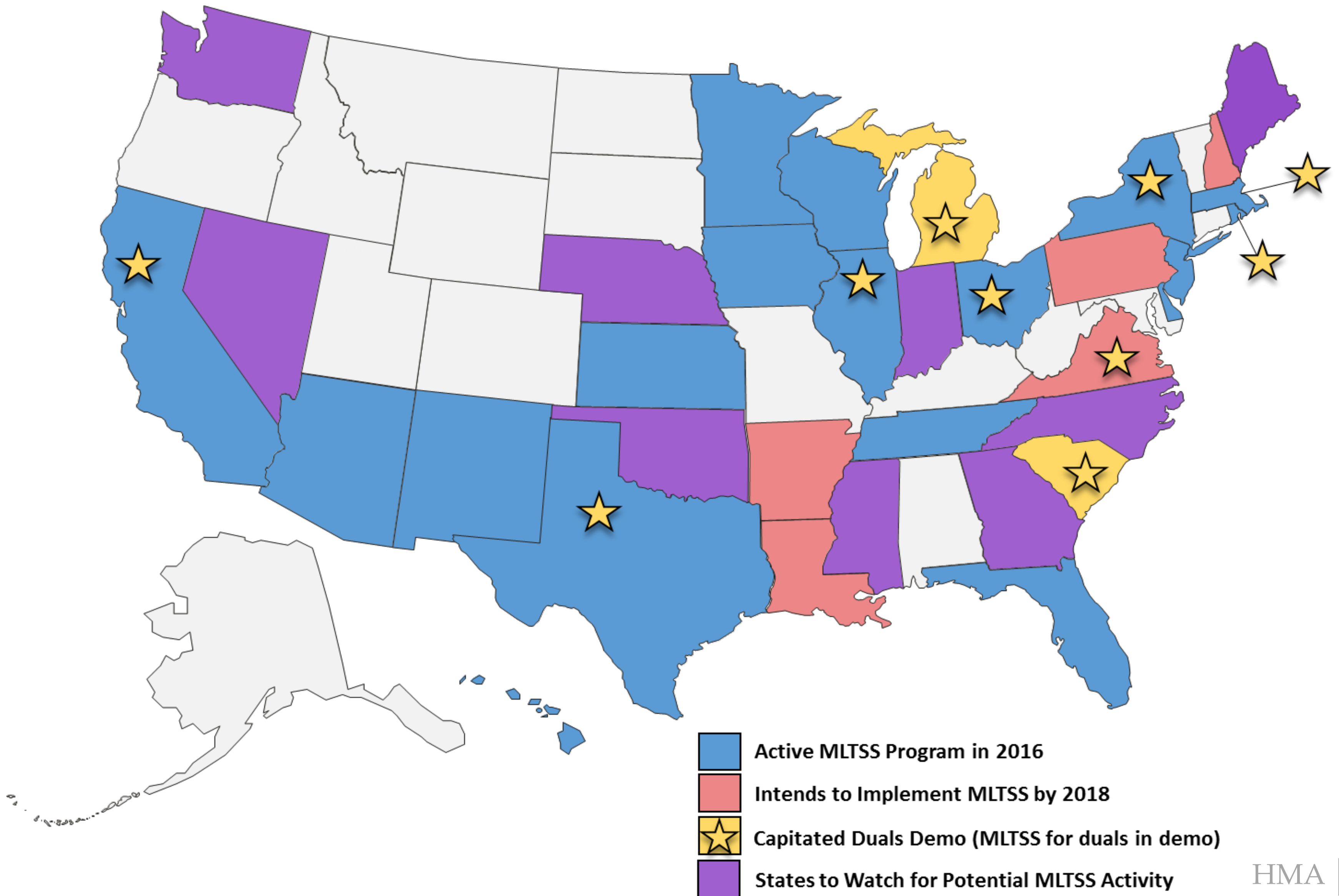
Questions/Discussion

Medicaid Trends

Managed Care Trends

- Managed Long Term Supports and Services
- I/DD Medicaid Managed Care

Medicaid Managed Long Term Services and Supports (MLTSS)



I/DD Medicaid Managed Care

- The prevalence of I/DD is roughly 0.5%
  - Approximately 1.5 million persons
  - Research indicates I/DD population has a high incidence of co-occurring chronic physical health conditions
- Historically "carved out", states are now clearly moving to introduce a range of initiatives, including risk sharing, to coordinate and integrate care:
  - Aligning payment incentives with performance goals
  - Increased accountability for high quality care
  - Increased standards for Value Based Payment implementation in Managed care contracts
    - Iowa – 40% VBP by plan by 2018 – ALL POPULATIONS
    - Ohio – 80 % VBP by 2020

I/DD Medicaid Managed Care

- The main goals are difficult to argue
  - Care and Services that are:
    - Integrated
    - Coordinated
    - Holistic
    - Person Centered
    - Cost Effective

I/DD Medicaid Managed Care

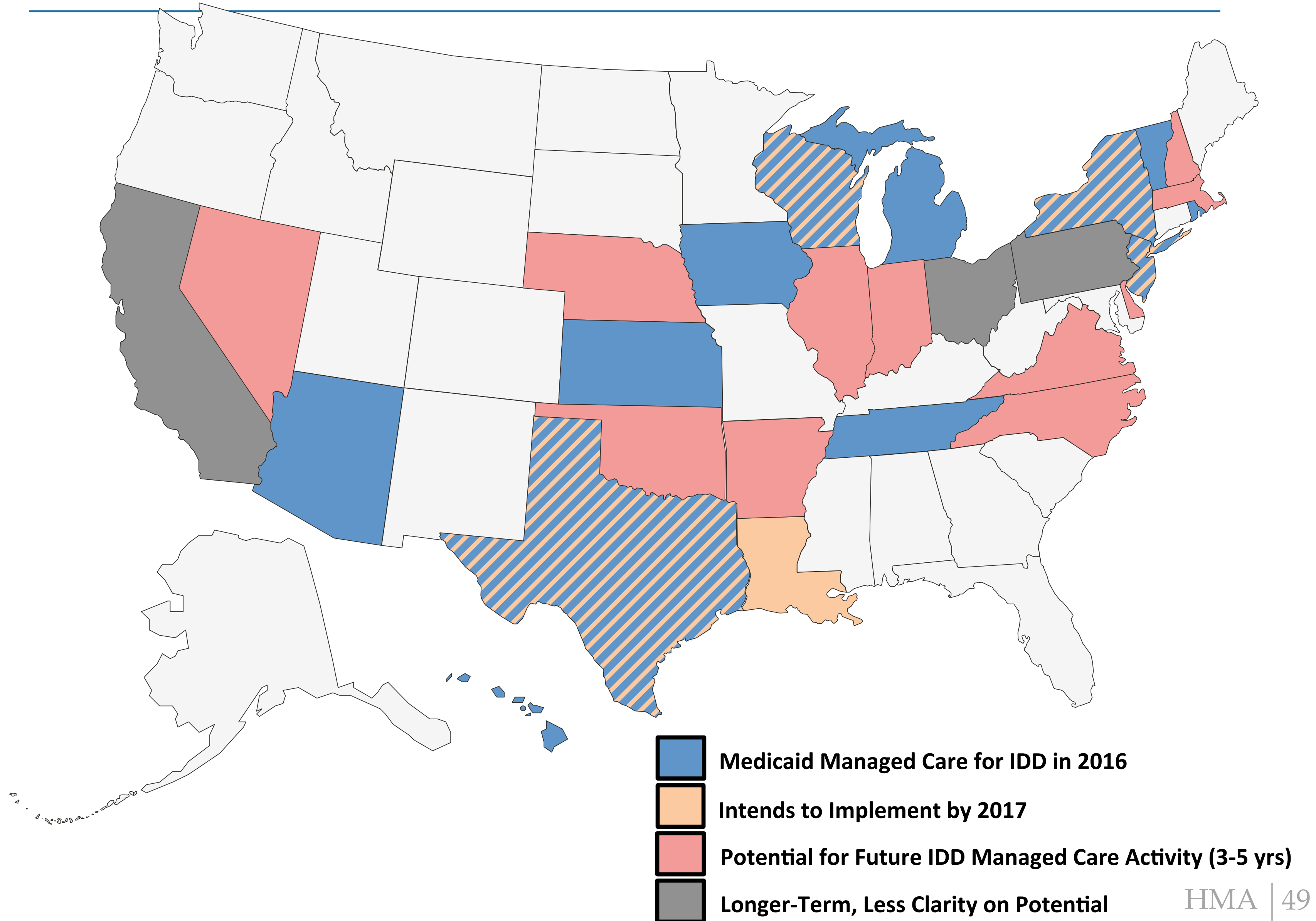
- Currently, two states utilize risk-based Medicaid health plans for acute care and LTSS for all I/DD beneficiaries:
  - Kansas: launched Feb. 1, 2014. Contracts with Anthem, Centene and UnitedHealth
  - Iowa: Launched April 1, 2016. Contracts with Anthem, AmeriHealth Caritas, UnitedHealth

- States with pending or incremental program implementation:
  - Tennessee: 2016
  - Texas: Pilot est. 2017/18
  - New York (DISCO/FIDA)
  - Virginia & Massachusetts (3-5 years out)
  - ~10 states contemplating risk-based managed care for I/DD LTSS.

- If all states currently planning/ contemplating managed care for I/ DD services were to move forward: ~this would be approximately a $20B impact (HMA est.)

Medicaid Managed Care for Individuals with Developmental Disabilities

Individuals with and Services for DD Covered by Managed Care



I/DD Managed Care Trends Summary

- 25% of Medicaid spending is LTSS that is currently not managed
  - One of the few opportunities for significant organic growth for MCOs
- Improved assessment, care coordination, integrated care and utilization management are an opportunity to generate savings while improving medical and social outcomes for people with complex needs
- States are moving to manage this care
- Several MCOs have been aggressive in this market (Anthem, Centene, United, Molina)

Other State Efforts

- States that are not pursuing risk based managed care for people with I/DD are still "managing care"

- Examples include:
  - Standardized assessments
  - Conflict Free Case Management

Other State Efforts: Standardized Assessments

- States increasingly adopting I/DD assessment instruments, often administered by "independent" third parties or subject to independent review
  - Inventory for Client and Agency Planning (ICAP)
  - interRAI
  - Supports Intensity Scale (SIS)

Other State Efforts: Standardized Assessments

- States increasingly using assessment instruments for resource allocation, rate setting and individualized budget development
- Even non-standardized assessments are, ideally, designed to support equitable distribution of scarce resources based upon severity of need
- Consistent assessment and reassessment is a necessary approach to Population Health Management *but* it is "only a piece of the development of the Individual Service Plans" and budgets

Other State Efforts: Conflict Free Case Management

- Conflict Free Case Management is essentially about properly aligning incentives
- States are taking typically diverse approaches to compliance
- Kentucky is well experienced with Conflict Free Case Management (CFCM)
- Ultimately, the relationship between CFCM and population health management, particularly Care Management and Care Coordination functions will need to be the focus of risk sharing designs
- We will address this further under Provider Opportunities

Questions/Discussion

Managed Care Trends

Intermission

Critical System Elements and Challenges

- Health Plan Roles
- Provider Opportunities and Challenges
  - Continuum
  - Service Providers
  - Provider Led Entities
  - Service Design Key Elements

Health Plan Roles

- The Role of Health Plans in the 2020s
  - Organizing highly integrated systems of care for complex beneficiaries may be beyond the reach of health plans as they operate today
  - The opportunity to do this may be in deep collaboration with providers
  - As providers assume risk, there will be demand higher levels of control over resource utilization, clinical strategy, and other factors
  - The "division of labor" between plans and providers will change; many functions performed by plans today will become unnecessary or be shifted to providers in the future

Health Plan Roles

- The Role of Health Plans in the 2020s
  - New roles will revolve mainly around performance measurement, with special attention to quality and outcomes
  - Developing performance benchmarks for serving persons with I/DD will be critical
  - Plans will become partners to providers, providing the data, analytics, benchmarking and other resources needed to improve clinical results
  - Plans are likely to be the ones that must *systematically* integrate services that are outside the mainstream of health care, i.e., so-called social determinants. This may include housing, transportation, nutrition, employment, education, social engagement, etc.

Health Plan Roles

- The Role of Health Plans in the 2020s
  - In this vision, the plans are contracting with **highly-organized** groups of **risk-bearing** providers, **paying them on the basis of quality and outcomes**, and **feeding them a continuous flow of information** describing their performance and indicating opportunities for improvement

Health Plan Roles

- The Role of Health Plans in the 2020s
  - Shifts from "Legacy" to "Advanced"
    - A "legacy" environment of FFS payment, plan-based medical policy, UR, and care- and case-management
    - An "advanced" environment moving past claims, leaving medical policy and care management to provider entity partners, and providing robust performance measurement, benchmarking and other data-based resources to support quality and outcomes improvement

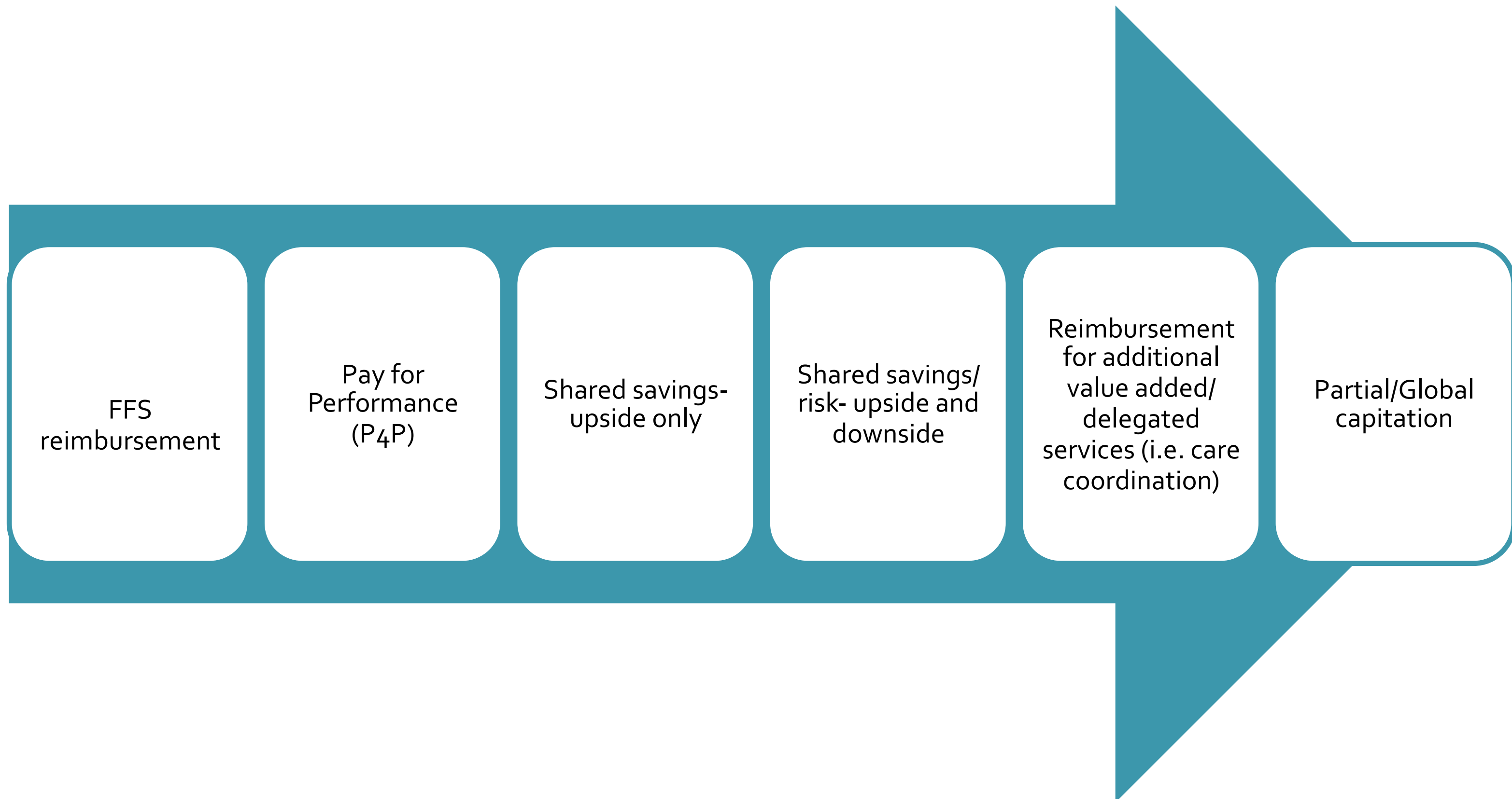
The Division of Labor

- States (or Other Jurisdiction)
  - Policy Control
  - Selection of Plans
- Health Plan (or Risk Bearing Intermediary)
  - Assume population-based risk/health
  - Create network/contract with provider entities
  - Administer non-FFS payment systems
  - Monitor, track, measure performance of providers
- Provider Led Entities
  - Assume risk for assigned/attributed membership
  - Develop and administer systems for clinical/service integration
  - Develop and administer systems for financial integration
  - Develop and administer systems for accepting and acting upon performance measurement results to improve quality and outcomes

Questions/Discussion

Health Plan Roles

Provider Opportunities and Challenges



Services Providers

- Common to all Service Providers
  - Need adequate reimbursement to support cost/quality
  - Workforce – pressures on recruitment, retention and affordability
  - Need increased understanding and awareness of integrated care
    - Common chronic health conditions for population
    - Monitoring and managing total person health
    - Awareness and ability to impact total cost of care

Services Providers

- Individually or in Partnership Developmental Areas
  - Value Based Purchasing Readiness
  - Understanding *and* Articulating provider ability to impact Total Cost of Care
    - Value proposal development for payers
  - Data Competencies/Capacity (claims, costs, care coordination, health information exchange, etc.)
  - Partnership with and Input from People served
    - Your knowledge of and relationships with individuals and families can be your greatest asset
    - Advisory and engagement processes can drive outcomes

Provider Led Entities

Provider Led Entities

- When CMS or the states create requirements for "value-based" payment, they are indirectly setting in motion the development of Provider Led Entities (PLEs)
- In most cases, "value-based" payment means provider risk through capitation, bundled payments or substantial gain/loss-sharing systems
- These payment presuppose advanced PLEs, i.e., **organized groups of providers that have achieved clinical and financial integration and are equipped to accept risk**

Provider Led Entities

- Value Based Payments (VBP)
  - States view VBP as central to reform
  - VBP based on the assumption that payment drives care delivery and that moving away from FFS will improve quality and reduce costs
  - VBP refers to any activity that state Medicaid programs are doing to move providers away from FFS, which rewards volume, to alternative payment models that reward value and outcomes

Provider Led Entities

- Value Based Payments (VBP)
  - Models are being implemented either directly with providers, or by requiring managed care entities to implement alternative payment models
  - This includes implementing quality and cost requirements into managed care contracts
  - VBP holds great promise, but requires
    - Significant resources
    - High-quality, comprehensive and timely data
    - Advancements in payment models
    - Accurate and relevant performance metrics

Provider Led Entities

- An industry of vendors to support PLEs is also developing, e.g., Evolent, Valence, Conifer, Envolve
- Important developments may be seen in IN, NY, TX and many other places

Provider Led Entities

- State Medicaid programs are looking to provider-led entities (Accountable Care Organizations or ACOs) to **integrate care** and assume accountability for cost and quality
  - States vary in their approaches to holding providers accountable for cost and quality outcomes
  - States vary in their roles/expectations for MCOs and relationship with Medicaid ACOs
  - Even in States that are not presently contracting with Managed Care Organizations for the management of I/DD Populations, these concepts and constructs are emerging

Provider Led Entities

- Expectations:
  - States/payers expect that PLEs must be able to manage total cost of care of each member and their panel as a whole.
  - Entities are measured against quality metrics and appropriate benchmarks, measures are **comprehensively focused on outcomes**, process, patient experience.
  - Entities must have capability to measure quality and cost performance against benchmarks; analytics, informatics, and reporting are critical to success

Provider Led Entities

Critical System Elements and Challenges

1. Capitalization
   - Staffing and health information infrastructure
2. Patient population size
   - Research suggests attributed patient population needs to be 5,000 – 20,000 for reasonable statistical confidence when determining impact on costs for the population in general population health management ACO models
   - Smaller providers participating with multiple payers face fragmented risk pools
3. Management information access
   - Need access to timely and actionable claims and clinical data
   - Research suggests many safety-net provider-led ACOs have limited analytic infrastructure, including Medicaid claims data, access to health information exchange, poorly leveraged EHRs, limited staff for analysis and limited analytic software

– *Source: Safety-Net Provider ACOs: Considerations for State Medicaid Purchasers, Bailit Health Purchasing, Jan 2016*

Provider Led Entities

" There is currently no uniform federal definition of an ACO and the concept continues to evolve. Generally, an ACO is a group of health care providers or, in some cases, a regional entity that contracts with providers and/or health plans, that agrees to share responsibility for the health care delivery and outcomes for a defined population."

Source: KFF, June 2015

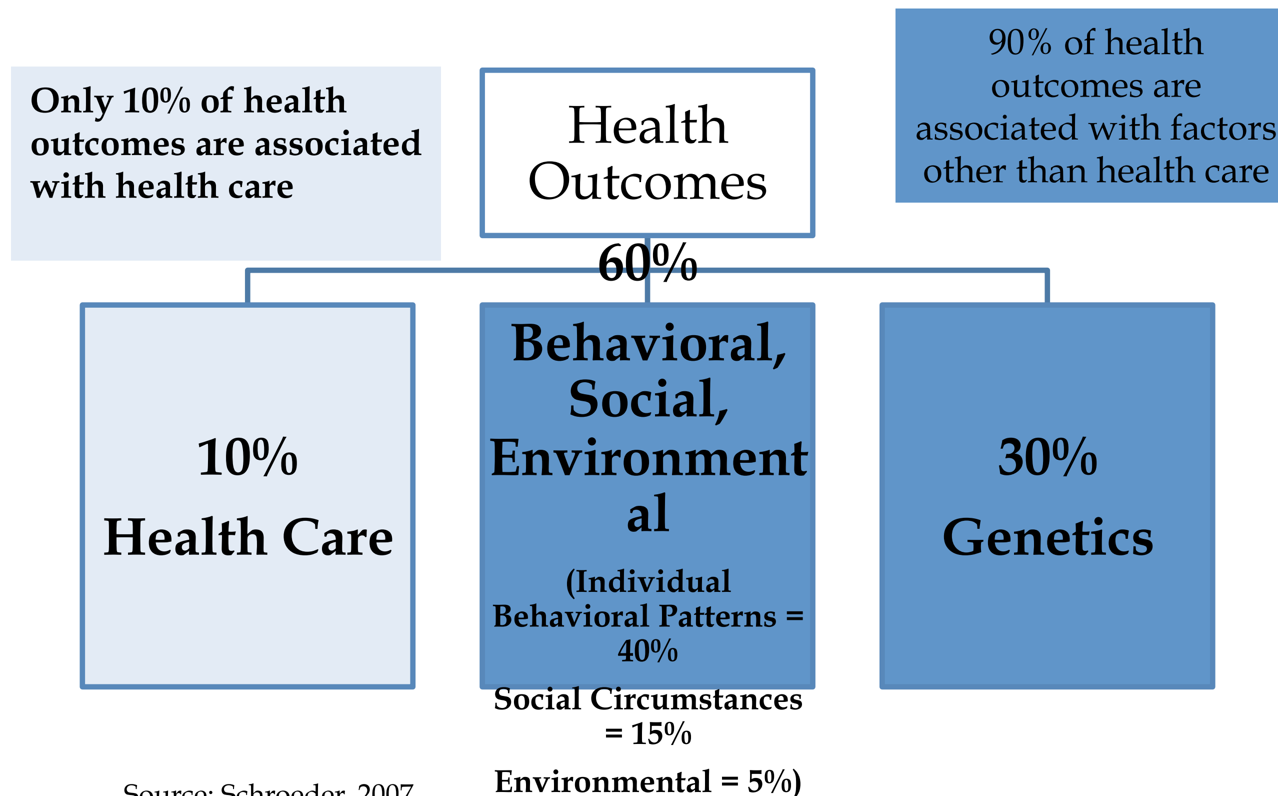
Questions/Discussion

Service Providers and Provider Led Entities

Service Design Key Elements

- Value Proposal:
  - LTSS Providers have more access to, and may spend more time with individuals than anyone else in their lives
  - Healthcare's impact on individual health, and healthcare spending, is limited

Health Care's Influence on Health, Limited



Source: Schroeder, 2007

Service Design Key Elements

- Articulating a concept of care
  - There is no one right way to approach this population; we will have to conceive and articulate approaches that reflect individuals' goals, preferences and quality of life
  - The people with I/DD LTSS needs consist of many distinct (and not necessarily exclusive) sub-populations, each of which requires its own carefully thought-through approach
  - Within these concepts of care, services must be individualized and person centered ethically, morally, legally and to achieve optimal outcomes
  - All must be done within resource constraints

Service Design Key Elements

- Every serious thinker has identified as a crucial component the development of a centralized, multi-provider, real time HER
- Any effective delivery system for complex members that achieves integration requires technology that enables all providers to see everything all the time
- Who will build this? How will it be implemented? States will likely expect risk bearing intermediaries, often health plans, to solve this problem

Service Design Key Elements

Information Systems

Aspiring ACOs should have expertise and develop functionality for:

- Acquiring and managing data and information system resources (i.e., management information system, data applications, interoperability)
- Being able to understand provider data platforms and limitations
- Working collaboratively with providers to facilitate development of their IT/data expertise
- Assisting providers to have registry functionality (through a care management platform, or other separate application)
- Facilitating interoperability solutions for and with providers (e.g., helping to develop/connect with health information exchange (HIE) services)
- Facilitating data sharing agreements especially with other agencies and community based organizations that have data related to populations (e.g., housing, transportation, education)

Service Design Key Elements

Operationalizing the delivery system

- It seems clear that a large, loose provider network is not what is required
- Payer (State/MCOs) demands and expectations for providers will be dramatically higher than they are today; the conventional provider contract is probably not an adequate tool
- Payers will want to contract with highly integrated, specialized networks that don't exist today
- Organization among common *and* different types of providers will be necessary
- Creativity and innovation in establishing new kinds of partnerships and networks in order to preserve critical parts of the existing provider system serving low-incidence, high needs populations will be important

Service Design Key Elements

Clinical

There are important contributions needed from clinicians to lead or contribute to population health management.

- Input from clinicians is critical to inform overall measurement and reporting strategies including:
  - Knowledge of current evidence based standards of care, clinical guidelines and protocols, and care models
  - Knowledge of process and outcomes metrics
  - Ensuring data is reported in accessible, actionable format tailored to needs of the end user
  - Ensuring data is used as part of informing and impacting services

Service Design Key Elements

Population Health Management Operational Tasks

1. **Target Population Planning** e.g., data analysis to target individuals for appropriate levels of care management (targeting and risk stratification), assigning accountability for comprehensive care management to a care manager/team (provider attribution or empanelment), defined processes for individual care management, and monitoring Enrollees' utilization, health status and progress against articulated care management goals (e.g. chronic condition levels of control, home and community based services, employment and other person-centered health goals.)
2. **Outreach, Initiation, and Engagement** e.g. direct communications/contacts with individuals and allies to initiate and/or sustain engagement in person-centered assessment, care planning, and care management
3. **Screening and Assessment** e.g. initial and ongoing screening and assessment of physical, mental and social (whole person, community based: employment, housing, education, transportation) needs, ADLs and care plan goals

Service Design Key Elements

Population Health Management Operational Tasks

4. **Comprehensive Integrated Care Planning and Care Management** e.g. working with care team to identify/document/coordinate goals & interventions based on initial/ongoing assessment and person centered planning
5. **Team Communications and Collaborative Interactions** e.g. systematic processes supporting timely sharing of information about assigned enrollees as part of ongoing care management including registry reports, alerts, huddles, case staffing
6. **Linkages, Referrals and Follow-Up** e.g. facilitating care plan activities incl. access to disability appropriate health care supports, medication adherence, referrals, appointments and follow up, social supports, links to home and community based resources
7. **Monitoring, Reporting and Quality Improvement** e.g. using health information systems including registry, alerts (ADTs) and other data to monitor utilization, health status, progress against goals, home and community based options and opportunities for QI

Service Design Key Elements

Care Management And Care Coordination are Key

Integrated Care Management and Care Coordination

Care Management

- Population level management and monitoring
- More "High Tech" than "High Touch"
- Supports Care Coordination

Care Coordination

- Individually focused coordination and monitoring
- More "High Touch" than "High Tech"
- Supports Individual and Family

Care Management

- Care management programs apply systems, science, incentives, and information to improve health care practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively.
- The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.
- Care management involves responsibility for comprehensive aspects of population health management, including assessment, care planning, monitoring and progress against goals identified by the consumer and their supports in concert with inputs from the care team. As part of an integrated care model and integrated service delivery settings, lead care management roles are most often played by clinicians i.e., registered nurses/advanced nurse practitioners or other clinicians with distinct expertise in care management of co-occurring chronic physical, I/DD and behavioral conditions.

Care Coordination

- "Care Coordination" means services that help to execute and support the plan of care.
- Care coordination entails a range of administrative activities such as coordinating referrals and appointment reminders, collecting records and updating registries, and making information available for use by care managers.
- Care coordination can also include direct interactions with Enrollees under the direction of care managers, to provide health promotion, coaching and self/family-care management supports, individual and family supports, and community referrals to address social supports.
- Depending upon staffing models, billing requirements, and consumer needs, a Care Coordinator could be licensed but is often a non-licensed worker responsible for communications, data collection, and administrative tasks related to coordination. Task sharing can be part of how care coordination functions occur, including roles of Peer Supports and other supportive staff with good attention to detail and communication skills.

Service Design Key Elements

- Individualized, Person Centered Supports
- Key community expectations and integration needs: inclusion/integration; self-determination; employment; family support and; civil rights
- Natural, community and family supports
- Supports encompass multiple systems: health; education; employment; residential/housing; income maintenance; transportation
- Rely on different types of services, more supportive and therapeutic in nature and provided by individuals who are less likely to have formal licensure or credentialing and often come from the communities they serve
  - Health plans have varying experience working with providers of these services and the individuals who need them
- Social determinants of health drive outcomes and expenses
  - Housing, transportation, nutrition, etc.

Service Design Key Elements

- The fundamental questions are: who are you today, and what do you want to become in the future?
- The reality is that providers now live in a world with MCOs, ACOs and other provider-led entities; the status quo is over
- The rise of PLEs and ACOs has changed the roles, functions, responsibilities and relationships of providers, MCOs and States
- Providers, individually and as part of PLEs have the most opportunity to impact variables related to beneficiary health, through direct access and appropriate influence
- How will you leverage this value with the State, potentially with MCOs, together and individually?

Questions/Discussion

Service Design Key Elements

Discussion of Kentucky's Path Forward

- Near Term
  - Recoupment/Audit Relief
  - Relief of Administrative Burdens
  - Exceptional Support Rates
- Longer Term
  - Waiver Amendment
  - Other?

Discussion of Kentucky's Path Forward

Discussion

Discussion of Kentucky's Path Forward

Thank You!!!

Discussion of Kentucky's Path Forward

Optional Example: Indiana

Provider Led Entities

- Example: The Indiana Integrated Healthcare Provider Association
  - In anticipation of increased MCO management of benefits and services for LTSS and other services, a group of providers began developing an ACO-like managed care model for the ABD/ LTSS population not enrolled in Hoosier Care Connect (Indiana Medicaid managed care) in 2013
  - Target population includes individuals with: Intellectual and Developmental Disabilities, Physical Disabilities, Mental Health diagnosis, Substance Use Disorders, Traumatic/Acquired Brain Injury and Aged/Elderly Individuals
    - Individuals with a level of care determination being served in an institution or waiver or dually eligible individuals
    - This is estimated to be 200,000 individuals statewide with an estimated $3.6 Billion in State and Federal Medicaid expenditures for their supports and services

Provider Led Entities

- Example: The Indiana Integrated Healthcare Provider Association
  - IIHPA formed as an association in 2015
  - 9 current members, including providers of: Home Health, IDD Services, Community Mental Health Centers, Nursing Facilities, Health Plan, and Case Management Services
  - IIHPA is working with the incumbent Indiana health plans (Anthem, Centene and MDWise) to develop the ACO model within the existing managed care infrastructure in the state
  - KEY ELEMENT: LTSS Providers as the Accountable Care Lead for the Attributed Beneficiary

Provider Led Entities

- Example: The Indiana Integrated Healthcare Provider Association
- LTSS Lead is significant in that the model acknowledges, and creates accountability for, the role the LTSS provider has in total health care expenditures
- ACO model design considerations include:
  - Attribution of members based upon Primary Service Provider (PSP) designation who would serve as the designated Accountable Care Lead (ACL)
  - For the LTSS population the PSP would be the provider providing the majority of services (i.e. Nursing Facility, Residential Habilitation)

Provider Led Entities

- Example: The Indiana Integrated Healthcare Provider Association
- Initial payment model would utilize gain sharing or "shared savings" methodology
  - Allows current fee-for-service payments to flow through MCOs
  - Allows an adjustment in financial and operating model of providers
- Providers are open to sub-capitated, risk sharing arrangements, but need to develop capabilities and expertise
- The savings pool is divided into two distinct pools, global and local
  - The global savings pool is driven by metrics the ACO at-large has to achieve, with individual providers being eligible on the basis of achieving metrics
  - The local savings pool is driven by provider/population specific metrics that are reserved for designated provider types

Provider Led Entities

- Example: The Indiana Integrated Healthcare Provider Association
- MCO responsibilities would initially include:
  - Claims Payment
  - Credentialing
  - Quality Measurement/Monitoring
  - HIT Infrastructure
  - Data Analytics and Reporting
  - Disease Management and
  - Fraud and Abuse Compliance

Provider Led Entities

- Example: The Indiana Integrated Healthcare Provider Association
- ACO responsibilities would initially include:
  - Case Management System
  - HIT Infrastructure
  - Data Analytics and Reporting
  - Network Development,
  - Care Coordination and
  - Grievance and Appeals

Provider Led Entities

- Example: The Indiana Integrated Healthcare Provider Association
- Covered services include:
  - State Plan services
  - Waiver services (ABD, TBI, Community Integration, Habilitation and Family Supports)
  - Intermediate Care Facilities for IDD services
  - Child and adult Psychiatric Residential Treatment Facility services
  - Inpatient Psychiatric services
  - Mental Health Rehabilitation services
  - Nursing Facility services and
  - Money Follows the Person services

Provider Led Entities

- Example: The Indiana Integrated Healthcare Provider Association
- The group is actively working with the State Medicaid Director on a regional pilot program to roll out this model in 2017
- There is a particular sense of urgency within the administration with the political realities of the incumbent Governor currently campaigning as the Republican Vice Presidential nominee