



MLTSS – a 360° view

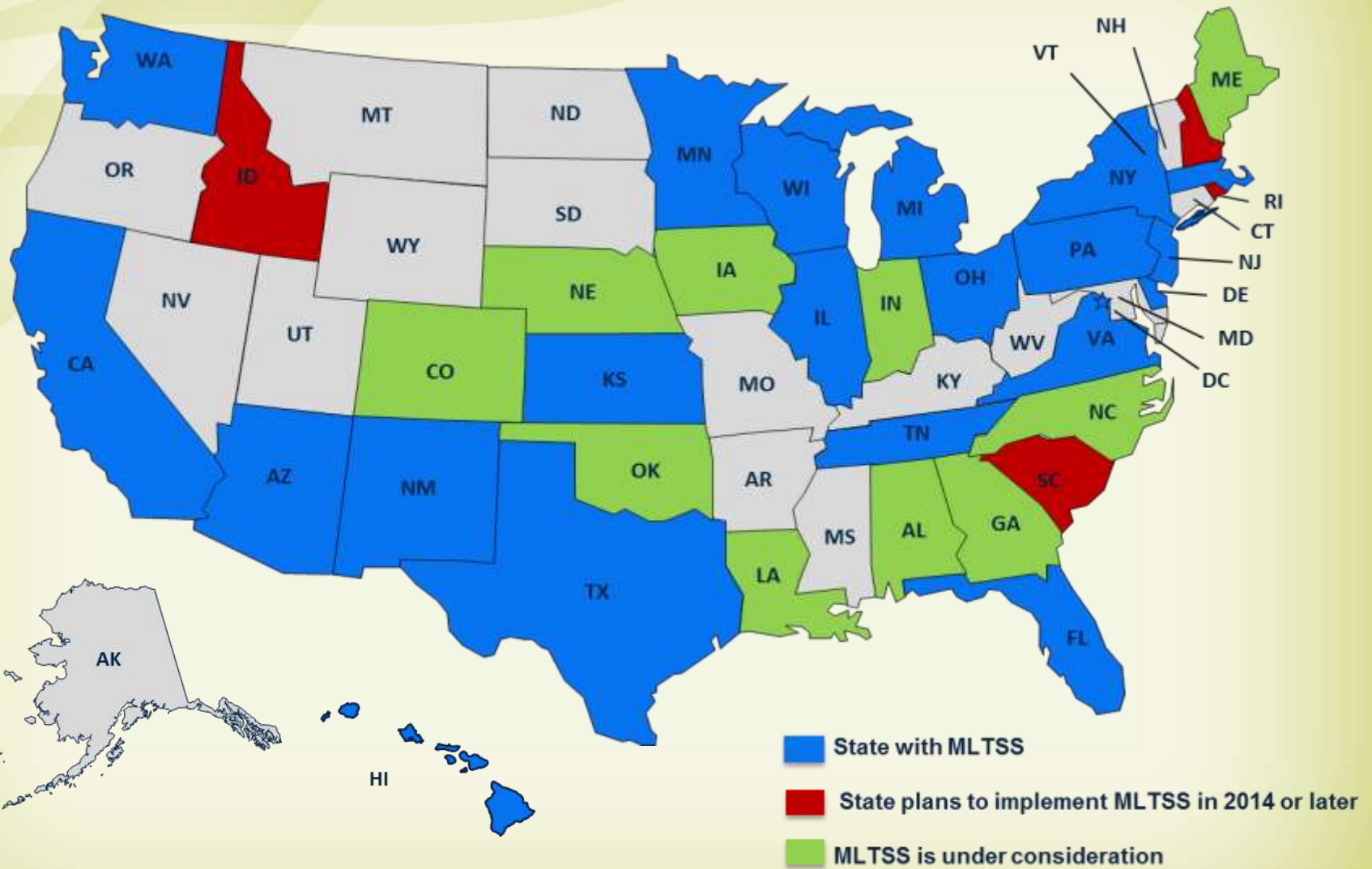
2014 HCBS Conference

Camille Dobson
Deputy Executive Director

9/15/2014

www.nasuad.org

National Scope of MLTSS Programs



Context for today's intensive

- Pace of implementation / expansion has slowed given States' focus on ACA requirements
- MLTSS continues to be one of the primary focus areas in Medicaid
- Awareness and knowledge are critical to addressing the challenges such a delivery system change poses

Context for today's intensive

- Goal for Intensive: Share perspectives from key players in MLTSS programs
 - States
 - Health Plans
 - Stakeholders
 - Providers
- Outcome of Intensive: Attendees leave with new knowledge to take back and apply in their state

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- In efforts to go 'green', we are not using paper evaluation forms.
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- It will help NASUAD provide the most engaging and informative intensive possible in 2015!
- THANK YOU



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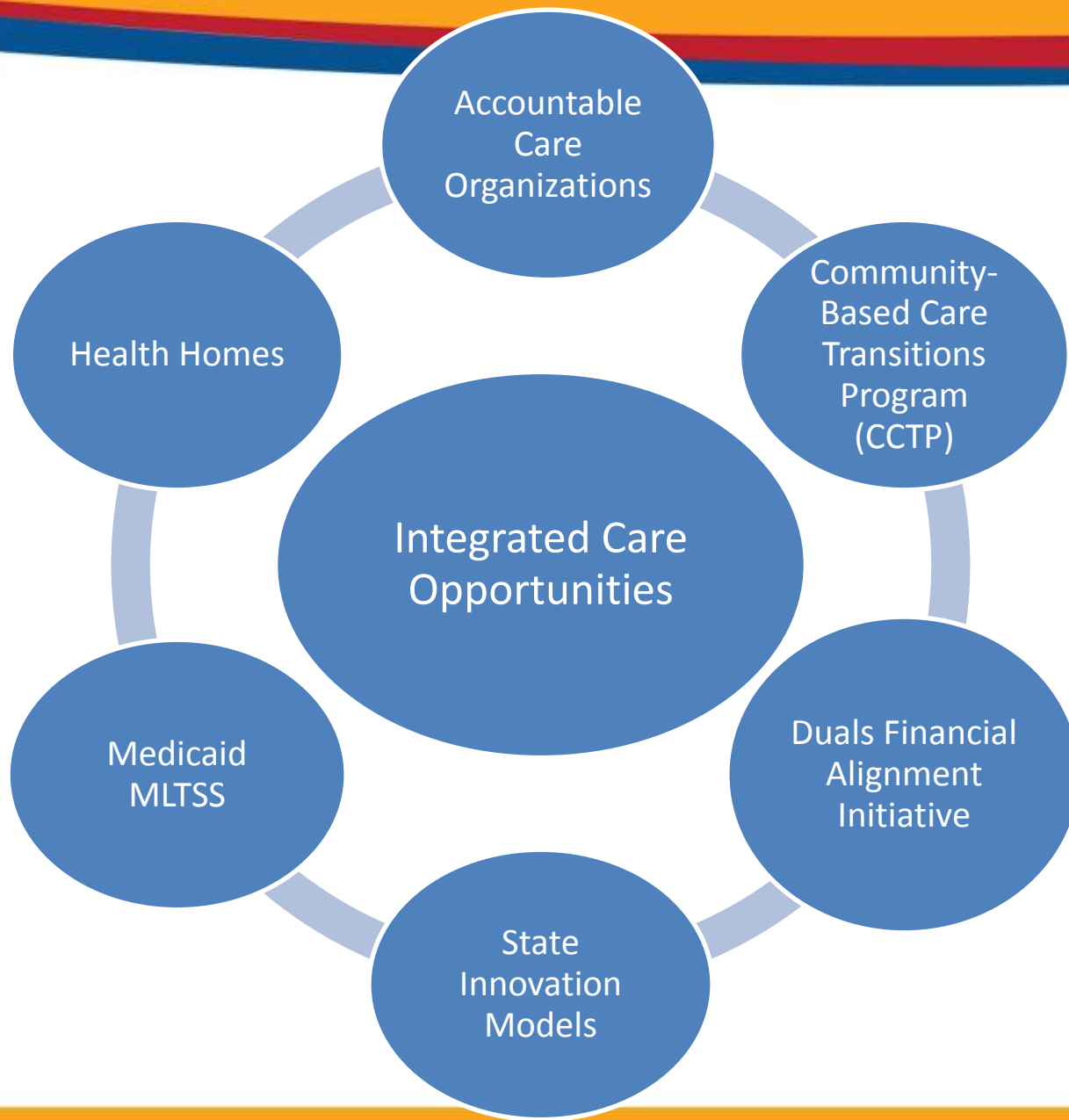


HHS Perspectives and Activities

Marisa Scala-Foley

*Acting Director, Office of Policy Analysis and Development
Center for Disability & Aging Policy*

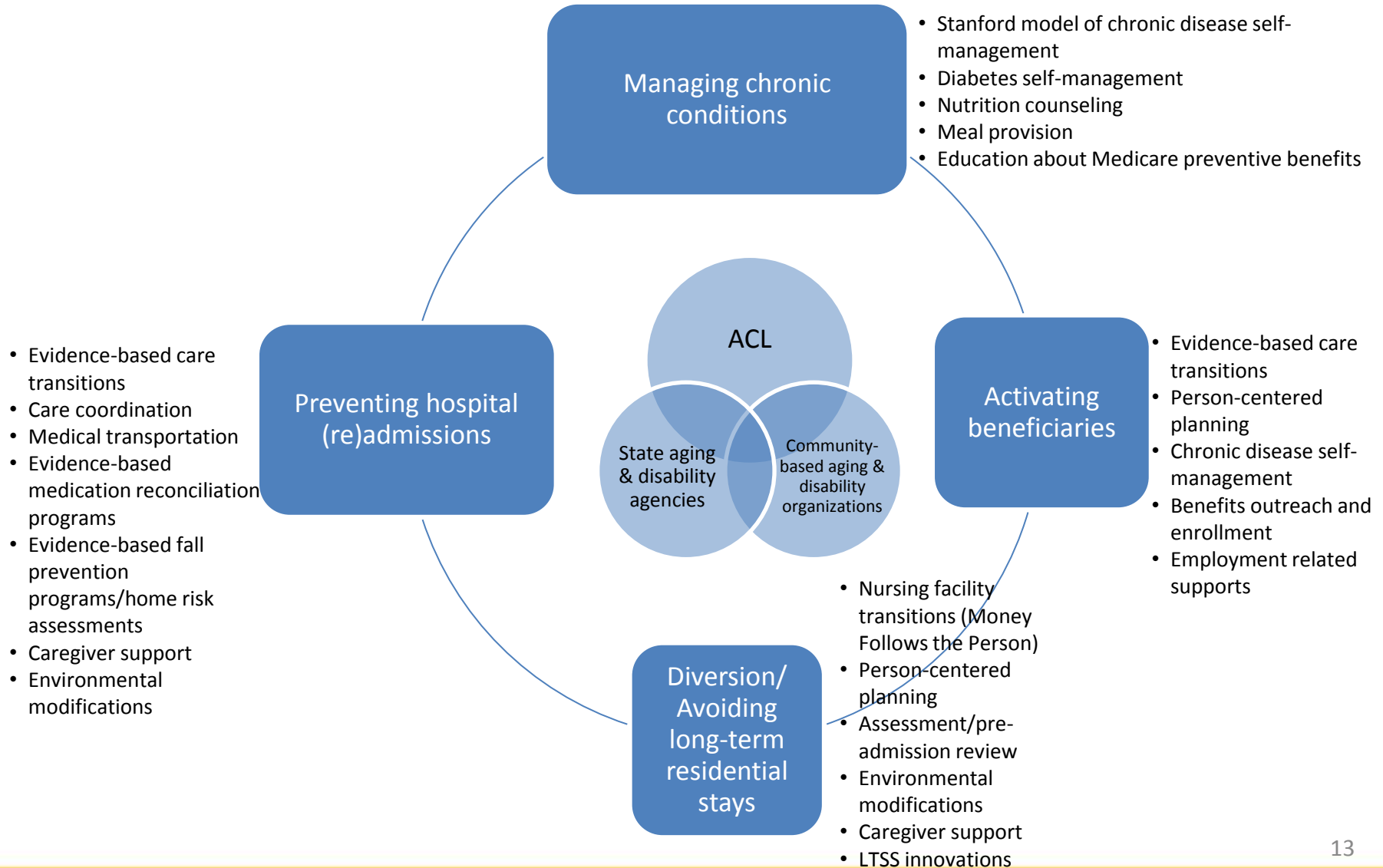




For integrated care entities (especially health plans), the question becomes...



Where do our networks add value?





© 2012 Ted Goff

“Every step of the sales process went perfectly except the part where the customer buys our product.”

ACL Business Acumen Activities

2012: Grants to national partners to build the business capacity of aging and disability organizations for MLTSS

2012 - Present:
Engagement with public and private partners

2013-Present: Business Acumen Learning Collaborative

Business acumen learning collaborative

- Targeted technical assistance to build business capacity of *community-based integrated care networks*
- **Goal:** Each network will have at least one new contract with an integrated care entity by the end of 2014.
- Site leads:
 - Partners in Care Foundation (CA)
 - San Francisco Department of Aging and Adult Services (CA)
 - Healthy Aging Regional Collaborative (FL)
 - Elder Services of the Merrimack Valley (MA)
 - The Senior Alliance and the Detroit Area Agency on Aging (MI)
 - Minnesota Metro Aging and Business Network (MN)
 - AAAs of Erie and Niagara counties (NY)
 - PA Association of AAAs, Inc. in partnership with the PA Centers for Independent Living (PA)
 - North Central Texas Council of Governments (TX)

A few success stories

- One of the leads for our Michigan learning collaborative site has secured its own Medicare number and intends to begin billing for services rendered to ACO beneficiaries of two large ACOs in their area. The proposed services include care transitions, HCBS, diabetes self-management, and chronic disease self-management
- As of August, networks within the learning collaborative have 10 signed contracts with integrated care entities (health plans, ACOs, physician practices, health systems), and 10 additional contracts under negotiation
- Conversation among the sites has evolved over the course of the collaborative, and sites are now exploring issues related to network infrastructure – information technology, billing, and more

New Jersey's Move to Managed Long Term Services and Supports (MLTSS)

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HCBS CONFERENCE SEPTEMBER 2014

**PRESENTER:
LOWELL ARYE, DEPUTY COMMISSIONER
NJ DEPARTMENT OF HUMAN SERVICES**



Backdrop for Move to MLTSS

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- 1995 – Medicaid managed care was introduced in NJ to improve quality, health outcomes and contain costs for Medicaid and NJ FamilyCare clients.
- July-October 2011 – The aged, blind and disabled populations, and duals (individuals with both Medicare and Medicaid benefits) were moved into managed care for Medicaid benefits.
- HCBS and facility-based long term care stayed in the Fee For Service (FFS) system.
- July 2011, Medical Day Care, Personal Care Assistance and therapies moved into managed care.

NJ Comprehensive Medicaid Waiver (CMW)

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- NJ CMW demonstration 1115 (a) was approved effective 10/1/12-6/30/17 to:
 - Implement statewide health reform and expand current managed care programs to include managed long term services and supports and expand home and community based services (HCBS) to some populations.
 - Combine authority for several existing Medicaid and CHIP waiver and demonstration programs.
 - Create a funding pool to promote a health delivery system transformation.

Comprehensive Medicaid Waiver and MLTSS

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- Enables NJ to expand Medicaid eligibility and coverage options for people who needed HCBS but who were ineligible for Medicaid due to income.
- Gives NJ broad authority to modify rules for efficiency while providing quality care.
- Combined four existing HCBS waivers:
 1. Global Options (GO) for Long Term Care;
 2. AIDS Community Care Alternatives Program (ACCAP);
 3. Traumatic Brain Injury (TBI); and
 4. Community Resources for People with Disabilities (CRPD).

MLTSS Stakeholder Process

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- Steering Committee was launched in 3/12 and still meets at least quarterly:
 1. Assessment to appeals
 2. Assuring access
 3. Provider transitions
 4. Quality management
- Developed MLTSS principles to guide policy development.

MCO and State Readiness Review

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- In Summer 2013, State and MCOs submitted to a request for information (RFI) to assess MLTSS readiness.
- Tracking progress took place from 4-6/14, including:
 - Development and fine tuning of existing policies;
 - Creation of a staffing plan;
 - Creation of a training plan, and
 - Evaluation/development of IT systems and infrastructure.
- MCOs had to be ready for testing by 4/15/14.
- Weekly calls held between State and the MCOs to discuss progress, obstacles and successes.

Array of Services under MLTSS

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- **Specific Services:**

- Care Management;
- Respite;
- Personal Emergency Response System (PERS);
- Home and Vehicle Modifications;
- Home Delivered Meals;
- Assisted Living;
- Behavioral Health Services;
- Community Residential Services; and
- Nursing home care.

MLTSS Training Strategy

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- Focus on the education/training of stakeholders, including providers and advocates, to reach the approximately 13,000 consumers affected:
 - Aging and disability network on MLTSS (consumer focus)
 - MCOs on Aging and Disability Network topics
 - Sister state agencies and state hotlines on MLTSS (consumer focus)
 - Providers with focus on MLTSS, MCOs and State issues

NJ FamilyCare MLTSS

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- As of 7/1/14, NJ FamilyCare MLTSS includes the HCBS which was provided by Medicaid waivers as well as care in a nursing home when needed
 - Approximately 13,000 were enrolled in these Medicaid waivers and moved into MLTSS on 7/1/14.
- **Access To:**
 - Health care providers and services within the managed care network to meet needs; and
 - A care manager to help coordinate medical, long term services and supports, behavioral health services and NJ FamilyCare State Plan services, i.e., medical day care and personal care assistance, through an individualized plan of care.

Exclusions to MLTSS on July 1, 2014

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- About 27,000 Medicaid fee-for-service (FFS) beneficiaries in long-term care facilities:
 - FFS Medicaid beneficiaries who are in custodial nursing home care before 7/1/14
 - Medicaid beneficiaries living in Special Care Nursing Facilities (SCNFs) as of 7/1/14 will remain in the current FFS for two years (until 7/1/16)

Continued...

Exclusions to MLTSS on July 1, 2014

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- Division of Developmental Disabilities' CCW (Community Care Waiver) or Supports Program beneficiaries
- People with Pervasive Developmental Disabilities (DD)
- Intellectual/DD Beneficiaries in out-of-state HCBS settings
- Persons receiving inpatient services for intellectual or developmental disability and mental health illness in a psychiatric hospital
- PACE Program beneficiaries
- Persons enrolled in Dual Eligible Special Needs Plans (D-SNP), unless nursing home level of care (then move to Medicaid MCO for MLTSS)

No Wrong Door/Single Entry Point

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- New Jersey has a standardized process by which “new” enrollees can apply for MLTSS system:
 - Individuals age 21 and over should contact their local Aging and Disability Resource Connection (ADRC), also known as the Area Agency on Aging (AAA).
 - If you are applying on behalf of your child or an individual under age 21, you can contact your local County Welfare Agency or the Division of Disabilities Services (DDS).
- For NJ FamilyCare eligibility, individuals must apply at County Boards of Social Services, also known as County Welfare Agencies.

Significance of Care Management

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- As of 2/1/14, the MCOs had assumed Medicaid Waiver care management (CM) for all newly enrolled GO participants and transfer cases.
- Weekly conference calls were held with each MCO to identify and address issues, concerns, and provide technical assistance in the development of their MLTSS policies and procedures.
- CM meetings held throughout Spring 2014 to update current Medicaid Waiver care managers and MCOs who were new to CM on the transition plans.

MLTSS Approval Process

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- The DHS has retained responsibility for clinical eligibility determination; the CM function rests with the MCOs.
- MCO contract establishes clear delineations between determining clinical eligibility; developing and authorizing plans of care; establishing service caps; and overseeing quality assurance management.
- State must approve assessment findings and ensure that the findings match the health care needs of the MLTSS members, as detailed in the plans of care.
- NJ-Choice assessment tool sets the standard.

Continuity of Care Provision

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- Effective 7/1/14, current providers had to continue to provide the authorized services and hours identified in the participant's current plan of care beyond 6/30/14 until the MCO care manager notifies the provider that the participant has a new plan of care.
- Each MCO needs to work directly with the providers regarding a member's plan of care. As of 7/1/2014, the provider's primary point of contact regarding a member's services is the MCO care manager.

MLTSS Quality Strategy

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- Several State agencies are involved, but the Division of Medical Assistance and Health Services has authority over programs and exercises oversight and monitoring.
- Besides the existing NJ Family Care managed care contract requirements, MLTSS reporting requirements are in the MCO contract.
- The External Quality Review Organization will conduct a unified set of mandatory external quality review activities outlined in 42 CFR438.358, including the annual assessment of operations, performance measures and quality improvement projects, that will review the quality of the NJ FamilyCare plan and MLTSS requirements.
- NJ's approach is to use nationally recognized benchmarks and to establish performance benchmarks.



For More Information

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WWW.STATE.NJ.US/HUMANSERVICES/



Managed Long-Term Services and Supports Intensive: State Perspectives on MLTSS

**Kari Bruffett, Secretary
Kansas Department for Aging and Disability Services**

Sept. 15, 2014

Why Reform?

Kansas Medicaid and CHIP had used managed care models for children and families since the 1990s.

But Kansas Medicaid historically was not outcomes oriented.

The most complex consumers were stuck in the fee for service model, with services defined by which programs they were in.

Fueled by fragmentation, costs rose at an annual rate of 7.4 percent over the decade of the 2000s.

In Old Medicaid, budget concerns would trigger rate reductions and create waiting lists for certain services.

What Did Kansas Choose to Do?

Kansas developed KanCare, a coordinated managed care program for nearly all beneficiaries and services.

A centerpiece of KanCare was **integrating managed long term services and supports (MLTSS) with physical and behavioral health.**

After an initial one-year delay of the inclusion of MLTSS for members with intellectual or developmental disabilities (ID/DD), now all HCBS services are included.

When and Where?

- Summer 2011: Medicaid Public Forums/Webconferences
- November 2011: KanCare announced; RFP released
- January 2012: KanCare concept paper
- June 2012: KanCare contracts signed: **Statewide**
- August 2012: Section 1115 demonstration application
- Summer and Fall 2012: Educational tours across Kansas
- Sept-Oct 2012: Readiness reviews
- January 2013: KanCare Go-live
- Summer 2013: Public meetings; submission of amendment
- November 2013: I/DD readiness reviews
- February 2014: I/DD LTSS Go-live

How Was MLTSS Implemented?

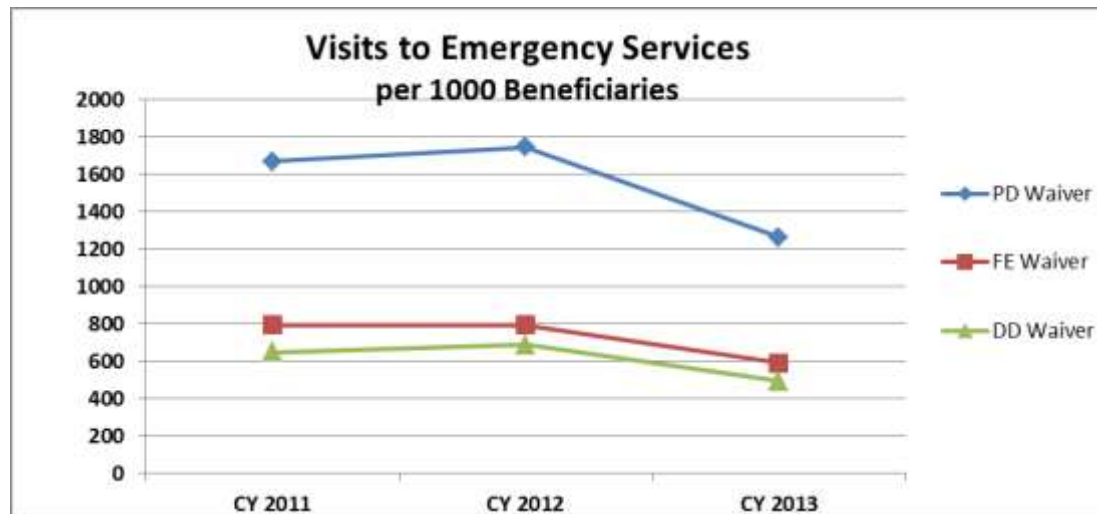
- MLTSS run concurrently on the KanCare Section 1115 demonstration and seven 1915(c) waivers.
- While KanCare predated the 2013 CMS guidance on MLTSS, many of the key elements addressed in the guidance are reflected in the KanCare model.

Examples: Readiness reviews, rapid response calls, ombudsman, educational tours, blended rate cells and performance measures to incentivize community integration

How Is It Working?

Snapshots:

- About twice as many HCBS members experienced increases in their Plans of Care in 2013 than those who had decreases.
- Emergency Room usage for HCBS Waiver program participants was reduced by 27%.



ID/DD Transition

Enhanced implementation protections:

- Provider- and consumer-focused education sessions and issue logs
- Friends and Family engagement in design of consumer communications
- Extended continuity of care period
- Easing of select systems edits during transition
- Collaborative care planning process
- State review of proposed reductions in plans of care

How Is It Working?

ID/DD Implementation:

Since February 1, the denial rate for DD HCBS claims has been a steady 2%. It is a similarly low 3% for DD TCM claims.

Average number of days to process DD claims has also held steady at around 5.7 days.

The DD “underserved” list, which was created more than a decade ago, has been eliminated.

More Resources

For more information about KanCare:

www.kancare.ks.gov

Centene Overview

Better Health Outcomes, Lower Costs.™

**2014 Home and Community Based Services
MLTSS Pre-Conference Intensive
September 15, 2014**



Centene Overview



Established in 1984 in Milwaukee, WI
and Headquartered in **St. Louis, MO**

Employs approximately
10,000 individuals



Provider networks include
over **215,000 physicians**
and **2,000 hospitals**

Serves government
sponsored healthcare
programs in **21 states**



A **Fortune 500** company (**#251**), Centene Corporation (NYSE: CNC) expects **revenues of \$14.2 to \$14.8 billion** for 2014 and currently has \$2.2 billion in cash and investments.



Centene's Purpose

Transforming the health of the community one person at a time

Our Mission

Better health outcomes at lower costs

Our Brand Pillars

Focus on individuals + Active Local Involvement + Whole Health

Our beliefs

- We believe in treating the whole person, not just the physical body.
- We believe treating people with kindness, respect and dignity empowers healthy decisions.
- We believe we have a responsibility to remove barriers and make it simple to get well, stay well and be well.
- We believe local partnerships enables meaningful, accessible healthcare.
- We believe healthier individuals create more vibrant families and communities.

Our Philosophy

Local Approach & Job Creation

Centene's core philosophy is that quality healthcare is best delivered locally. Our local approach enables us to provide accessible, high quality and culturally sensitive healthcare services to our members. Our care coordination model utilizes integrated programs that can only be delivered effectively by a local staff, resulting in meaningful job creation within the communities we serve.

Care Coordination

Our proprietary care management programs promote a medical home for each member and enable Centene to partner with its trusted providers to ensure members receive the right care, in the right place, at the right time.





Healthcare Compliance

State and Healthcare Effectiveness Data and Information Set (HEDIS) reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management team.

Current Operations

At-Risk Government Sponsored Membership

Ark.	_____	16,400
Ariz.	_____	7,100
Calif.	_____	118,100
Fla.	_____	230,300
Ga.	_____	331,400
Ill.	_____	22,400
Ind.	_____	198,700
Kan.	_____	145,000
La.	_____	149,800
Mass.	_____	50,800
Minn.	_____	9,400
Miss.	_____	85,400
Mo.	_____	58,100
N.H.	_____	37,100
Ohio	_____	181,800
S.C.	_____	96,300
Tenn.	_____	21,100
Texas	_____	938,000
Wash.	_____	151,700
Wis.	_____	70,800

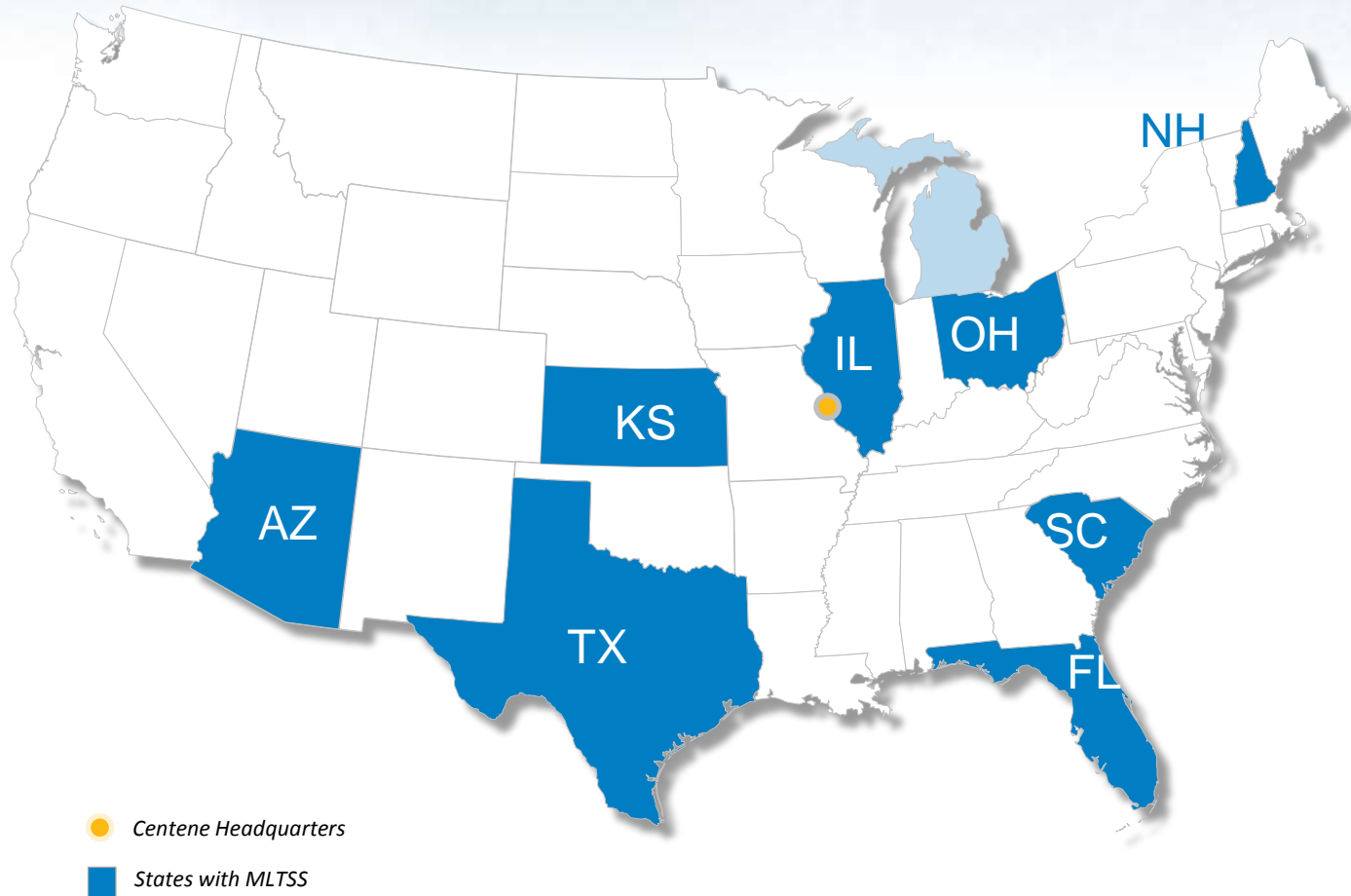
-  Centene Headquarters
-  States with health plan operations
-  States with health plan implementation
-  States with business operations

Notes:

¹ Centurion has correctional healthcare membership in MA, MN and TN

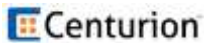
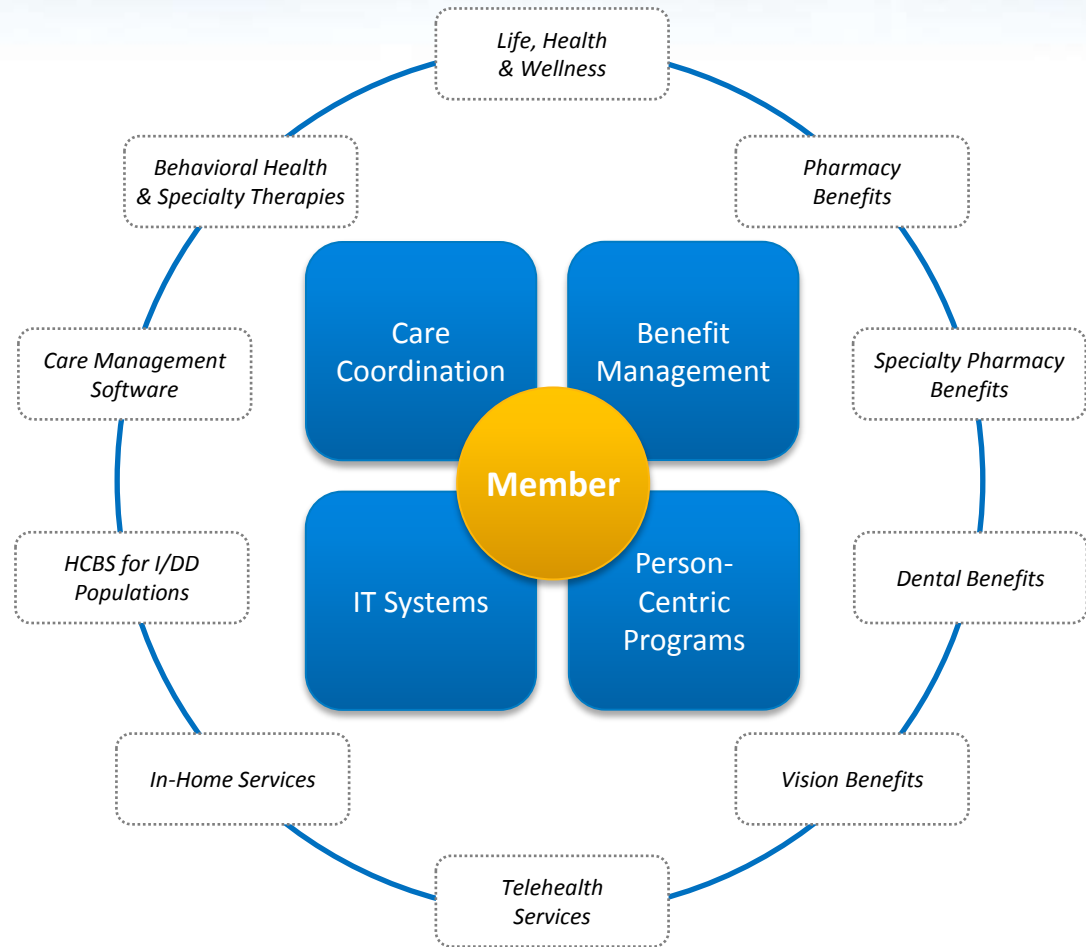
² Entry underway with Fidelis Secure Care – Dual Demonstration Project anticipated to go-live in late 2014.

Current MLTSS Operations



Specialty Company Resources and Expertise

Total Solution Integration
physical health,
behavioral health,
pharmacy services, and
ancillary services



Centurion is a correctional healthcare joint venture between Centene and MHM Services Inc. Currently has contracts in MA, MN and TN.

Centene Overview

Better Health Outcomes, Lower Costs.™



CareSource
Managed Care Long
Term Services and
Supports

September 15, 2014



CareSource



- Non-profit, mission driven
- Ohio's first mandatory Medicaid MCP in 1989
- Second largest Medicaid HMO in US
- 1,600 + employees
- Medicaid over 1 million members
- Medicare Special Needs Plan
- HCBS Waivers
- Multiple States
- URAC and NCQA accreditation
- Headquarters Based in Dayton, Ohio with regional offices in Cleveland, Columbus, and Louisville, KY.

Mission: *To make a lasting difference in our members' lives by improving their health and well-being.*

MyCare Ohio & LTSS

- Paradigm shift for Managed Care
- New thought processes
- Our introduction to HCBS/LTSS (RFP-2013)
- Community Partnerships (AAAs)
- Member as the pilot, MCO as the co-pilot



MyCare Ohio



- A new coordinated approach to providing health care and long-term services and supports
- Coordinates Medicare and Medicaid benefits into one managed care plan

Advantages

- One point of contact for care
- Care Management Support 24/7
- A team of professionals
- One ID card
- Focus on prevention and wellness
- Nurse Advice Line
- Better coordination= Better health outcomes
- Your providers will submit claims to only 1 place



Ohio ICDS Population

Dual (MCR/MCD) eligible participants:

- Community (non-waiver)
- HCBS Waivers
 - PASSPORT
 - Choices
 - Assisted Living
 - Ohio Home Care
 - Transitions II “Carve Out”
- Institutional



Who is eligible for My Care?

- Age 18 and older with both Medicaid and Medicare at the time of enrollment
- Eligible for full Medicare Parts A, B, and D
- Reside in an ICDS Demonstration county.

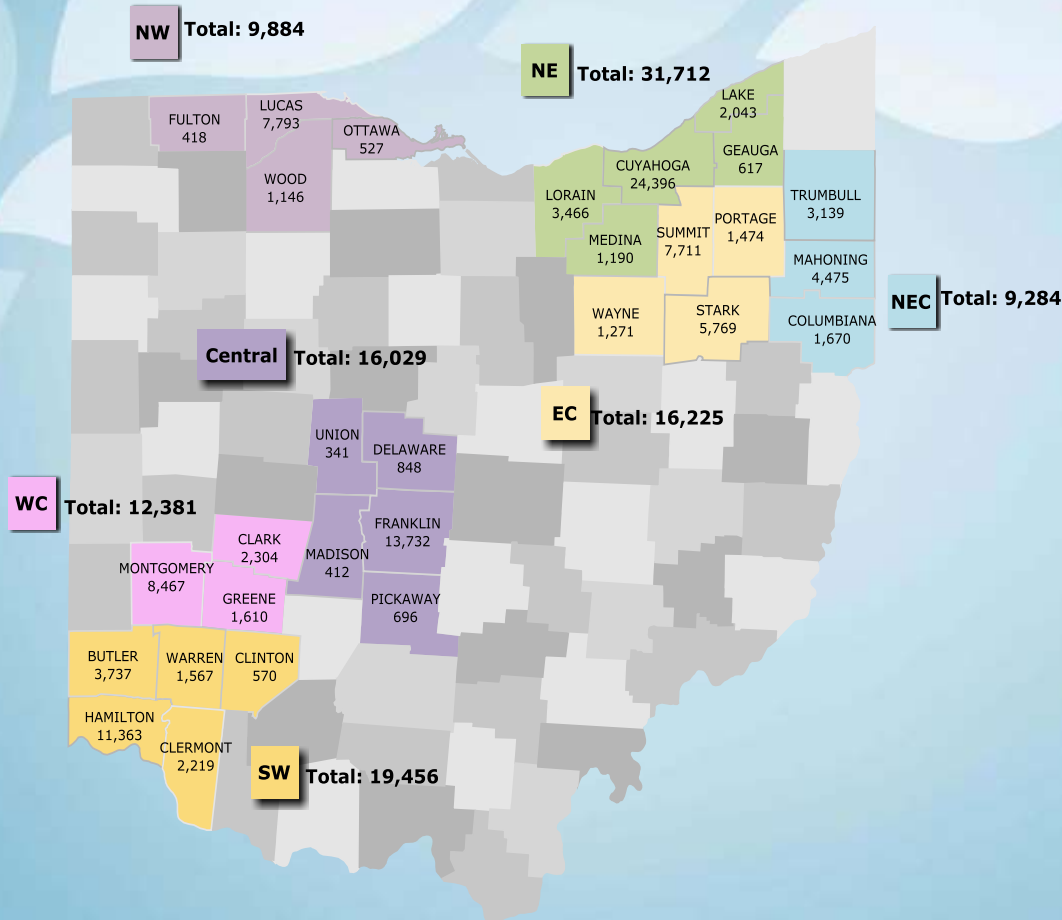


ICDS in Ohio

- Three way contract ODJFS/CMS/MCP
- Second demo to launch nationally
- 7 regions
 - 3-5 counties each
 - 115,000 dually eligible members
 - Five MCPs have been selected
- Winning plans:

	NW	SW	W Central	Central	E Central	NE Central	NE
1	Aetna	Aetna	Buckeye	Aetna	CareSource	CareSource	Buckeye
2	Buckeye	Molina	Molina	Molina	United	United	CareSource
3							United

Ohio Demonstration Areas



Goals for individuals

- Improve the beneficiary experience in accessing care
- Deliver person-centered care
- Promote independence in the community



My Care Individuals

- Community Well individuals
- HCBS individuals
- Individuals in a Nursing Facility



Community (Non-HCBS/LTSS)

- Few signs of unstable health or psychosocial conditions
- May be independent or receive informal or formal supports
- Likely appropriately accessing and receiving medical and social services

MyCare HCBS Individuals

- Condition is generally controlled, but with regular monitoring due to chronic or progressive nature
- May have frequent exacerbations
- HCBS services are primary focus in achieving member goals to remain safely in the community



MyCare Institutional Individuals

- Condition may be unstable or subject to instability
- May require 24 hour care
- Clinical risk factors, high utilization of service needs

Member Experience



Community Focus

Hi touch, in person
Trans-disciplinary
care teams
Local resources
Regional staffing



Community-based

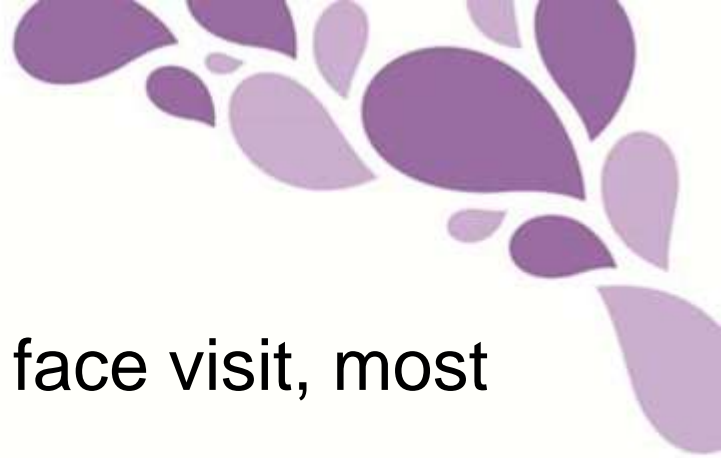
RNs and Licensed
Social Workers
Navigators
Health Educators
Waiver Service
Coordination



Community Partners

LTCFs and ALs
Area Agency's on
Aging
Centers of
Independent Living
Community Mental
Health Centers

Focus on person-centered, holistic care and support



New Benchmarks in Care Coordination

- All members must have a face to face visit, most within 75 days.
- Assessment and visit requirements
 - Intensive 15 days / monthly visit for life of demo
 - High 30 days / monthly visit for 6 months
 - Medium 60 days / visit 1st 2 months, then quarterly
 - Low 75 days / visit 1st 4 months, then biannually
 - Monitor 75 days / visit 1st 6 months, then annually
- Initial and ongoing (event based) assessments, as well as annual reassessment.

Assessments

- Initial and reassessments will be conducted in-person and telephonically depending on the level of stratification (intensive, high, medium, etc.)
- Reassessments will occur within 365 days regardless of care setting



Assessments

- Assessments must be updated when any of the following occur:
 - Change in enrollee health status or needs
 - Change in diagnosis
 - Change in caregiver status
 - Change in functional status
 - Significant health care event (e.g. hospital admission, transition in care setting)
 - If requested by the enrollee, caregiver, etc.

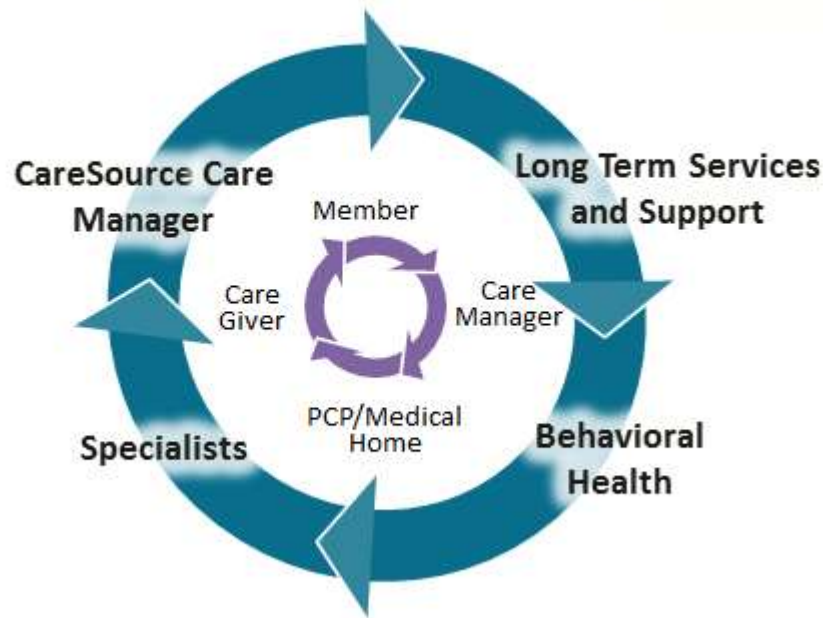
Coordination of Care Model

Our tailored approach to care coordination enables our staff to build an **individualized, comprehensive plan of care** that can adapt based on an Enrollee's developing needs and personal goals.



Trans-Disciplinary Care Team

Member-centered group that functions as a unit to **cultivate member relationships** and **promote self care** and management.



Member as the Pilot

- The guide who leads or conducts over a course
- The helmsman of a ship
- To steer or control the course



Case Manager as Co-Pilot

A co-pilot is a person who is fully qualified to fly (an [aircraft](#)) and sits alongside the pilot, also known as the captain. While the pilot is the person primarily responsible for handling the aircraft, the copilot can provide relief to allow the pilot to take breaks, as well as intervening in emergencies. In order to [become a copilot](#), it is necessary to receive pilot training and to certify to fly a given type of aircraft in addition to receiving a [medical certificate](#) from aviation authorities that provides authorization to fly.

Clinical Staffing for MyCare Ohio

CareSource's Care Management staffing structure allows for **comprehensive, consistent, and member goal-driven care.**

The **Care Management Team will be a diverse group**, each having interest in the health, welfare, safety and well-being of the Enrollee.

This team will:

- Include those who have the experience and expertise to address the member's needs
- Administratively support the Care Managers in fulfilling the member's needs
- LTSS model will have strong presence of social workers, RNs and community resource experts



Michele M. Hammond, MSW, LSW
Director of Care Management,
HCBS/LTSS Integrated Care ~
CareSource

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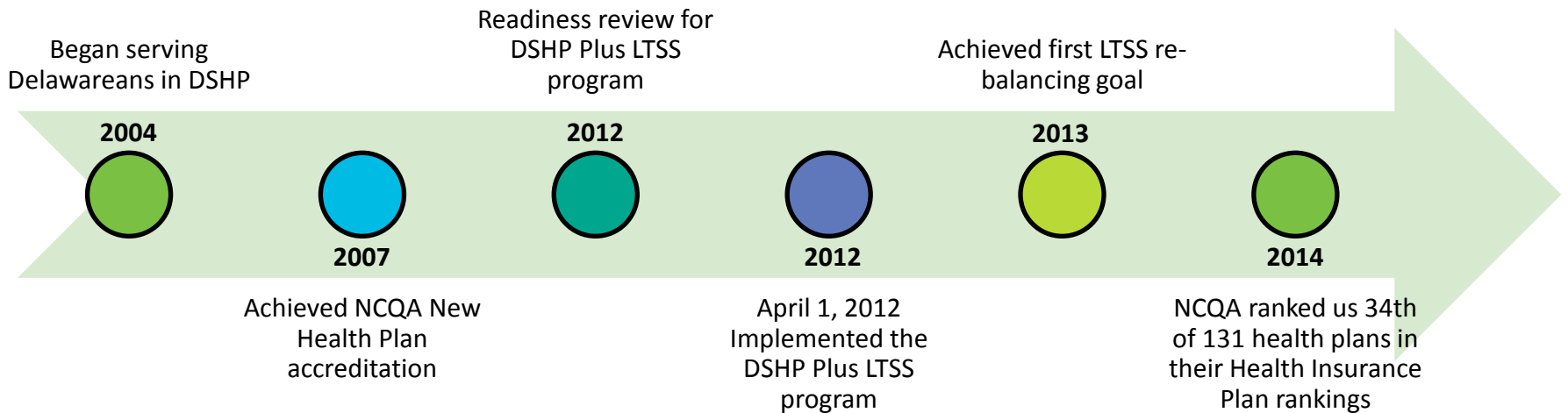
*CareSource*TM

2014 HCBS Conference

Patricia Wright
September 15, 2014



Who we are: 10 years serving Delaware

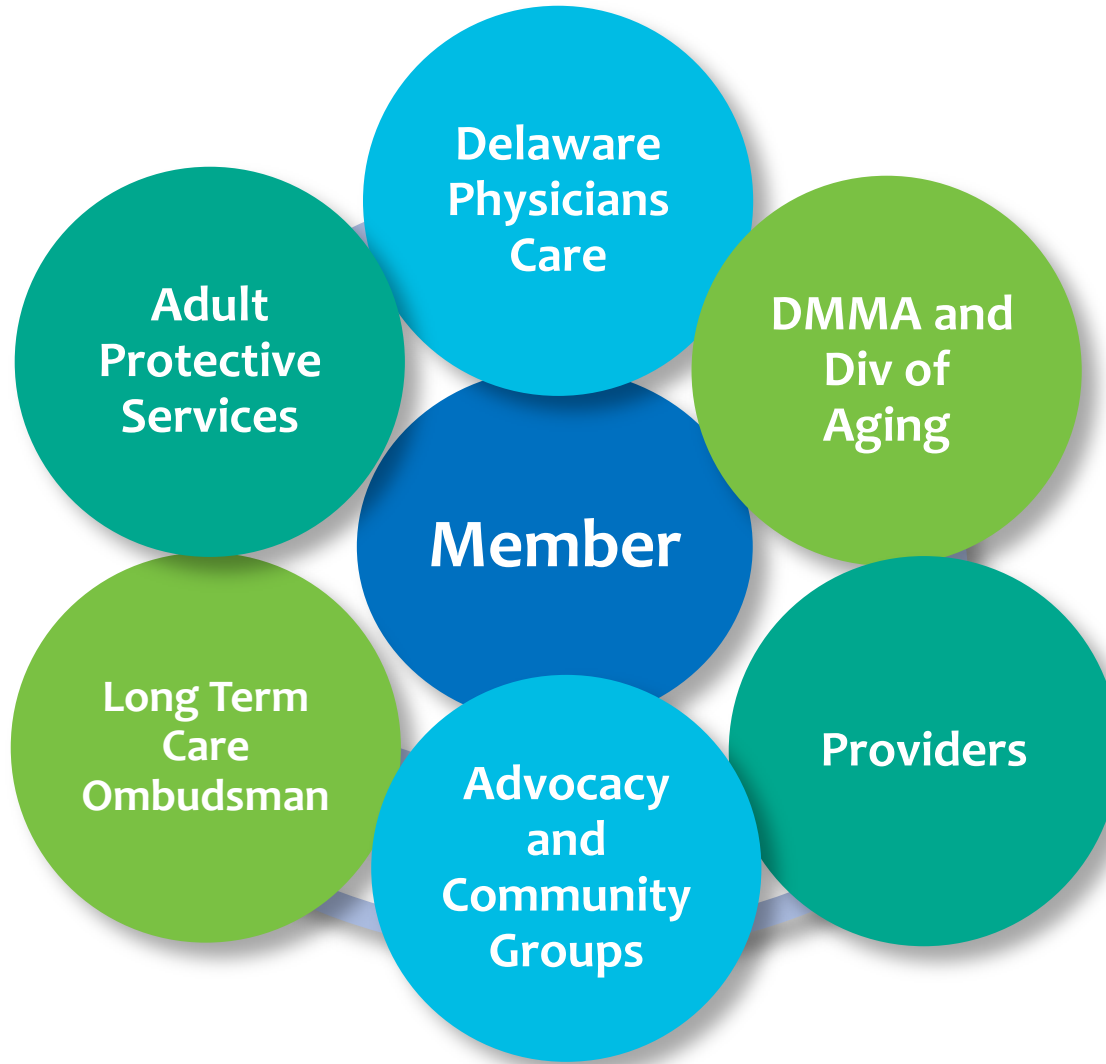


- **Members meet state defined medical and financial criteria and includes individuals previously enrolled in the AIDS Waiver**
- **Nursing Facility/Institutionalized (all ages, all needs)**
- **Home & Community Based Services (HCBS) groups**
- **Money Follows the Person**
- **MFP, Core and Enhanced benefits**

Integrated person-centered care



Collaborative partners



Integrated care strategy: person-centered care

- Individualized case manager
- Face-to-face assessment
 - Bio-psychosocial needs
 - Personal preferences
 - Identification of supports
 - Condition specific assessment as needed
- Develop collaborative goals to support
 - Member needs
 - Personal preferences
 - Care provided by family/others (unpaid care)

Integrated care strategy: person-centered care

- Plan of Care
 - Care Plan
 - Service Plan
 - Member signs the Plan of Care

- Members Right
 - To change case manager at any time
 - To appeal service change
 - Release of Information
 - Mental Health
 - Substance Use

LTSS integrated person-centered quality measures

- Timely, comprehensive member assessments
- Inter-rater reliability
- Supervisory case file and observational audits
- Monthly metric reporting to the state
- Community tenure

Thank you



Patricia Wright, Director of LTSS

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Strengthening Long-Term Services & Supports Through Meaningful Consumer Engagement

ALICE DEMBNER
SENIOR POLICY ANALYST
LONG-TERM SERVICES & SUPPORTS



National HCBS Conference
September 2014
Arlington, VA

About Community Catalyst



- Nonprofit health care advocacy organization
- Network of advocates in 40+ states
- Building advocacy infrastructure
- Leading broad-based issue campaigns

Why Engage Consumers?

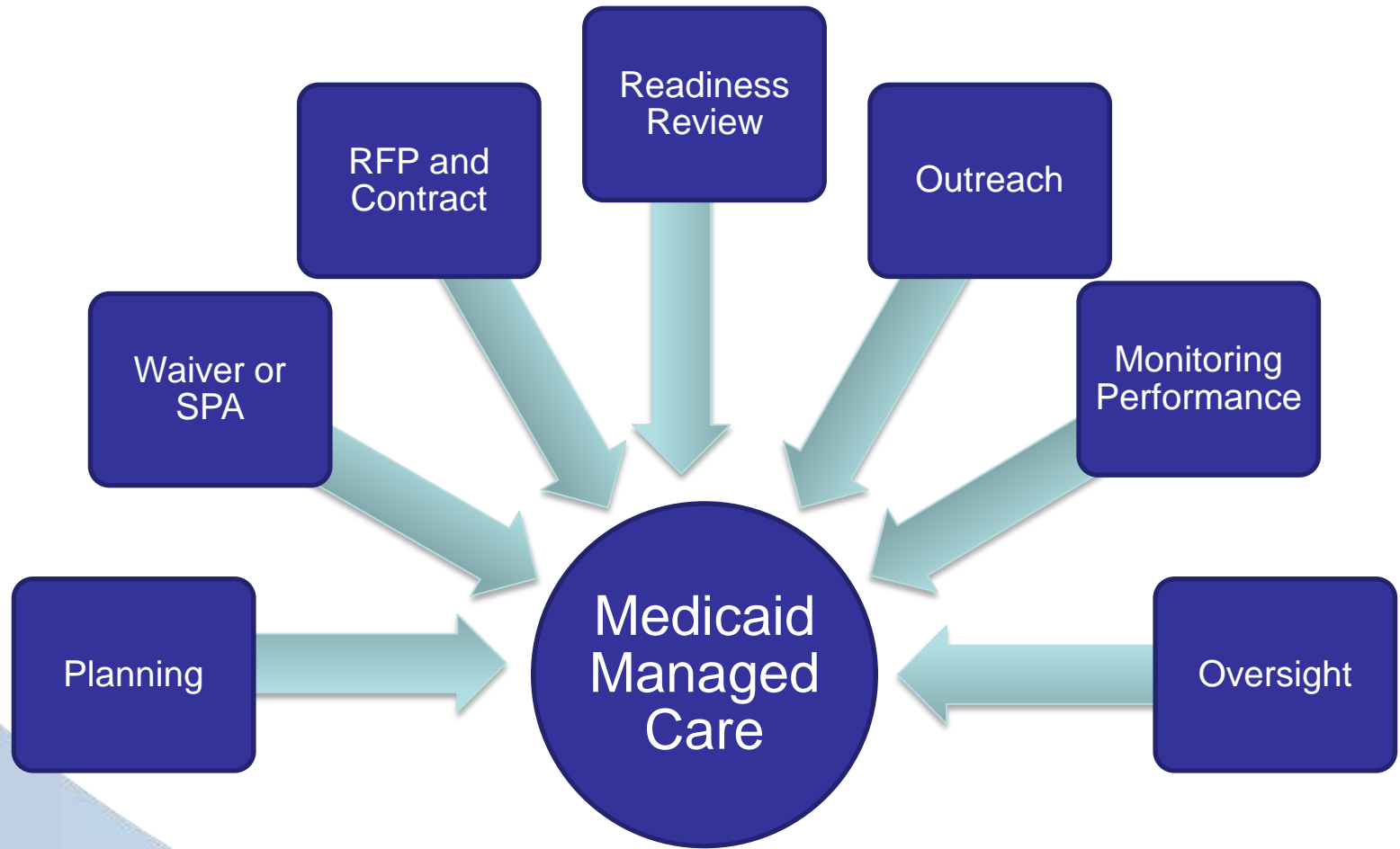
- **Consumers offer first-hand knowledge**
- **Identify and meet needs**
- **Resolve problems early**
- **Potentially save money**
- **Required by CMS**
 - MLTSS guidance
 - Duals standards and conditions

State Consumer Advisory Council

- **Joint outreach to consumers**
 - State to use consumer produced fact sheet
- **Joint problem-solving on transportation issues**
 - Sharing real examples and solutions

BEST PRACTICES

Create an Engagement Plan



Use a Ladder of Engagement



Surveys,
evaluations



Town hall
meetings,
focus
groups



Oversight
boards,
workgroups

Remove Barriers

- Ensure accessibility, culturally and linguistic competence
- Offer supports to facilitate participation
 - Transportation
 - Interpreters
 - Compensation
 - Training
- Measure and improve effectiveness through quality improvement process

Resources

- Consumer Engagement Toolkit

<http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement>

- Strengthening LTSS Tool

<http://www.communitycatalyst.org/resources/tools/mmltss>

- Alice Dembner, William Dean

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COORDINATED CARE ALLIANCE

Building the Plane While It's Flying

A decorative graphic consisting of several parallel white lines of varying lengths, slanted diagonally from the bottom left towards the top right, set against a blue gradient background.

Organization that is comprised of 29 community based organizations that serve seniors and people with disabilities across the State of Illinois

- ▶ Created and incorporated in 1999 to act as the “bridge ” between Managed Care Organizations and our community based partners to insure that **quality services** are provided to persons in need in a comprehensive, coordinated, efficient and effective manner.

COORDINATED CARE ALLIANCE

The members of the Coordinated Care Alliance, through collaboration with managed care, health care and direct service organizations, provide efficient and effective coordination of quality services that enhance the health and welfare of vulnerable populations.

MISSION STATEMENT

THROUGH OUR MEMBERS, CCA OFFERS THE FOLLOWING SERVICES:

- ▶ Comprehensive Assessments & Reassessments
 - ▶ Care Planning
 - ▶ Care Coordination
 - ▶ Monitoring and Problem Solving
 - ▶ Case Management
 - ▶ Community Based Resource & Referral Networks
- 

BUILDING THE PLANE WHILE WE'RE FLYING



CHALLENGES



INTERNAL:

29 ORGANIZATIONS

CONSISTENCY

TRAINING

DECISION MAKING

DATA/INFORMATION EXCHANGE

QUALITY CONTROL/ASSURANCE



EXTERNAL

4 PARTNERS

CONSISTENCY (RATES & SERVICES)

TRAINING

DECISION MAKING


DATA/INFORMATION EXCHANGE

QUALITY CONTROL/ASSURANCE

COMMUNICATIONS



SUCCESS TO DATE

- Survived and Thrived since 1999
 - Proudly Partnered with:
 - Blue Cross Blue Shield
 - CCAI
 - Meridian Health Plan
 - Molina
 - One contract Pending
- 



QUESTIONS?





Managed Care and AAA Transformation: The Texas Experience

Doni Green, North Central Texas Council of Governments



Network Challenges: Funding

- Minimal state funding
- Overwhelming reliance on flat federal funding, coupled with dramatic population growth
- Responsibilities for administration and direct services, with small staffing complements



Network Challenges: Doggone Independence

- Predominance of output data, with patchwork of inconsistently gathered/reported outcome data
- Differences in service mix, performance history, and willingness to change



Managed Care: A Vast and Changing Landscape

- Went statewide 9/1/14, covering more than 5M Texans
- Carved in acute care for adults with intellectual/developmental disabilities 9/1/14; will gradually carve in LTSS
- Will implement duals demonstration in most populous counties 3/1/15
- Will carve in nursing facilities 3/1/15




Saddling Up

- Applied to the ACL in 2013 for Targeted Technical Assistance to Build Capacity to Contract with Managed Care Organizations
- One of nine projects chosen to participate in learning collaborative



Building our Network

- State Unit on Aging (1)
- Area Agencies on Aging (23)
- Aging and Disability Resource Centers (3)
- Local Authorities for Intellectual and Developmental Disabilities (13)
- Local Authorities for Mental Health



Developing our Menu of Services (1)

- HomeMeds
- Care Transitions
- Matter of Balance
- Chronic Disease Self-Management
- Diabetes Self-Management
- Stress-Busting for Family Caregivers
- Benefits Counseling
- Nursing Home Relocation



Developing our Menu of Services (2)

- Nutrition Education
- Care Consultation
- Caregiver Support Consultation
- Demand-Response Transportation



Developing our Brand

“Texas Healthy at Home”

- Wellness, broadly defined, including physical and behavioral health
- Community-based focus

Knowing Region and Trends that Affect Plans (1)

- 53% of emergency department visits in STAR+PLUS potentially preventable
- Overall STAR+PLUS ratings 4x > than national rates
 - Diabetes complications (573%)
 - Uncontrolled diabetes (552%)
 - Diabetes long-term complications (483%)
 - Lower extremity amputation (363%)



Knowing Region and Trends that Affect Plans (2)

- Readmission rates among Medicare patients highest post-discharge to nursing home (22.7%), v. discharge to home (19.3%)
- Mental health and substance abuse account for 8.5% of initial admissions but 25.8% of potentially preventable readmissions



Defining our Target Audiences

- Providers of Medicaid waiver services for older/disabled Texans
- Duals Demonstration providers
- Medicare Advantage Plans
- Medicare Part D Plans



Determining MCOs' Interests

Interests on continuum, from highly clinical to unskilled but labor-intensive

- Evidence-based programs
- Members whose costs near cost cap
- Behavioral health
- Cell phones
- Home visits



Addressing MCOs' Points of Pain ⁽¹⁾

- Reduce potentially preventable inpatient admissions
- Reduce potentially preventable emergency department (ED) visits
- Reduce potentially preventable readmissions (PPRs)
- Reduce nursing facility admission rates

Addressing MCOs' Points of Pain (2)

- Carve-in of nursing facilities
- More rigorous service coordination standards
 - Nursing facility residents must receive quarterly face-to-face visits annually
 - Waiver participants must receive minimum of two face-to-face visits annually
 - Members with substance abuse/behavioral health issues must receive one face-to-face visit annually



Addressing MCOs' Points of Pain (3)

- Lack of real-time claim data



Our Value Proposition in “AAA-speak”

- Evidence-based programs that reduce cost of care/need for higher level of care
- Trusted and visible source of “boots on the ground,” with ability to assess members face-to-face, provide consults, support caregivers, and connect members with non-Medicaid services

Our Value Proposition in “MCO-speak” (1)

Texas Healthy at Home Triple Aim:

1. Improve member’s experience of care
 - Increase tenure in home and community
 - Reduce preventable ED visits
2. Improve population health
 - Prevent avoidable admissions and readmissions
 - Decrease nursing facility admissions



Our Value Proposition in “MCO-speak” (2)

3. Reduce overall per-capita cost

- Help nursing home residents return to community



Undergoing a Culture Change

- Determining cost of services
- Quantifying benefits
- Assuming risk
- Enhancing focus on quality
- Increasing flexibility and responsiveness

Developing Administrative Capacity ⁽¹⁾

- Obtained Medicaid provider number
- Developing more sophisticated process for cost-modeling
- Developing organizational structure
 - Forming non-profit association
- Selecting Administrative Services Organization (ASO)
 - Adapting contracts, quality assurance procedures, and sanctions and penalties



Developing Administrative Capacity (2)

- Developing claims management system
- Choosing common information technology platform v. extracting data from disparate systems
 - No funds for IT development
 - Desire to avoid duplicate data entry
- Developing relationships with hospitals



Building Out our Network

- Conducted statewide training for Care Transitions
- Conducting two statewide trainings for HomeMeds
- Conducting statewide master training for Stanford Chronic Disease/Diabetes Self-Management
- Exploring feasibility of replicating INTERACT, now offered by two AAAs



Lessons Learned

- Build relationships with plans from top-down and bottom-up
- Learn what's important to plans
- Don't wait until everything is in place—it never will be!
- Educate network, and expect participation rates of less than 100%
- Engage consultants/mentors as you can
- Engage SuA



2014 NASUAD HCBS Conference MLTSS – a 360° View

September 15, 2014

Carol H. Steckel, MPH
Senior Director, Public Policy
WellCare Health Plans, Inc.

Disparities in Dental Access for MLTSS Consumers

Issues

- Medicaid covered benefits (for adults) ... or not...
- Fear
- Costs
- Move toward cosmetic dentistry in the dental profession
- Mid-level practitioners

Dental Benefits Under Medicaid

- Must **MINIMALLY** include:
 - Relief of pain and infections
 - Restoration of teeth
 - Maintenance of dental health

- **EPSDT**
 - All services that are medically necessary
 - States must develop dental periodicity schedule

Dental Benefits for CHIP

- CHIP Expansion programs must follow the Medicaid benefit rules
- Separate CHIP programs must provide dental coverage “necessary to prevent disease and promote oral health, restore oral structures to health and functions, and treat emergency conditions.” There are two choices for a state:
 - Providing dental coverage that meets the CHIP requirements or
 - Benchmark dental benefit package

How Big is the Problem?

In 2008, 4.6 million children did not obtain needed dental care because their families could not afford it

In 2011, there were approximately 33.3 million unserved individuals living in dental Health Professional Shortage Areas

In 2006, only 38% of retired individuals had dental coverage

CDC Study: over the past decade, dental caries (tooth decay) in children ages 2 to 5 have increased

A study about the oral health status of adults with Intellectual and developmental disabilities conducted in August, 2012 found:

- 87.8% of the dentate participants were reported to have caries experience
- 32.2% had untreated caries
- 80.3% were diagnosed with periodontitis
- 25% of the participants had only a limited ability to accept any dental intervention without the application of advanced behavior management techniques.

IOM Study: Improving Access

Conclusions:

1. Improving access to oral health care is a critical and necessary first step to improving oral health outcomes and reducing disparities.
2. The continued separation of oral health care from overall health care contributes to limited access to oral health care for many Americans.
3. Sources of financing for oral health care for vulnerable and underserved populations are limited and tenuous.
4. Improving access to oral health care will necessarily require multiple solutions that use an array of providers in a variety of settings.

Healthy People 2020

Oral Health Goal:

To prevent and control oral and craniofacial diseases, conditions, and injuries, and improve access to preventive services and dental care.

- Link between overall health and well-being and oral health
- Community water fluoridation
- School-based dental sealant programs (can prevent up to 60% of tooth decay in treated teeth)
- Socioeconomic factors such as education level, income, race and ethnicity impact access to oral health services
- Not all barriers are access issues, while limited access to needed dental services is an issue awareness of the need for care, especially for very young children is also an issue, fear, cost
- People with disabilities and other health conditions like diabetes are more likely to have poor oral health

WELLCARE ACTIVITIES TO IMPROVE ORAL HEALTH CARE



Get Your Annual Dental Checkup. Get Your Gift Card!

We want to make sure you receive (or your child receives) a yearly dental exam. This is for members between 1 and 21 years old. Get your (or your child's) exam before December 31, 2012. If you do, you will receive a \$10 gift card* to a retail store.



Getting your free gift card is easy.

- Call your (or your child's) dentist. Make the appointment for a checkup. There is no cost for this service.
- Follow through! Make sure that you go (or your child goes) to the appointment.
- Complete **PART 1** on the back page.
- Have the dentist complete **PART 2**.
- Ask someone at the dentist's office to fax the completed form to WellCare of Kentucky. Our fax number is 1-877-709-1703.

When we receive the completed form, we'll mail your gift card within 60 days to the address you listed. Be sure to fill out every field – we can't send your gift card* until we receive all the information.

You (or your child) must be enrolled in the plan at the time of the service, as well as when the gift card is processed for mailing.

Oral health is important!

People of all ages need to have an annual dental visit. We encourage everyone 1 year of age and older to have this preventive care visit. A dental exam has many parts. During the exam, the dentist will examine your mouth, check for abnormal conditions, and clean your teeth.

Need help making an appointment?

If you do not (or your child does not) have a dentist, or you need help making an appointment, contact Customer Service. The toll-free number is 1-877-389-9457 (TTY/TDD: 1-877-247-6272). Call Monday–Friday, 7 a.m. to 7 p.m. Eastern.

Para solicitar este documento en español o para escuchar la traducción llame al Servicio al Cliente al 1-877-389-9457 (TTY/TDD: 1-877-247-6272).



WellCare Initiatives

Georgia

- Implementing Dental Home program
- Dental Vans

Illinois

- Dental services just carved back into managed care on 7/1/2014

Florida (and 14 other states)

- Enhanced benefits include assistance in selecting dental providers who will coordinate with members' primary care physicians
- a newly developed smart phone application to help members easily access benefit information and customer service support

DentaQuest

Incorporating Dental Benefits in Medicaid and Medicare Managed Care Plan Designs

Joe Vesowate

DentaQuest Regional Vice President

September 15, 2014



Stop Me if You've Heard This One

- Budget Writers and Policy Makers Need to Be Sold on Expanded Benefits – What's the “IRR?”
- Care Integration is Key to Good Program Management
 - Physical, Mental, Dental
 - Case Management...**Care Coordination**...**Service Coordination**...Service Management...Targeted Case Management...**Integrated Care Model**...**Primary Care Case Management**
- The “Iron Triangle” of Access, Cost and Quality – How Much of A Balancing Act?



- States ***must*** provide medically necessary services for children
- Adult benefit levels vary a good bit:
 - 12 provide extensive benefits
 - 20 offer limited benefits
 - 16 offer emergency benefits
 - 3 offer no benefits
- States increasingly turn to Managed Care as a “fix” for administrative, access and cost problems
 - Expertise, cost/risk management, flexibility



Adult Medicaid

TARGET

At least 30 states have a comprehensive Medicaid adult dental benefit

ORAL HEALTH FOR ALL 2020

PRIMARY

SECONDARY

Effective strategies/roadmaps (replicating success in other states)

- Resources to harness ACA to expand Medicaid adult dental coverage
- Resources to implement an incremental approach/moving along the continuum

Effective program administration

- Cost-effective administration
- Provider/care access network

National strategy

- National advocacy group engagement and support
- Ongoing monitoring of state-by-state status on coverage-level continuum
- Congressional champions and leadership

Financing mechanism

- Successful efforts in other states (general fund or targeted financing mechanism)
- Payer engagement and support

State-based legislative champions and leadership

- Awareness/education/resource campaign
- Advocacy to support leaders who champion issue
- Lobbying capacity

Advocacy community engagement and leadership

- Provider engagement and support
- Consumer engagement and support

Medicaid Examples

California – Adult services expanded in 2014

Colorado – Adult benefits added in 2014; ASO contract to oversee dental services

Idaho – Restored comprehensive benefits for adults with special needs and other specific populations in 2014

Illinois – Recent legislation restores adult dental benefits

Massachusetts – Restored dentures for adults, effective 2015

Missouri – Limited benefits for adults, effective 2015

South Carolina – Restored emergency adult benefits in 2015



Medicare Landscape

- Many older Americans enter their retirement years with good oral health due to a lifetime of employer-sponsored dental benefits.
- Traditional Medicare only provides coverage for limited hospital-based oral surgeries required in conjunction with other treatments.
- Older adults who did not have access to employer-based coverage find themselves in later life with oral healthcare needs and no means of financing that care.
 - Almost 70 percent of Americans age 65 and older do not have dental coverage.





- The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) serves people enrolled in both Medicare and Medicaid (dual-eligibles).
- Established by the ACA
- The goal is to make sure Medicare-Medicaid enrollees have full access to seamless, high quality health care and to make the system as cost-effective as possible.
- They partner with States to develop new care models and improve the way Medicare-Medicaid enrollees receive health care.

CMS Website: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html>



- Benefit Design – What are your goals and how do they fit together?
 - Cost, Quality, Access – achievable through strong contract requirements
 - Network Adequacy requirements – e.g., distance, open panels
 - Outcomes – Texas uses an “at-risk” model to make MCOs and DMOs accountable for quality; other states do similar things
 - Cost – MLRs, administrative cost caps; risk sharing
- Carve-in, carve out – where do you want control to reside?
 - Behavioral Health is the most often cited example, but oral health is emerging in the conversation
 - “Trust, but verify”
- ASO or Risk? What are the trade offs in terms of control and outcomes?
 - Depends on who you ask. States vary in terms of how they want it done.



Comment on The “Iron Triangle”

Emergent thought: Access is fairly constant and the “iron trade off” is cost for quality until bundled payments combined with an ethos of shared responsibility for quality are universal.

“...I would say the key is not single-payer per se but population-based budgeting together with universal access, and a shared ethos to improve quality within budgetary frames that give the lie to the so-called iron triangle...the Iron Triangle is an American myth for lazy and unobservant policy leaders.”

Excerpted from: “Universal health care and the Iron Triangle myth of U.S. policy makers” by

Donald W. Light, Ph.D., Professor, UMDNJ-SOM

Visiting Researcher, Center for Migration & Development, Princeton University, Resident Fellow, Edmond J. Safra Center for Ethics, Harvard University, Senior Fellow, Center for Bioethics, University of Pennsylvania



Important to Know When Designing an Oral Health Program:

- More likely to have poor oral hygiene, periodontal disease and untreated dental caries
- Can be more difficult to provide daily care and treatment – issues are complex
- Caregivers and family members are vital in supporting oral health
- Scarcity of providers to serve the population may create access problems
- Federal reports call attention to lack of comprehensive health status data

Suggested reading: *The oral health status of 4,732 adults with intellectual and developmental disabilities*”

JADA, 2012, 143(8):838-846; 10.142/jada.archive.2012.0288



Discussion

For More Information:

- <https://www.DentaQuestFoundation.org>
- <https://www.dentaquestinstitute.org>

Or Contact me:

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