N.C. Department of Health and Human Services

# Research Summary from Discussions with Stakeholders in Identified Managed LTSS States

## Whole Person Integration Workgroup

December 15, 2014

# Scope of Workgroup

- To identify and synthesize the necessary information based on current data, NC and nationally recognized best practices to recommend methods and administrative structures to improve integration of physical, behavioral, long-term services and supports.

# Questions for Teams

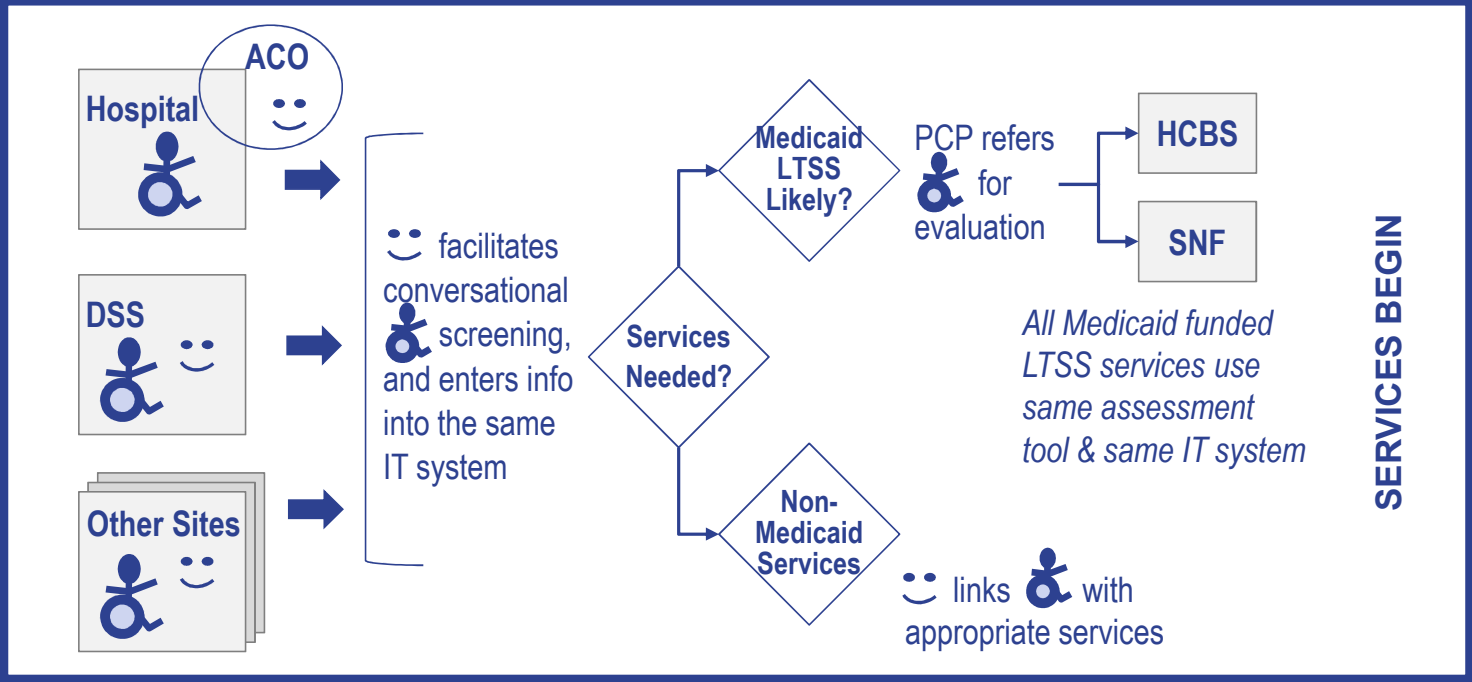
- Questions outlined on relevant slides
  - We encourage you to use your national networks/list serves to help in answering these questions.
- Additional:
  - What are implementation challenges related to this model (both nationally and NC-specific)
  - In addition to personal experience are there citations or studies support your recommendation?
  - If your answer depends on certain factors, please note these.
  - What additional questions emerge?

# Potential LTSS Reforms

| Fee-for-Service LTSS | | Shared Risk LTSS | Managed LTSS (Capitation Payment) | | |
|---|---|---|---|---|---|
| Enhance current FFS system with uniform assessment & usher function | Same, plus physical health ACO responsible for LTSS care transitions | ACO fully coordinates LTSS; costs of LTSS counted in ACO gain/ loss | Capitation to limited special needs plan for LTSS services only | All LTSS-qualifying recipients enrolled in full-service special needs plan | LTSS and all other Medicaid recipients together in full-service health plan |

# Overviews of Potential Models

# Potential Entry/Assessment Model




*Regardless of entry point, Usher stays as Client's point of contact until Client is successfully linked with services*

# What Are ACOs?

Accountable care organizations are networks of health care providers who

(1) deliver coordinated care across multiple settings

(2) agree to be held accountable for

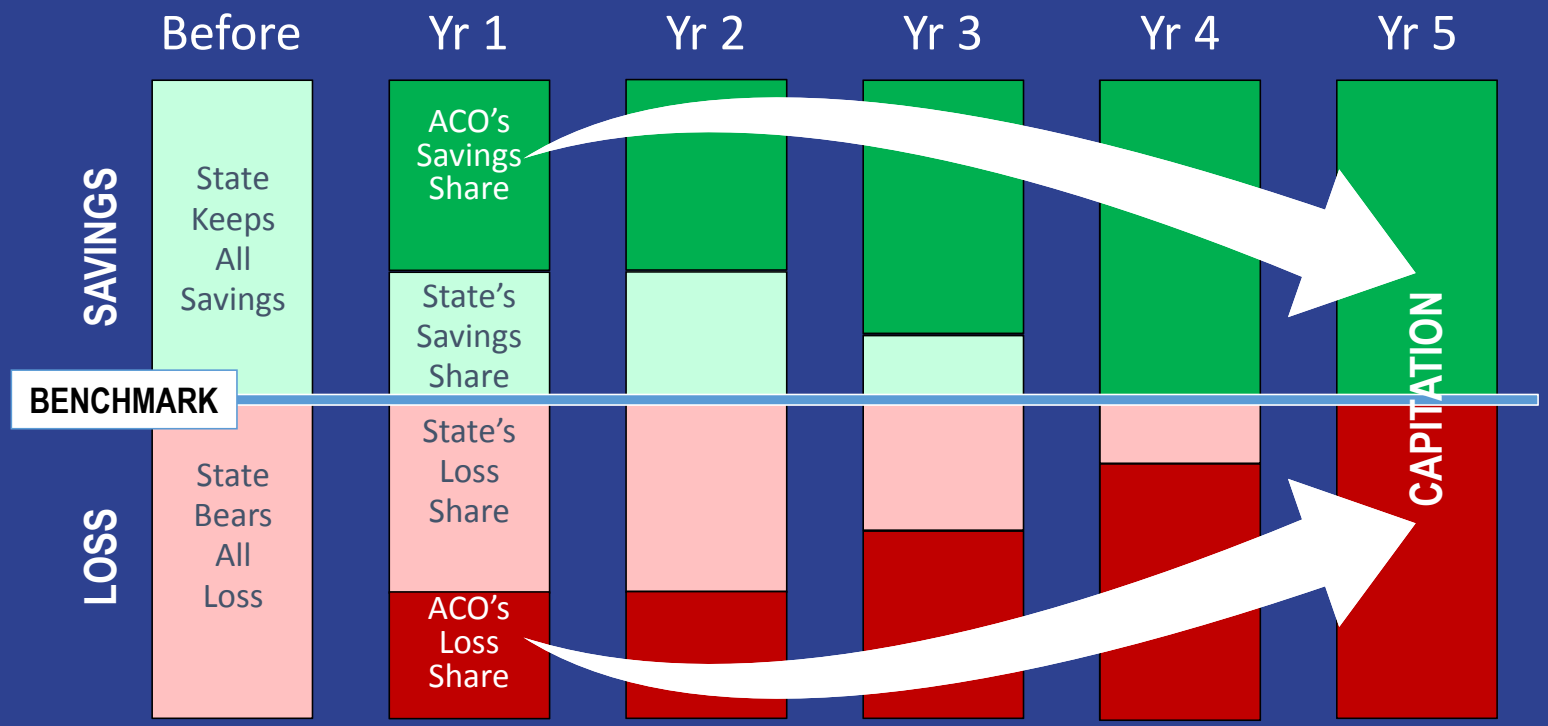
a) improving quality of care and

b) slowing the rate of spending growth.

*Medicare, private payers, and some state Medicaid now use ACOs*

*NC has 18 ACOs today, 12 accepted into Medicare; more forming*

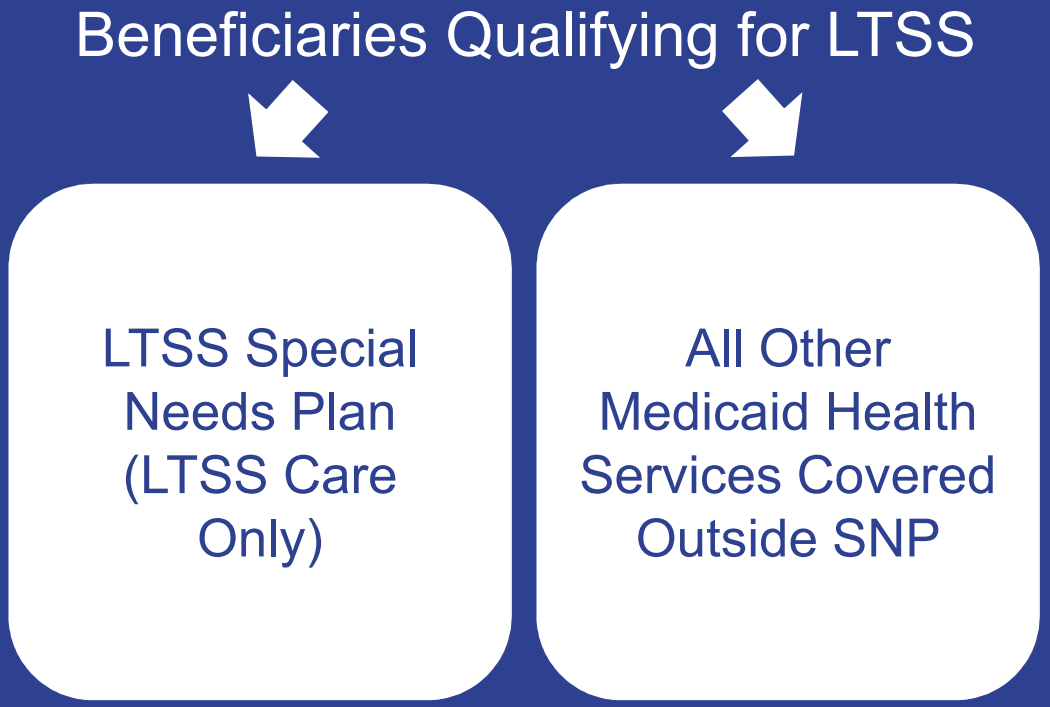
# ACOs Take Rising Share of Risk




*ACO gain/loss share adjusted based on quality performance*

# What Might Managed LTSS with Capitation Look Like in NC?

# Limited Special Needs Plan



# Full-Service Special Needs Plan

| Beneficiaries Qualifying for LTSS | Other Medicaid Beneficiaries |
| --- | --- |
| Special Needs Plan: All Medicaid Covered Health & LTSS Services | All Medicaid Covered Services |

# Universal Plan

Beneficiaries Qualifying for LTSS +
All Other Beneficiaries

Single Capitated Health Plan
Covering All Medicaid Services
for All Categories of Beneficiaries

# Workgroup Deliverables

- To provide recommendations on identified potential models of service delivery.
- To generate proposed quality and performance measures that should be considered for integration into any model.
- To identify ways to attain whole-person care integration within the current delivery system.

# Questions This Workgroup Will Help Answer About the Models

# FFS with Enhancement

- Assuming all services remain in a FFS model (except behavioral health), how do these refinements also "bend the cost curve" and achieve predictability?

# ACOs

- To better coordinate between physical health and LTSS – recognizing hospital episodes as pivotal – should ACOs manage LTSS services or is it best that ACOs *not* manage LTSS services and be connected only through performance measures?

# Managed LTSS

| SNP Limited to LTSS | Full-Service SNP | Universal Plan |
|---|---|---|

For each of the 3 options:

- How does this option support whole-person care?
- What are the limitations of this option related to whole-person care?

# Discussion

- Recommendations by mid-December
  - Will share info learned from other states
  - First round to synthesis completed by November 12
  - Quality measure discussion can (and should) continue into 2015
- How to organize the learning?

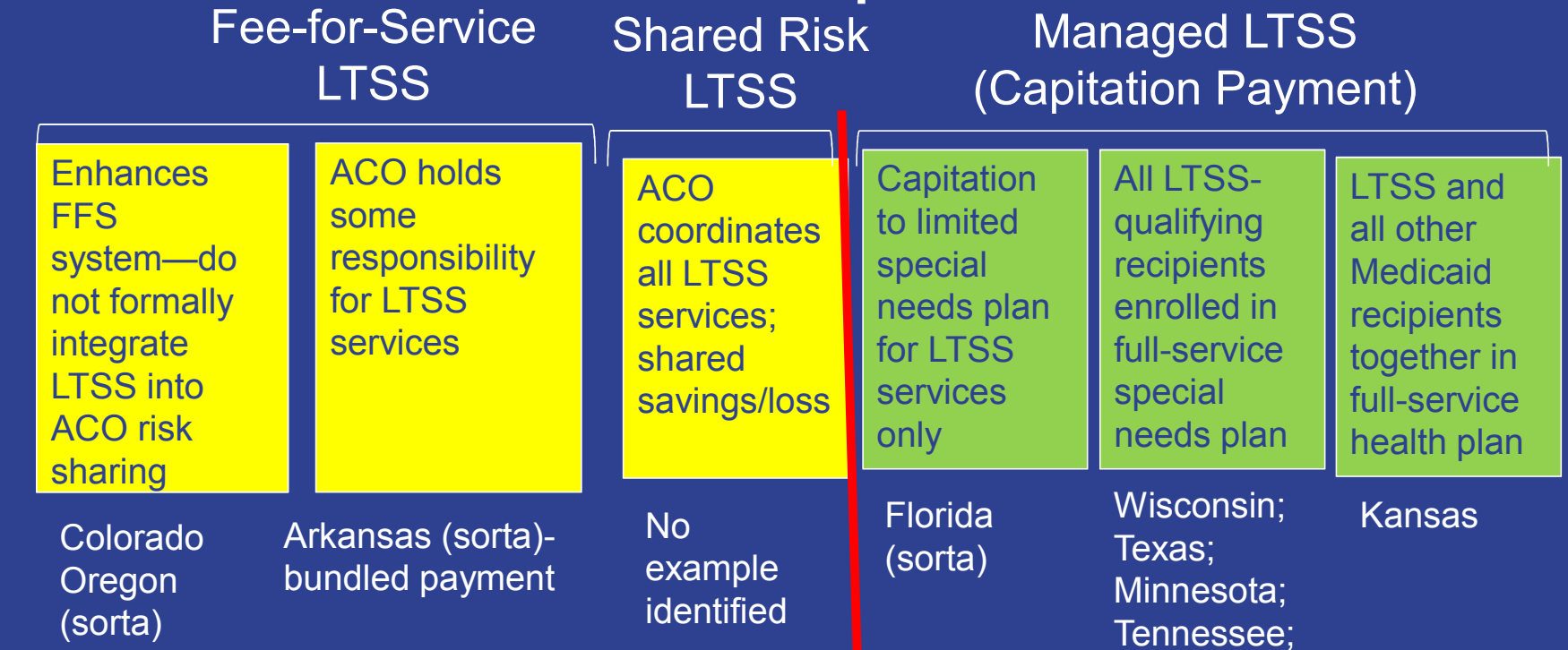
# BIG THANKS

To Lee, Carrie and their Research Teams!

# Preliminary Observations and Conclusions from Research Teams

The following slides summarize research teams' activities and conclusions. The Department's final conclusions are under development. Research teams' observations will inform Department's final conclusions.

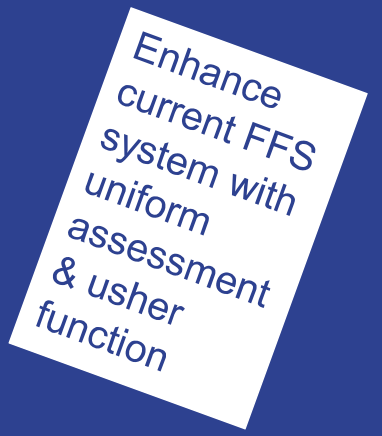
# Where Researched States Fit on the Spectrum




ACOs may serve LTSS beneficiaries' physical health needs without assuming responsibility for LTSS services.

Other populations may also be covered by managed care.

# Take Aways for Our Current Proposed Enhancements




- Usher function should prioritize counseling high risk, high need beneficiary. Must allow for various options for accessing information about LTSS services.
- Unified assessment encourage a comprehensive approach and more efficient information sharing.
- Identify and document current linkage design to better identify gaps while developing roles and responsibilities.
- Could use existing partners and expect stronger coordinated care.
- Ability to share information among team members becomes vital
  - IT needs

# Take Aways from Other ACO States

- Need for common IT platform is critical.
- Importance of strong coordination and communication among care partners.
  - LTSS and physical health entities often speak different languages
- Researched Plans do not currently fully integrate LTSS into accountable, risk sharing model, though several researched states recognized importance of it.
  - i.e. Arkansas' value-based, bundled payment for attendant care

# Team Members

- Mr. Ari Anderson – Advocate representative
- Ms. Mary Bethel – AARP
- Ms. Sam Bowman-Fuhrmann – Advocate representative
- Ms. Jane Brinson – NC CAP/DA, Wilson Medical Center
- Ms. Lee Dobson – BAYADA Home Health Care, Inc.
- Mr. John Gibbons – RHA Health Services, Inc.
- Ms. Robin McCarson – BAYADA Home Health Care, Inc.
- Ms. Swarna Reddy – Division of Aging and Adult Services
- Ms. Holly Riddle – Division of Mental Health, Developmental Disabilities and Substance Abuse Services
- Ms. Jody Riddle – NC Area Agency on Aging, Region L
- Mr. Stephen Smith – Interim HealthCare, Inc.
- Ms. Virginia Steelman – BAYADA Home Health Care, Inc.
- Mr. John Thoma – Transitions LifeCare, Inc.

# Objective

Compile lessons learned from various states to identify benefits and limitations of their Medicaid delivery system with the goal to inform North Carolina's Medicaid Reform dialogue as it relates to long-term services and support (LTSS)

# Potential LTSS Reforms

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# Research Framework

Study questions focused on:

- Benefits
- Limitations
- Operational challenges
- Metrics

Interviewed:

- Advocates, payors/regulators, and providers

# Managed Care States Researched by Group

# Benefits

**Cited by Multiple Respondents:**

- Care coordination and case management –AZ, FL, TX, MN, WI
- Elimination of waitlists –KS, WI

**Also Cited:**

- Transition back to community, reducing institutionalization –MN
- Expansion of Home and Community Based Services (HCBS) MN
- Investment in HCBS –MN
- Self-directed options –WI
- Managed Care Organizations (MCOs) innovative use of "value-added services" –TX

# Limitations

**Cited by Multiple Respondents:**

- MCOs don't understand LTSS – (TN-hospice, TX-IDD, FL, OH)
- Move to managed care prioritizes cost management and has negatively impacted at least some consumers- FL, MN, TN, WI

**Also Cited:**

- Assessment delays create access issues-MN
- Not all settings are included under plan- AZ
- Medicaid doesn't reward best practices nor does it penalize poor preforming MCOs -WI
- MCOs are highly politically connected -FL

# Operational Challenges

**Cited by Multiple Respondents:**

- Inadequate provider network –AZ, FL, WI, TN
- Lack of standardized policies and procedures – FL, OH, TN
- Delays in payments, high receivables –FL, KS, OH, TN
- Rate cuts and reductions in services –MN, WI
- No ability to negotiate, fear of retaliation –FL, KS

**Also Cited:**

- Administrative burden in service delivery –TX,
- Out of state companies severed case management relationships –KS

# Metrics

- Respondents did not identify quality LTSS-specific metrics – AZ, MN, WI
- Metrics are focused on contractual obligations rather than quality measures – FL, KS, OH, TN
- Metric identified often based in primary/acute care – OH, TN

**Other Tools Identified:**

- Consumer Assessment Healthcare Provider System (CAHPS)
- Patient satisfaction

# Take-Away

**Based on Observations from Multiple Respondents**:

- Hold MCOs accountable for quality outcomes and invest in quality practices (WI, TX, FL, AZ)
- Prioritize and invest in home & community based services -FL, OH, MN
- Going 'cold-turkey' to a MCO model produces challenges for recipients/providers (KS, OH recommending phased in approach)
- Ensure MCOs have knowledge of and experience in LTSS -FL, OH
- Establish clear parameters for rates -FL, TN

# Take-Away

## Also Cited:

- Ensure a medical loss ratio is included in the MCO contract to ensure value -FL
- Medicaid policy staff require a different skill set to effectively administer and oversee MCO activities -AZ,
- Consumer incentives to purchase LTC insurance will slow spend down -MN
- Integration of Duals model – AZ
- Deploy “value-added services” -TX
- Consumer/provider representation is a must, including an independent appeals process-AZ
- Open communications among the MCO and team to ensure appropriate, timely services-FL

# Next Steps

- Additional research synthesis.
- Department organizing its observations.
- Next Meeting :  January 7, 2014