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Dual Eligible Market Opportunities, Challenges, and Solutions

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National Dual Eligibles Summit

Los Angeles, California

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Dual Eligible Overview

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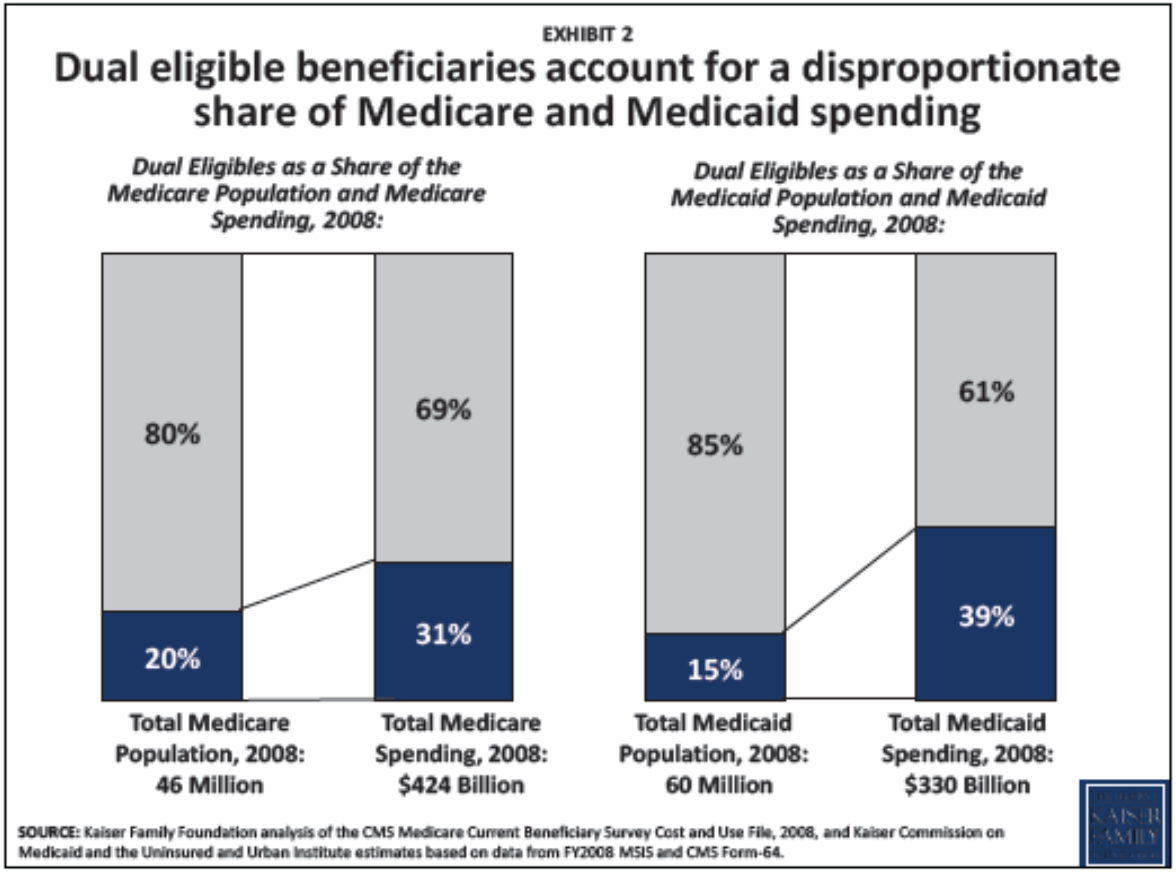
Population Overview

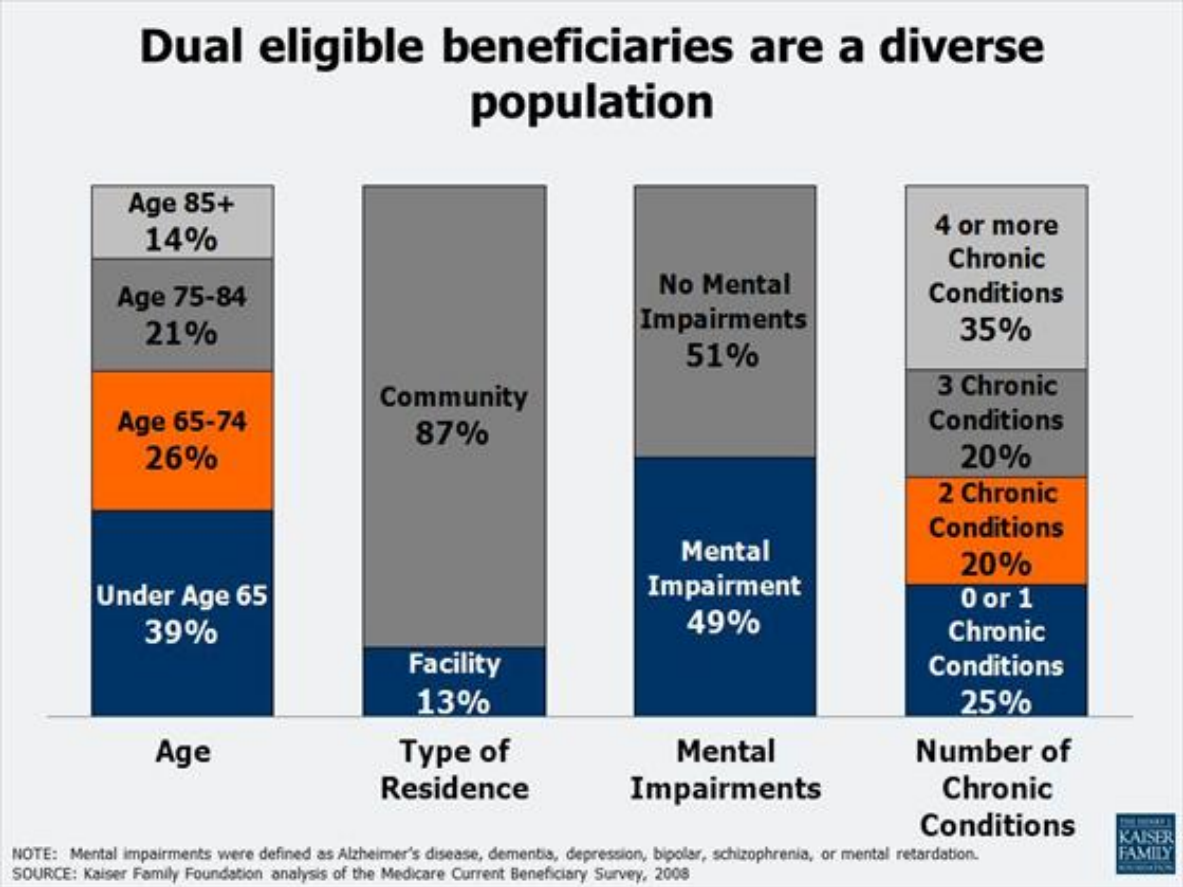
- Dual eligibles qualify separately for Medicare and Medicaid and receive benefits under both
  - Nearly 9 million individuals in the U.S.
  - Medicare is primary source of health insurance; Medicaid supplements
- **Greater health needs** and **higher utilization** than other Medicare or Medicaid beneficiaries



Source: Kaiser Family Foundation.

Population Overview

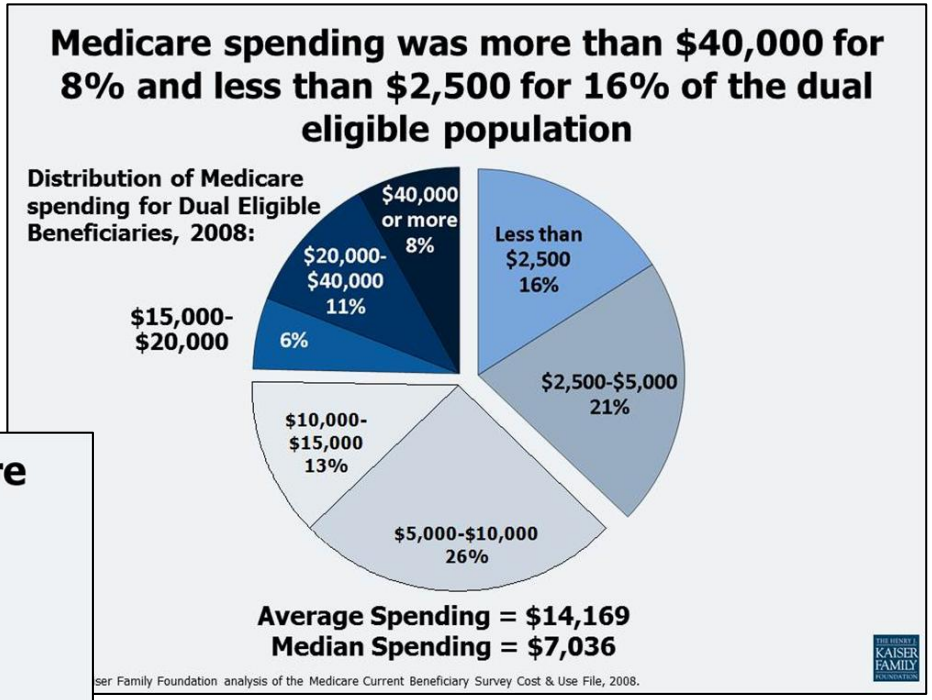
- Dual eligibles have a different demographic profile than other Medicare or Medicaid beneficiaries
- Four in ten are under 65 with permanent disabilities and 94 percent have less than 200 percent of the federal poverty limit

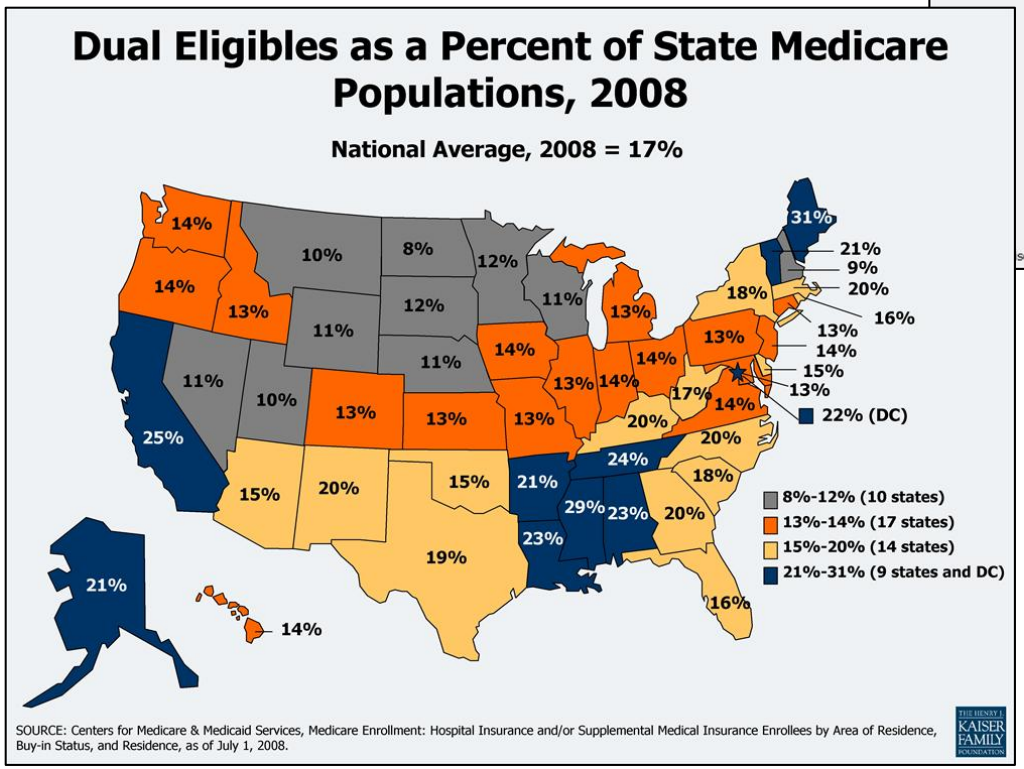


Source: Kaiser Family Foundation.

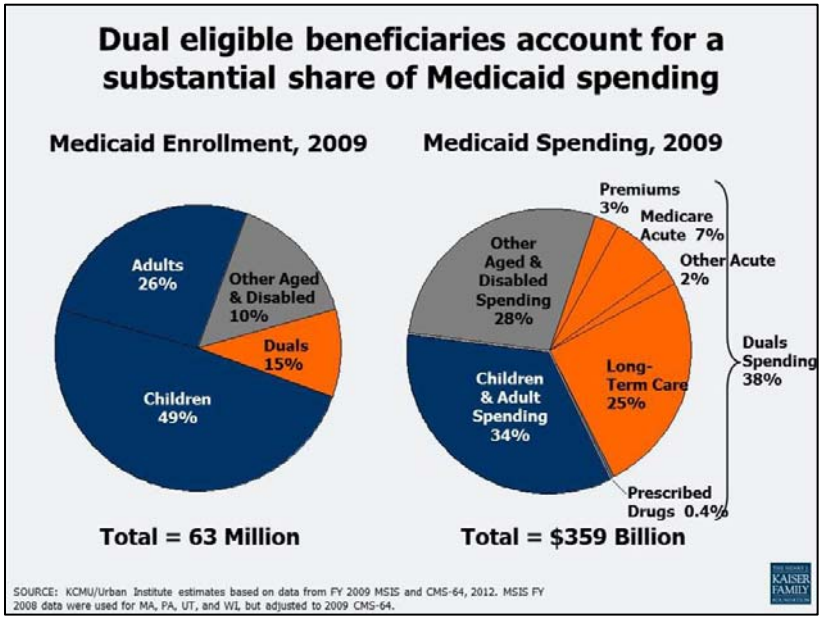
Dual Eligible Spending - Medicare

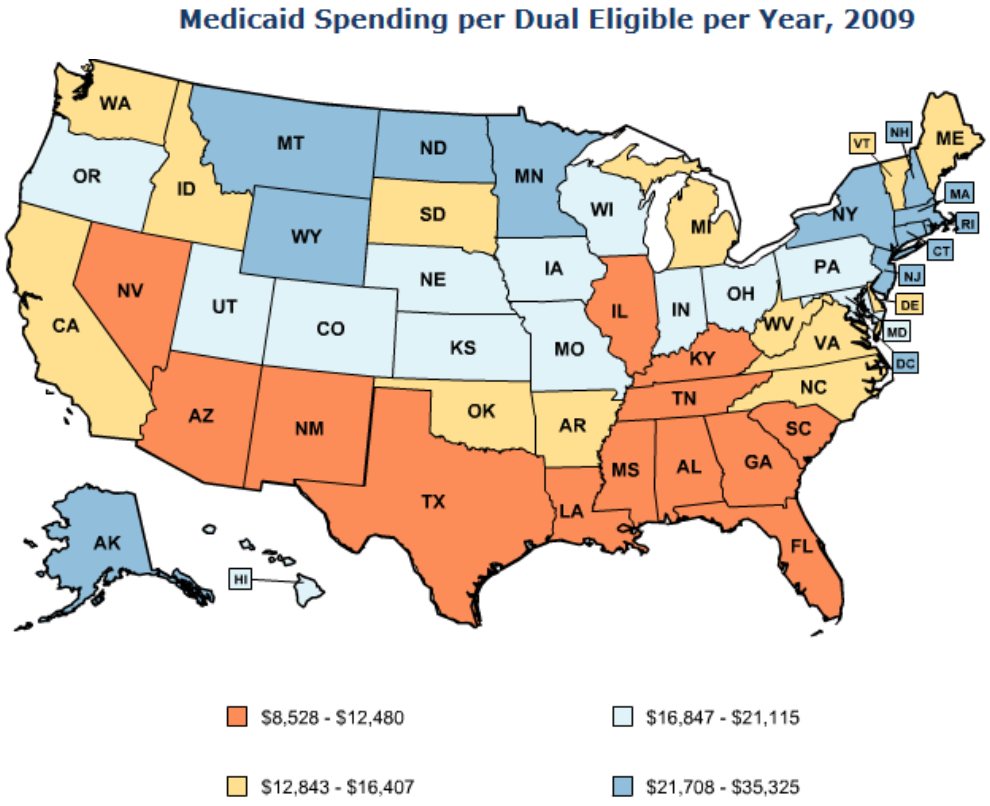
- In 2008, Medicare spending for dual eligibles averaged $14,169 per person – 1.8 times higher than spending for other Medicare beneficiaries, which averaged $7,933



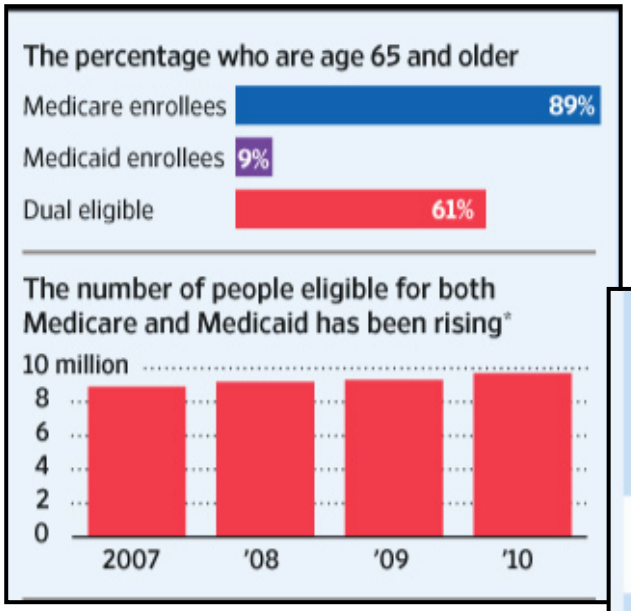


Dual Eligible Spending - Medicaid

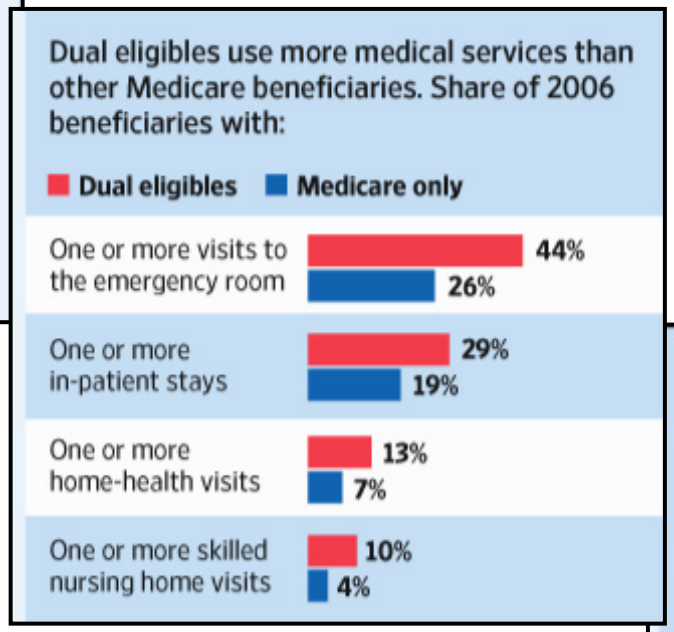


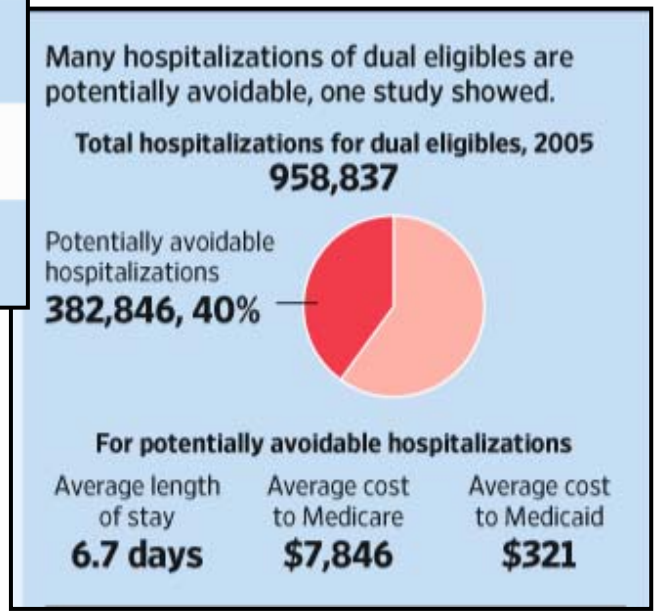


Profile of Dual Eligibles



- High utilization of expensive healthcare services
- Over 40 percent potentially avoidable inpatient hospitalizations





Source: Centers for Medicare and Medicaid Services; Kaiser Family Foundation

Who Are Dual Eligibles?

Mr. M

- 68 year-old non-English speaking Somali male
- Lives alone in federally subsidized apartment
- Family lives hours away and are not involved in his care
- No other Somali supports in community
- Multiple co-morbidities include:
  - Tuberculosis
  - Bulging vertebral disk
  - Unsteady gait
  - Severe post-traumatic stress disorder

Ms. F

- 75 year-old female
- Strong-willed; independent
- Multiple co-morbidities include:
  - Below-the-knee amputation
  - Peripheral vascular disease
  - Depression
  - History of alcohol abuse
- Recently transitioned back to community from nursing home
- Cannot perform daily tasks unassisted
- Difficulty obtaining sufficient

Ms. B

- 32 year-old female
- Suffers from schizophrenia
- Lives with elderly parents who have difficulty caring for her
- Multiple co-morbidities include:
  - Anxiety
  - Depression
  - Substance abuse
- Ends up in Medicare “donut hole” and cannot pay for medications

Source: CHCS: *From the Beneficiary Perspective: Core Elements to Guide Integrated Care for Dual Eligibles*.

Challenges with Serving Dual Eligible Population

- Wide range of conditions, circumstances, and healthcare needs
  - Coordination of care is difficult due to diverse population
- Medicaid and Medicare do not work well together due to different:
  - Benefits
  - Billing systems
  - Enrollment
  - Eligibility
  - Appeals procedures
  - Provider networks
- Financial misalignment causes huge barrier to care coordination
  - States have little incentive to improve care for this population (Medicare primary payer)
- Providers are challenged to understand how the different coverage's interact
- Data exchange between Medicaid and Medicare is poor
- Poor transition policies when Medicaid beneficiaries become eligible for Medicare
- Gaps in coverage, even when fully utilizing both programs
  - Example: No interpreter services covered when visiting specialist
- Payment methodologies need readjustment
  - Provider payments should be targeted to and appropriate for needed services
  - Example: Language services and skilled nursing care

Source: NSCLC: Medicare and Medicaid Alignment: Challenges and Opportunities for Serving Dual Eligibles.

Current State: Two Distinct Programs

- Existing service delivery models for dual Medicare and Medicaid beneficiaries are poorly integrated
  - Medicare benefits:
    - Traditional FFS
    - Medicare Advantage plans
    - Medicare Part D benefits
  - Medicaid benefits:
    - FFS arrangements
    - Medicaid managed care models
    - Waiver programs
    - Significant variance in delivery models among the states

Example of Fully Integrated Medicare/Medicaid program

- Program of All-inclusive Care for the Elderly ("PACE")
  - Integrates the financing and delivery of care for dual eligibles
  - Limited availability – 20,000 enrollees
  - Fully integrated benefits with capitated funding from Medicare and Medicaid
- Success in lowering inpatient days, nursing home stays, and costs

Source: Kaiser Family Foundation.

Medicaid and the Affordable Care Act and Medicaid Redesign

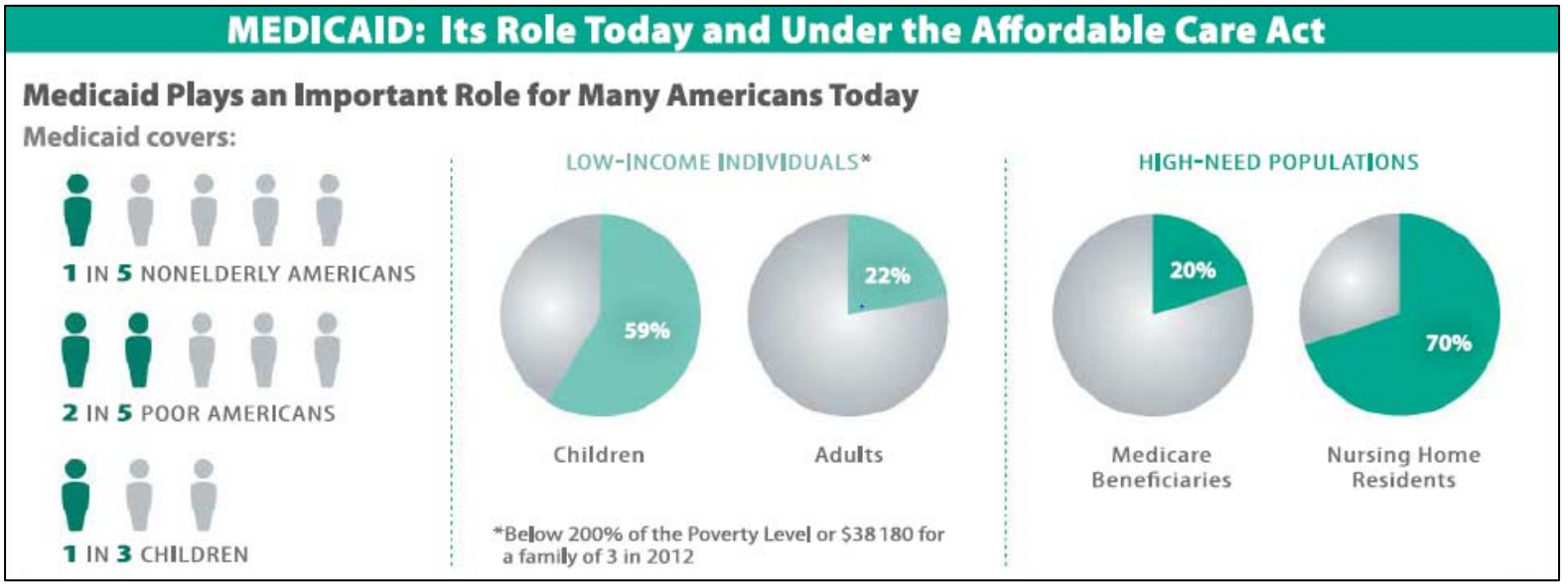
Patient Protection and Affordable Care Act ("PPACA")

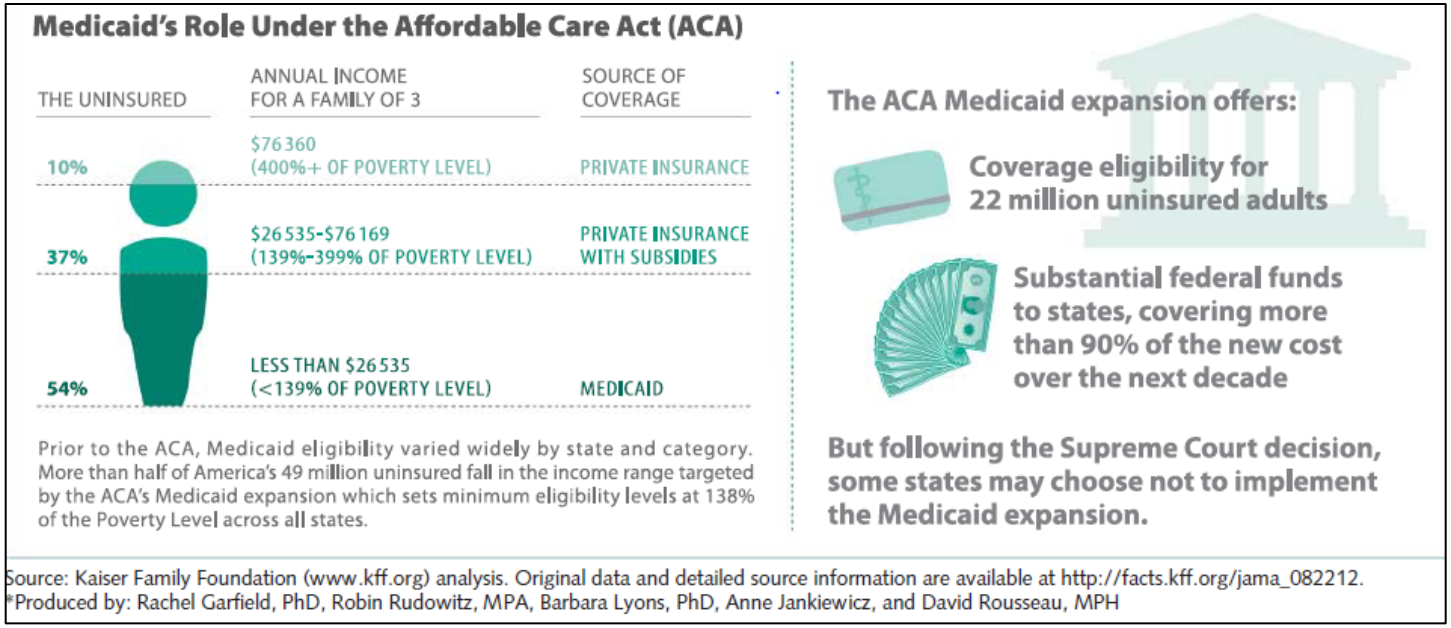
- On June 28, 2012, The Supreme Court ruled that states could not be coerced into Medicaid expansion
  - States may opt-in or opt-out of expansion
- Required expansion would have added approximately 17 million beneficiaries
- First three years funded 100 percent by federal funds
- Fifteen Governors have indicated they may not participate in Medicaid expansion, including:
  - Florida
  - Louisiana
  - Texas
  - Virginia
  - Nebraska
  - Iowa
  - Kansas
  - South Carolina
  - Wisconsin
  - Alabama
  - Georgia
  - Indiana

South Carolina Governor Nikki Haley was among the first state leaders to oppose Medicaid expansion after the U.S. Supreme Court decision.
Source: Chip Somodevilla/Getty Images

Source: HealthLeaders Media: "Medicaid Expansion Now in States' Hands"

Medicaid and the PPACA





Medicaid Redesign in New York

- Sweeping Medicaid reform in New York that began in fiscal year 2011-2012
- Medicaid and dual population: 5 Million
- Closely tied to implementation of the PPACA
  - One million New Yorkers accessing health insurance for the first time
  - Need for Medicaid Reform:
  - New York has the nation's largest Medicaid program
  - New York spends twice the national average of a per recipient basis
  - Medicaid is draining resources from other state budget priorities

Medicaid Redesign Team ("MRT") Two Phases

Phase 1:
Provided a blueprint for lowering Medicaid spending in state fiscal year 2011-12 by $2.2 billion.

Phase 2:
Developed a comprehensive multi-year action plan to fundamentally reform the Medicaid program.

Source: United Hospital Fund. "A Plan to Transform the Empire State's Medicaid Program." July 18, 2012

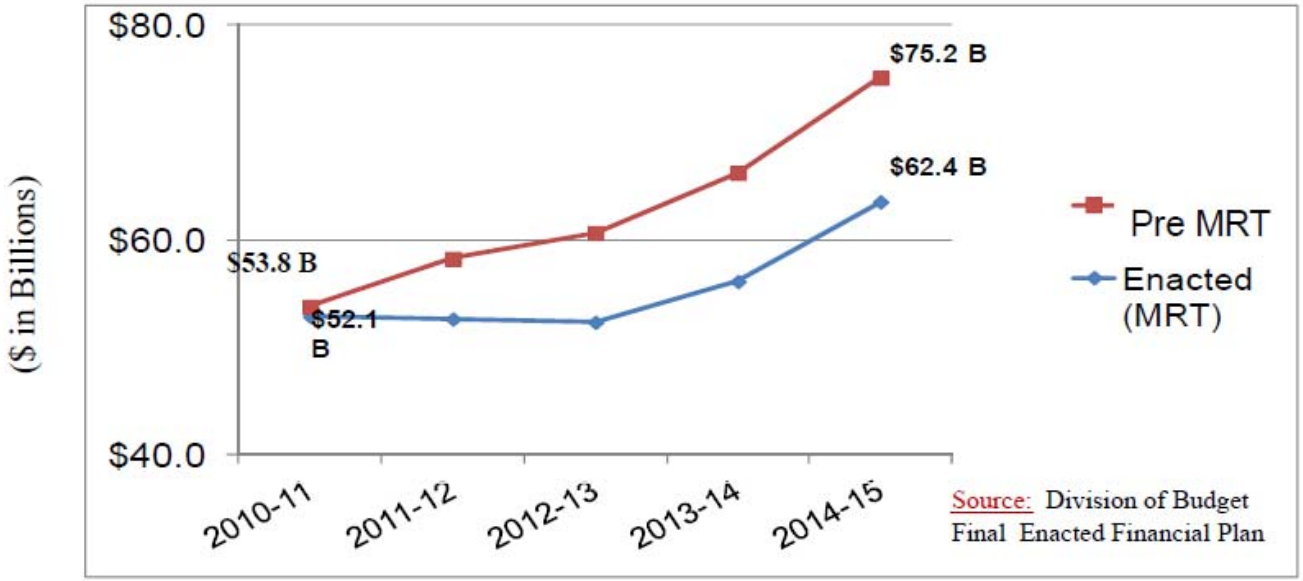
Medicaid Redesign in New York

- MRT implementation embraces the Centers for Medicare & Medicaid Services ("CMS") "triple aim"
  - **Improving Care**
    - Introduce care management and integrated care plans
    - Expand Patient Centered Medical Home program
    - Expand electronic health record
    - Implement behavioral healthcare delivery systems
  - **Improving Health**
    - Strategies to eliminate health disparities
    - Expand access to supportive housing
    - Redesign Medicaid benefit to improve health outcomes and lower costs
  - **Reducing Costs**
    - Global Medicaid spending cap
    - Strengthening the safety net
    - Payment reform to align incentives around value, not volume
    - Medical malpractice reform
    - Redefining state/local Medicaid roles

Source: United Hospital Fund. "A Plan to Transform the Empire State's Medicaid Program." July 18, 2012

Medicaid Redesign in New York – Cost Containment

- Year one state share savings target ($2.2 billion) was achieved
- Year one MRT savings for the federal government was enough to “flat line” the national growth rate in Medicaid
- Medicaid program spending held under global spending cap



State statute “bends the cost curve” by holding spending to Medical CPI (currently at 4%).

MRT (Phase 1) Saves the Medicaid Program IN TOTAL $34.3B ($17.1B Federal) Cumulatively over the Next Five Years

Source: United Hospital Fund. “A Plan to Transform the Empire State’s Medicaid Program.” July 18, 2012

Medicaid Redesign in New York – Year One Achievements

- One million additional Medicaid members (1.8 million in total) now accessing Primary Care Medical Homes
- 34 Health Homes have been established in 23 counties and 5,900 individuals have been assigned to Health Homes so far
- Approximately $3.9 billion was successfully transitioned from fee-for-service to managed care

Will full integration for duals have similar, positive results?

- Duals account for 15 percent of Medicaid beneficiaries
- Are responsible for 40 percent of Medicaid spending (share allocated to long-term care ("LTC"): 70 percent)

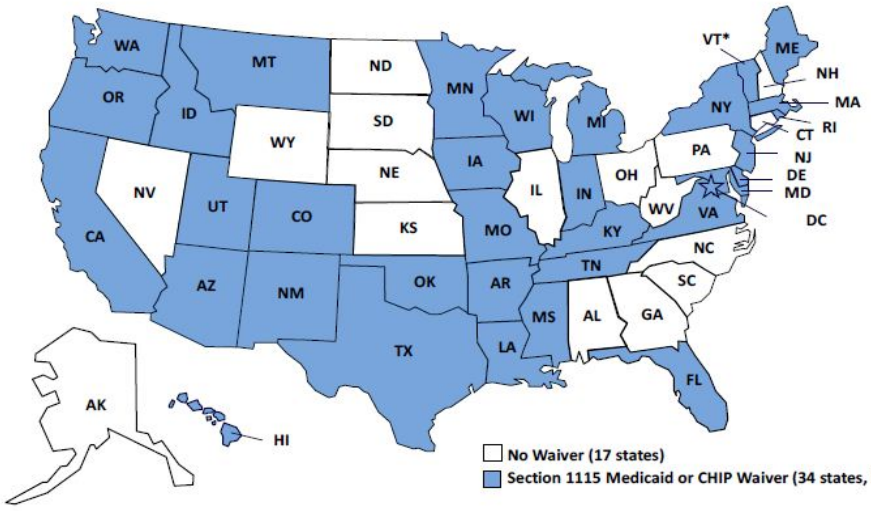
Source: United Hospital Fund. "A Plan to Transform the Empire State's Medicaid Program." July 18, 2012

Medicaid 1115 Waiver

- Section 1115 Medicaid demonstration waivers provide states ability to test new approaches to Medicaid
- 1115 Waiver activity has recently increased
  - Since enactment of PPACA, seven states have obtained Section 1115 waivers to expand Medicaid early
- Four states (California, Florida, Massachusetts, and Texas) make funds available to safety-net pool to cover uncompensated care costs
- Implications:
  - States are laying groundwork for reform
  - Will need strong state oversight and beneficiary protections in place
  - Share of Medicaid enrollees/expenditures under Section 1115 waiver will increase
  - Resource coordination is imperative due to concurrent reform and Section 1115 developments

Figure 1

States with a Section 1115 Medicaid or CHIP Demonstration Waiver, February 2012



Note: Map denotes states with at least one comprehensive Section 1115 Medicaid or CHIP demonstration waiver program in operation. It does not include more narrowly drawn Section 1115 waivers, such as family planning waivers.
Source: Centers for Medicare and Medicaid Services, "Section 1115 Demonstration List," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html, accessed May 7, 2012.

MetroHealth Section 1115 Waiver

- MetroHealth System and state of Ohio requested waiver to create program for low-income individuals not currently eligible for Medicaid
- Eligible patients would have benefits similar to Medicaid, but receive all services through MetroHealth network
- MetroHealth and community partners will provide medical services (including behavioral health)
- Unique waiver in that health system is heading the initiative
  - Could grant 20,000 uninsured adults the opportunity to go on Medicaid
  - Could gain a source of reimbursement for care that is now given for free
- Will help MetroHealth and state Medicaid prepare for 2014 (PPACA comes into play)
- Significant focus on proactive care and overall health outcomes

MetroHealth

Integrated Care for Dual Eligibles

Transforming Care for Dual Eligibles

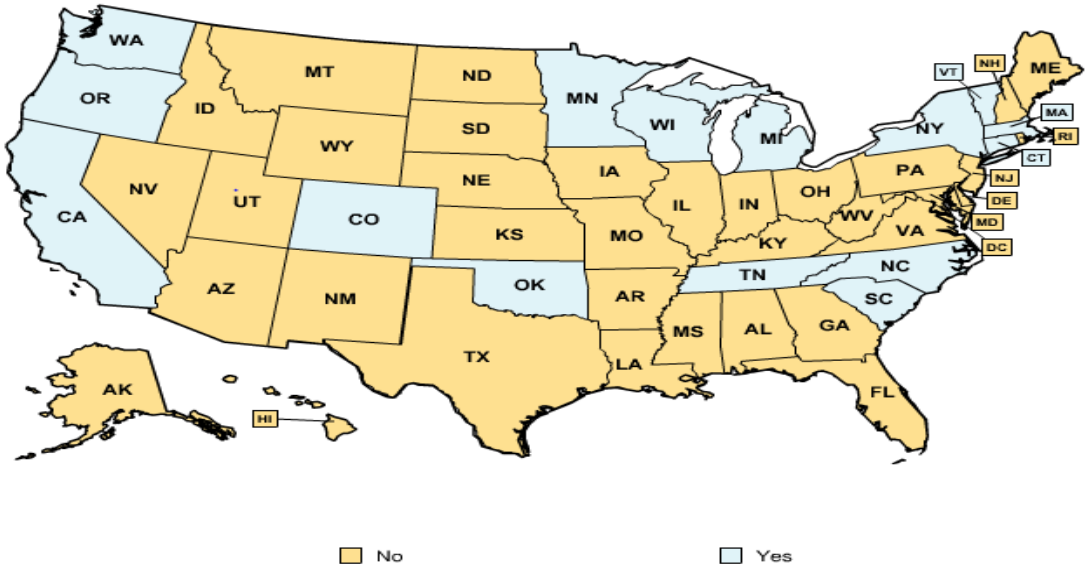
- Seven states participated in national initiative to develop integrated Medicare/Medicaid programs
  - May 2009 to December 2010
- Three overarching goals of program:
  - Improving care by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity
  - Improving health by addressing root causes of poor health
  - Reducing per-capita costs
- Nine core elements identified as essential for effective integrated care programs:
  - Comprehensive assessment to determine needs
  - Personalized (person-centered) plan of care
  - Multidisciplinary care team
  - Family caregiver involvement
  - Comprehensive provider network
  - Strong home and community-based options
  - Adequate consumer protections
  - Robust data-sharing and communications system
  - Financial incentives aligned with integrated, quality care

Source: CHCS: *From the Beneficiary Perspective: Core Elements to Guide Integrated Care for Dual Eligibles*.

Pilot Programs: Integrated Service Delivery Model

- National pilot project for dual-eligibles
- In April 2011, Center for Medicare and Medicaid Innovation ("CMMI") awarded contracts of up to $1 million for 15 states to develop models that integrate care for dual eligibles
- Medicare-Medicaid Coordination Office was created to improve integration of benefits for dual eligibles
- Seeks to identify the barriers to high quality, seamless, and cost-effective care

State Demonstrations to Integrate Care for Dual Eligible Individuals, 2011



Source: Kaiser Family Foundation. StateHealthFacts.org

Model Comparison

Significant Characteristics of CMS's Proposed Medicare-Medicaid Financial Alignment Models

	Capitated Model	Managed Fee-for-service Model
Parties	CMS, state, health plan	CMS, state
Entity responsible for care coordination	Health plan	State
Benefits Financing	Health plans receive prospective blended capitated rate from CMS and state	Providers reimbursed fee-for-service by CMS and state
Shared savings arrangements	CMS and state to share savings	State eligible for retrospective performance payment
Enrollment	Full duals. Passive enrollment permitted	Full duals. Passive enrollment not addressed
Quality evaluation	CMS and state to jointly select and monitor plans	State must meet specified quality threshold
Target Implementation	End 2012	End 2012

Source: Kaiser Family Foundation.

Proposed Service Delivery Models

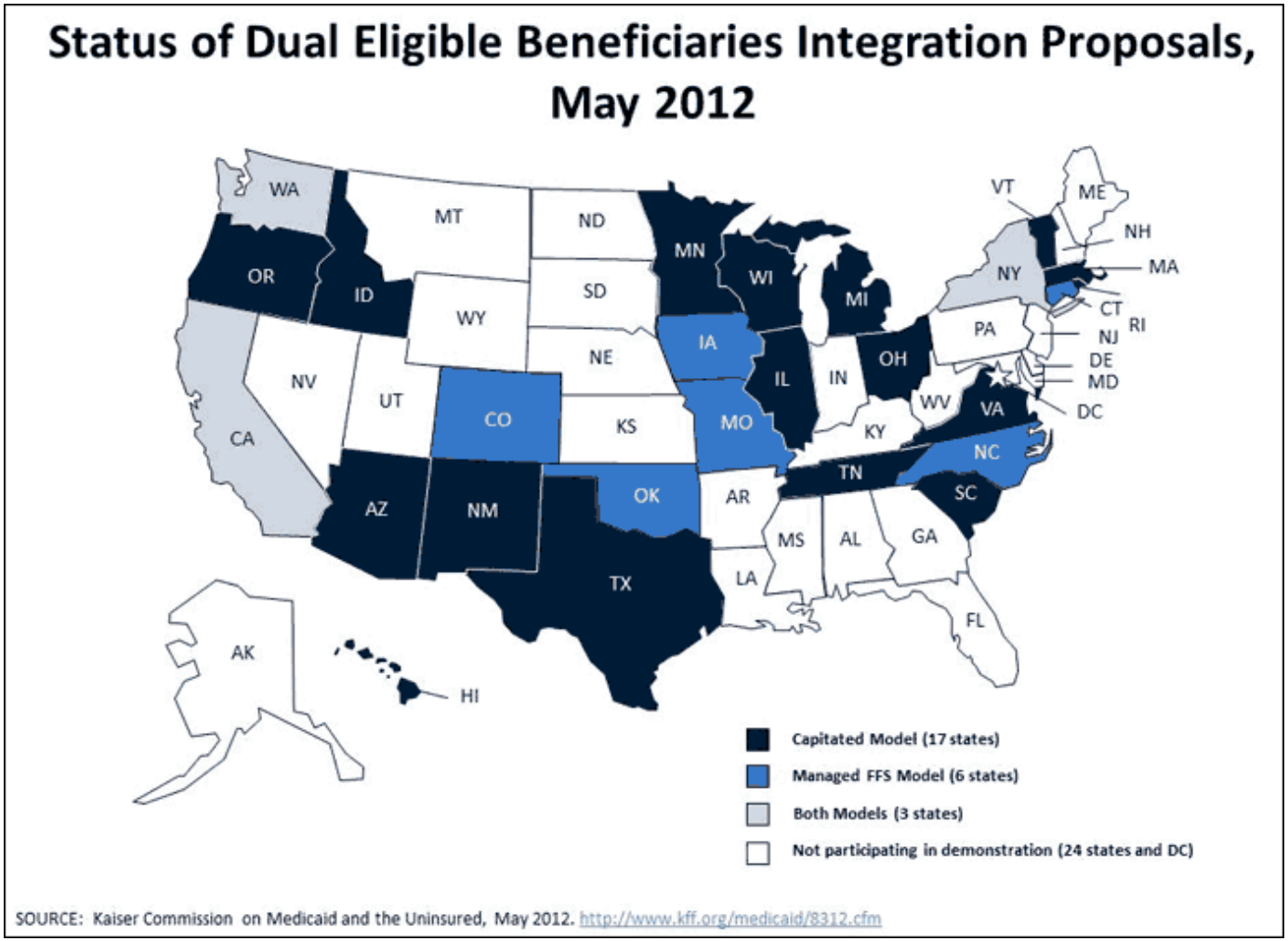
- State proposals included various forms of managed care, risk-based, and non-risk-based
- Wide variety across proposals
- Plans to retain existing PACE programs

15 Proposed Delivery Models	
Tennessee, Wisconsin	Contract with risk-based private managed care organizations (capitated payments)
California	Utilization of county managed care plans
Vermont	State Medicaid agency to become the managed care organization for dual eligibles
Colorado, Connecticut, North Carolina, Oregon, Oklahoma	Proposals which included accountable care organizations, integrated care networks, and/or primary care case management
Massachusetts	Managed care, direct provider networks, community health centers, medical ("MH") homes, acute hospital networks, ACOs
Michigan	MCOs, ACOs, SNPs, other capitated entities
Minnesota	Health homes, ACO/TCC, FFS
South Carolina	Health homes, MCOs or other risk-based entities
Washington	Managed care, FFS
New York	Will use the contract to determine the type of entity to be used to integrate care

Source: Kaiser Family Foundation.

Integrated Service Delivery Model Development

- Twenty-six proposed state demonstrations
  - Half planning to implement in 2013; others in 2014



Source: Kaiser Family Foundation.

Target Populations

- Some states proposed different or limited service delivery models for different geographic regions or for different subpopulations
- Target all duals (Connecticut, Michigan, North Carolina, Vermont) or all full benefit duals (California, Colorado, Minnesota, Oregon, Tennessee)
- Target populations varied across states
  - Massachusetts: focus on duals with disabilities ages 21 and 64
  - Washington: limit to full benefit duals who are needy aged, blind or disabled
  - Wisconsin: focus on duals who are elders or over 18 who require nursing home level of care
  - South Carolina: limit to duals with behavioral health diagnoses
  - Colorado, Massachusetts, Oklahoma, Oregon: included special emphasis on duals with mental health needs
  - Oklahoma: specific focus on higher risk/higher cost duals
  - States allowed to target duals in specific geographic areas so long as there is sufficient volume to evaluate the demonstration

Source: Kaiser Family Foundation.

Proposed Financial Arrangements

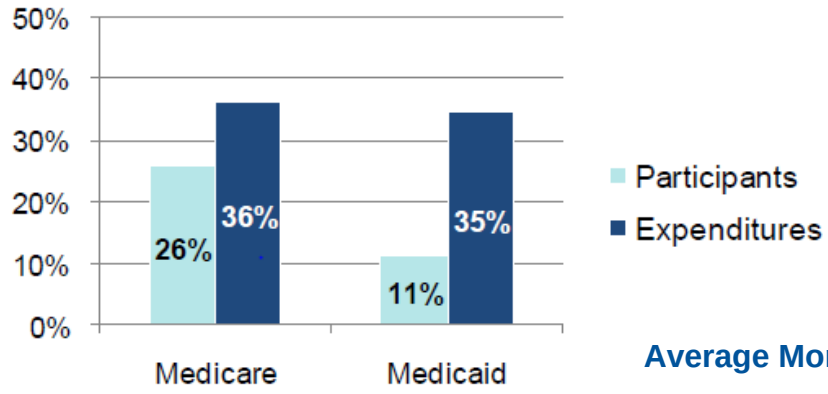
- Intended financial arrangements quite vague
- Medicare payments
  - None of the proposals were explicit in defining the level of Medicare payments per enrollee
- Shared savings
  - Several states acknowledged the potential to achieve savings
  - Most states did not address the extent to which savings would be shared with Medicare
- State Payments
  - Most states planned to use capitated methods to pay integrated care entities
  - Several states indicated an intention to share savings with managed care entities
  - Several states will use design stage to determine whether or how to share savings
  - Integration of Medicare/Medicaid funds
  - Few states indicated how they would integrate funds
  - Six states proposed combining funds at state level

Source: Kaiser Family Foundation.

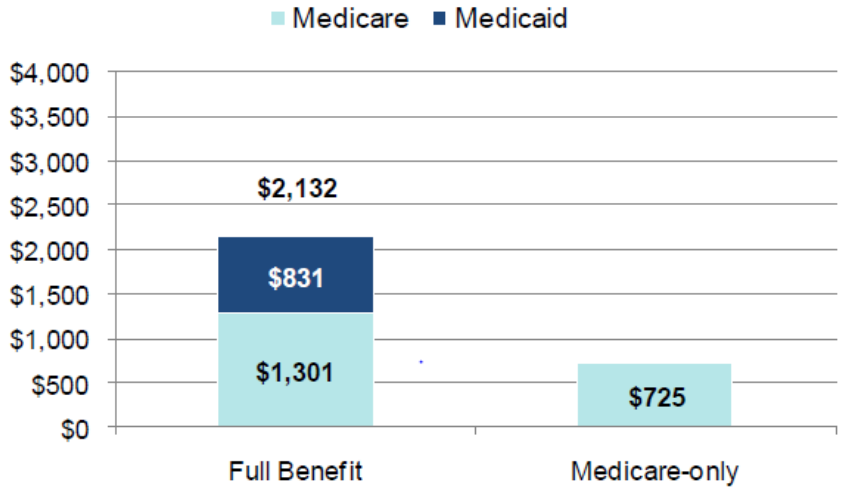
California Dual Eligible Profile

- 1,184,725 dual eligibles in California, 3 percent of state population
- Full benefit dual eligibles were nearly 3.5 times more likely than Medicare only beneficiaries to have had five or more chronic conditions

Medicare-Medicaid Enrollees as Share of Program Participants versus Share of Expenditures



Average Monthly Spending Per Person by Enrollment Status, 2007



Source: CMS: Medicare-Medicaid Enrollee State Profile: California.

California Dual Eligible Demonstration

- 1.1 million dual eligibles in California equals 13 percent of the nation's dual eligible population
  - 560,000 beneficiaries expected to participate
- Goal is to integrate behavioral health, social support, medical care, and long-term coverage
- Initial counties as participants in a three-year demonstration project:
  - Los Angeles
  - Orange
  - San Diego
  - San Mateo
  - Alameda
  - Riverside
  - San Bernardino
  - Santa Clara
- Will enroll portion of California's dual eligibles into integrated care delivery models
  - Official start date is June 2013
- Expected to save the state approximately $678.8 million in FY 2012 and $1 billion in FY 2013

Source: Becker's Hospital Review: *California Pick 4 Counties for Dual Eligible Demonstration,* April 9, 2012.

California Dual Eligible Demonstration

- Selected health plans will receive monthly payment from both Medicare and Medi-Cal
- Beneficiaries will have single health plan membership
- All eight plans currently operate Medicare Special Needs Plans and Medi-Cal managed care plans

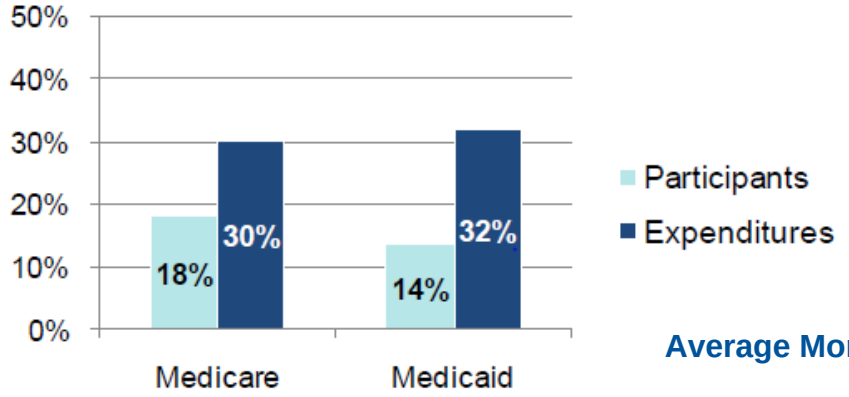
County	Plan
Los Angeles	L.A. Care Health Plan
	Health Net
Orange	CalOptima
San Diego	Care 1st
	Community Health Group
	Health Net
	Molina
San Mateo	Health Plan of San Mateo

Source: Becker's Hospital Review: *California Pick 4 Counties for Dual Eligible Demonstration,* April 9, 2012.

Illinois Dual Eligible Profile

- 332,415 dual eligibles in Illinois, 3 percent of state population
- Full benefit dual eligibles were over 2.5 times more likely than Medicare-only beneficiaries to have had five or more chronic conditions

Medicare-Medicaid Enrollees as Share of Program Participants versus Share of Expenditures



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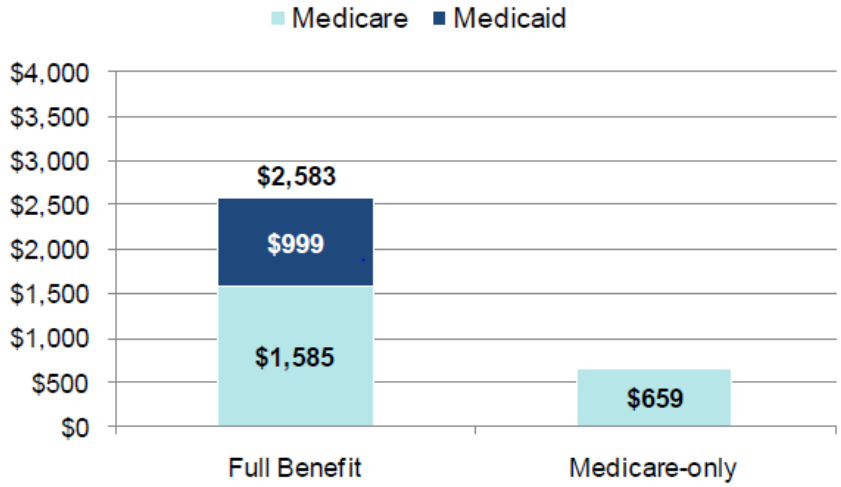


Source: CMS: Medicare-Medicaid Enrollee State Profile: Illinois.

Illinois Medicare-Medicaid Alignment Initiative

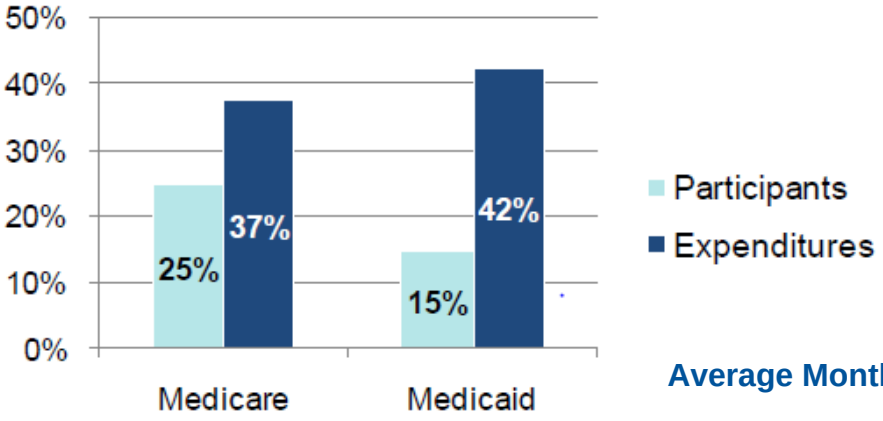
- Not selected as one of the fifteen demonstration projects by CMS
- Similar to Illinois' Integrated Care Program ("ICP") for seniors and adults with disabilities
  - Implemented 2011
  - Managed care program with a focus on provider collaboration and coordination of care
  - Proposed start date: January 1, 2013
  - Combine Medicare/Medicaid funding under capitation payment (eliminate cost-shifting incentives)
  - Target population: Full-benefit dual eligibles over the age of 21, excluding the spend down population
  - 172,000 beneficiaries eligible
  - Plans will serve Greater Chicago and/or Greater Illinois areas
  - Voluntary enrollment
  - Care delivery model anchored in a MH and personalized care teams
  - Expected Outcomes:
  - Increase in number of beneficiaries receiving coordinated care
  - Increase in health risk and behavioral health screenings
  - Increase in number of beneficiaries with care plans
  - Improved access to services
  - Reduced hospital admissions, emergency room ("ER") utilization, and non-emergency transportation costs
  - Improved beneficiary satisfaction

Source: Proposal: Illinois Medicare-Medicaid Alignment Initiative.

New York Dual Eligible Profile

- 738,736 dual eligibles in New York State, 4 percent of state population
- Full benefit dual eligibles were over 2.5 times more likely than Medicare-only beneficiaries to have had five or more chronic conditions

Medicare-Medicaid Enrollees as Share of Program Participants versus Share of Expenditures



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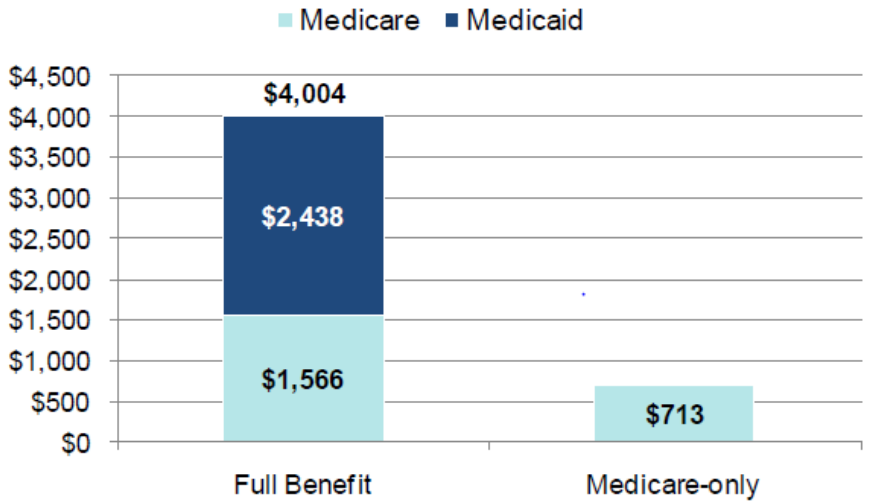


Source: CMS: Medicare-Medicaid Enrollee State Profile: New York.

New York State Demonstration Proposal

- Selected as one of the fifteen demonstration projects by CMS
- Primary goals of the program:
  - Reduce avoidable hospital/ER visits
  - Provide timely follow-up care
  - Reduce healthcare costs
  - Lessen reliance on long-term care facilities
  - Improve the experience and quality of care outcomes for the individual
  - Several coordinated approaches, involving the managed fee-for-service ("MFFS") and capitated models
  - MFFS: Integrated care through health homes to dual eligibles with two or more chronic conditions
  - Capitated approach: Fully-Integrated Dual Advantage ("FIDA") program provides comprehensive package of services to dual eligibles in eight New York counties
  - Includes those receiving services from the Office for People with Developmental Disabilities ("OPWDD")

Source: NYSDOH Demonstration Proposal to Integrate Care for Dual Eligible Individuals.

New York State Demonstration Proposal

	FIDA Managed Care	Health Home Program with Managed FFS
Target Population	■ Full dual-eligibles, age 21 and older, requiring community-based long-term care services for more than 120 days ■ Full dual eligibles , age 21 and older, receiving services from OPWDD	Full dual eligibles requiring 120 days or more of LTC services with: ■2 or more chronic conditions ■One chronic condition (HIV/AIDS) at risk of developing another ■One serious mental illness
Number of Beneficiaries Eligible for Demonstration	123,880 (+10,000 FIDA OPWDD)	126,582
Service Area	Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, and Westchester Counties FIDA OPWDD: Statewide	Statewide
Financing Model	Capitated Model	MFFS capitated model
Proposed Implementation Date	January 1, 2014	January 1, 2013

Source: NYSDOH Demonstration Proposal to Integrate Care for Dual Eligible Individuals.

Impact on Hospitals

- More than 25 percent of Medicare spending for dual eligibles is spent on inpatient services
- Dual eligibles use more acute services, including hospitalizations and ED visits, than other Medicare beneficiaries
- In California, dual eligibles make up 40 to 70 percent of Medicare inpatient discharges
- **RISK** that patients will be diverted to other providers due to managed care organizations

Implication

Hospitals with significant dual eligible populations must be selected as a preferred partner in the program. Otherwise, they will lose a significant amount of volume.

Dual Eligibles (Medicare/Medicaid)

What capabilities are you developing?

- Good assessment of each patient and development of an appropriate plan of care
- Care navigators who assist clients and their family or caregivers
- Reducing unnecessary hospital and nursing home costs
- Population management that will support your delivery system to thrive in new payment models
- Consider a build versus buy management approach
- Move from traditional “silo” to “service line” models of care
- Integration and coordination of the care within your health system
- Establish common performance measures that include cost, quality, and care coordination activities
- Crucial leadership is necessary to bring together the elements of successful care coordination programs

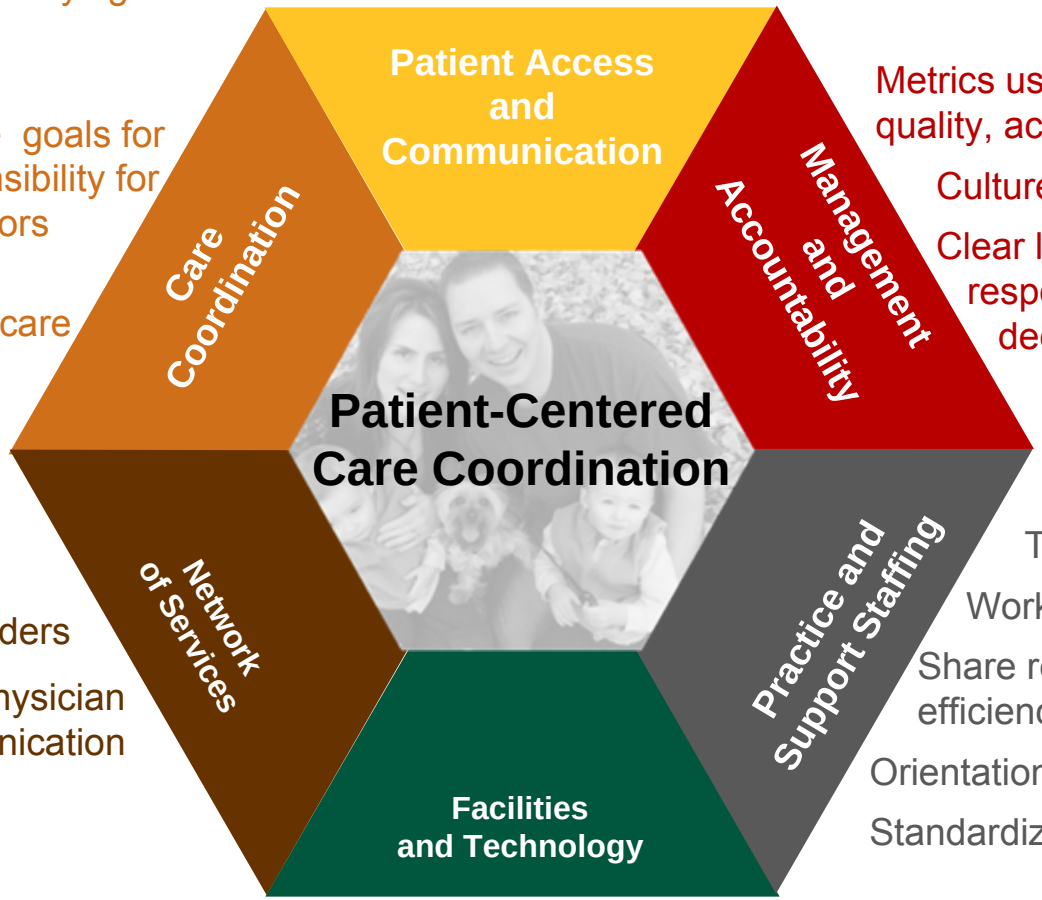
Implications and Priorities for Providers

- Partnerships with providers across the continuum of care
- Expand physician networks
- Identify potential relationships with health plans, pharmacies, LTC providers
- Various infrastructure enhancements:
  - Improve access to care (24-hour access)
  - Increase urgent care use for non-emergency health needs
  - Provide transportation to and from doctor's appointments
  - Increase the use of social services
  - Educate beneficiaries on health maintenance
  - Develop ambulatory care management
  - Improve data analytics and quality reporting

Coordinating Care for Dual Eligibles

Marge Mercury, RN, MS, CMCE, Senior Manager, The Camden Group

Guiding Principles for Patient-Centered Care Coordination



"When and how" based on patient preference and needs

Proactive in identifying patient needs

Ensure patients have goals for their care and responsibility for health related behaviors

Smooth transition of care processes

Metrics used to define performance: quality, access, efficiency

Culture of continuous improvement

Clear lines of authority/ responsibility and process for decision-making

Team orientation

Work to top of license

Share resources to maximize efficiency

Orientation and training

Standardized roles and work flows

Facilities support teamwork, and efficient work flow

Technology facilitates aims of care model

Aligned providers

Facilitate physician-physician communication

Source: The Camden Group

Clinical Profile

A Review

- **Dual eligibles use more** medical services (inpatient and outpatient hospital care, ER care, and skilled nursing care) than other Medicare enrollees because of their poor health and higher levels of health impairments
- **Dual eligibles over age 65**, are more likely to suffer from a chronic condition such as diabetes, heart disease, or Alzheimer's disease than other elders with Medicare coverage.
- **Dual eligibles under 65** years of age are more likely to have mental illness and mental retardation compared to other disabled individuals. This higher degree of impairment means that many dual eligibles need a more extensive range and different type of services than others with Medicare coverage.
- **24 percent** of dual eligibles need assistance with three or more activities of daily living—everyday tasks such as dressing, bathing, and toileting—compared to the six percent of other Medicare beneficiaries who need help with these tasks.[1]
- The **social and economic obstacles** faced by low-income patients, make it particularly difficult for vulnerable patients to navigate the complexities of the healthcare system. Care coordination is especially important for this population.

[1] Teresa Coughlin, Timothy Waidmann, and Molly O'Malley Watts, "Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries" (Washington: Kaiser Family Foundation, 2009), available at http://www.kff.org/medicaid/upload/7895-2.pdf).

Reforming Care Delivery

- The opportunity to integrate care across service settings offers great potential for improving the quality and cost-effectiveness of care for Dual Eligible population
  - Low-income seniors and younger disabled adults who are dually eligible for both the Medicare and Medicaid programs are among the most vulnerable patients in our healthcare system
  - Recognizing that these patients require intensive care coordination safety nets, health systems have begun operating innovative programs targeting the dual-eligible population
  - Medicare and Medicaid are each governed by their own policies and procedures, dual eligibles are forced to navigate a system with two sets of providers, benefits, and even enrollment cards
  - Coordination across Medicare and Medicaid has the potential to redirect resources from unnecessary hospital and nursing home use to better preventive and primary care as well as home and community-based long-term services and supports

Source: National Association of Public Hospitals and Health Systems

Existing Models

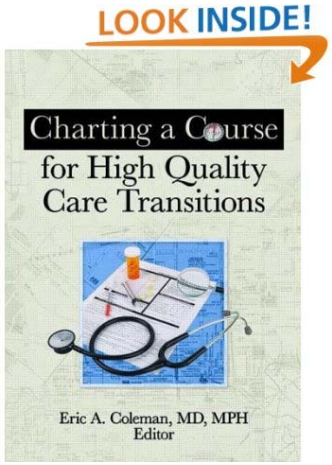
Care Coordination Models

- Eric Coleman's Care Transitions Program
- Mary Naylor's Transitional Care Model
- Better Outcomes for Older Adults through Safe Transitions ("Project BOOST") - Care Transitions
- Geriatric Resources for Assessment and Care of Elders ("GRACE") model (Counsell)
- Chad Boult's Guided Care Model
- Medicare Coordinated Care Demonstration

Care Transitions Program – Developed by Eric Coleman

Care Transitions Program

- Developed by Eric Coleman, professor of medicine; head of healthcare policy and research divisions at the University of Colorado
- Four week program with a transition coach to teach patients self management skills
  - Transition coach makes home visit and follow up phone call
  - Coordinates with primary care, specialist, community organizations, home health, and skilled facilities
- Care Transitions Interventions have shown a reduction of 30-day readmissions by 20 to 50 percent
- Model has been adopted by 750 organizations, 20 percent of which are hospitals



Source: www.caretransitions.org

Transitional Care Model Developed by Mary Naylor

Transitional Care Model

- Designed by Mary Naylor, professor of gerontology and director of NewCourtland Center for Transitions and Health, and colleagues at the University of Pennsylvania
- Targets older adults with two or more risk factors (hospitalizations, multiple chronic conditions or medications, and poor self-health ratings)
- Major objective of this model is to develop patient and caregiver knowledge, skills and access to resources that will prevent decline and re-hospitalization
- Critical to the model is a Care Coordinator as the Transitional Care Nurse ("TCN")
- TCN assesses patient in the hospital; visits within 24 to 48 hours of discharge and then once a week for the first month; followed by semi-monthly visits until discharge from the program
- Primary care provider receives a summary from TCN
- Model, which partners with Aetna and Kaiser, has cut readmissions by 28 percent within the first 24 weeks of the program and 13 percent within the year; per patient cost reduced 39 percent within the year after hospitalization.

Source: FierceHealthcare Daily Newsletter, September 26, 2012

Project Boost Developed by Society of Hospital Medicine ("SHM")

Project BOOST

- Led by national advisory board of recognized leaders in care transitions
- Emphasis is on key elements that help hospitals put interventions in place that reduce admissions:
  - Comprehensive intervention – identification of high risk patients on admission and target risk specific interventions
  - Comprehensive implementation guide – step by step instructions and tools
  - Longitudinal technical assistance - face-to-face training and year of expert mentoring
  - The BOOST collaboration – site communicate with and learn from each other
  - The BOOST data center – online resource center allows sites to store benchmark data
- Year long mentoring program providing expert coaching in place at 105 sites
- Early data from six sites reduced 14.2 percent readmission rate to 11.2
- Producing a 21 percent reduction in 30 day all-cause readmission rates

Source: Society of Hospital Medicine Website 2008

GRACE Program Developed by Steven Counsell

GRACE Program

- Is an integrated care model targeting low-income, dually eligible seniors with chronic conditions
- Steven Counsell, principal investigator of the GRACE clinical trial and Mary Elizabeth Mitchel, professor of geriatrics at the Indiana University School of Medicine
- In-home assessment and care management by nurse practitioner/social worker team in collaboration with the primary care physician
- Extensive use of specific care protocols for evaluation and management of common geriatric conditions
- Documentation in an integrated electronic medical record
- Use of a web-based care management tracking tool
- Integration with affiliated pharmacy, mental health, hospital, home health, and community-based services
- Conclusion – integrated home based geriatric care management resulted in improved quality of care and reduced acute care utilization among high risk group

Source: Indiana University "IU Home Pages March, 2011

Guided Care Model Developed by Chad Boult

Guided Care Model

- Designed to place a registered nurse in a primary care office
- Patients 65 years or older; whose scores are in the upper quartile of risk for using health services based on hierarchical condition category ("HCC") predictive model
- Guided Care Nurse ("GCN") performs eight clinical processes
  - Assessing the patient and primary caregiver at home
  - Creating an evidenced based care plan
  - Promoting patient self-management
  - Monitoring the patients condition monthly
  - Coaching the patient to practice healthy behaviors
  - Coordinating the patient's transitions between sites and providers of care
  - Educating and supporting the care giver
  - Facilitating access to community resources
- On average, results demonstrate 24 percent fewer hospital days; 37 percent fewer skilled nursing facility days; 15 percent fewer ER visits; 29 percent fewer home healthcare episodes and nine percent more specialist visits.

Source: (Am J Managed Care. 2009;15(8):555-559)

Medicare Coordinated Care Demonstration

- To examine whether coordinated care programs can improve medical treatment plans, decrease avoidable hospital admissions, and further benefit chronically ill beneficiaries without increasing program costs
- Program taught patients how to better adhere to self-care and medication regimens; and improving communication among physicians and between patients and physicians
- Findings: 13 of the 15 programs showed no significant differences in hospitalizations
- Viable care coordination programs without a **strong transitional care component are unlikely** to yield net Medicare savings

Transitional Care versus Care Coordination

Care Coordination

- Deliberate organization of patient care activities among two or more participants to facilitate the appropriate delivery of healthcare services
- Marshaling of personnel, and other resources, to carry out all required patient care activities
- Requires ongoing exchange of information among participants responsible for different aspects of care

Care Coordination By Health Stages

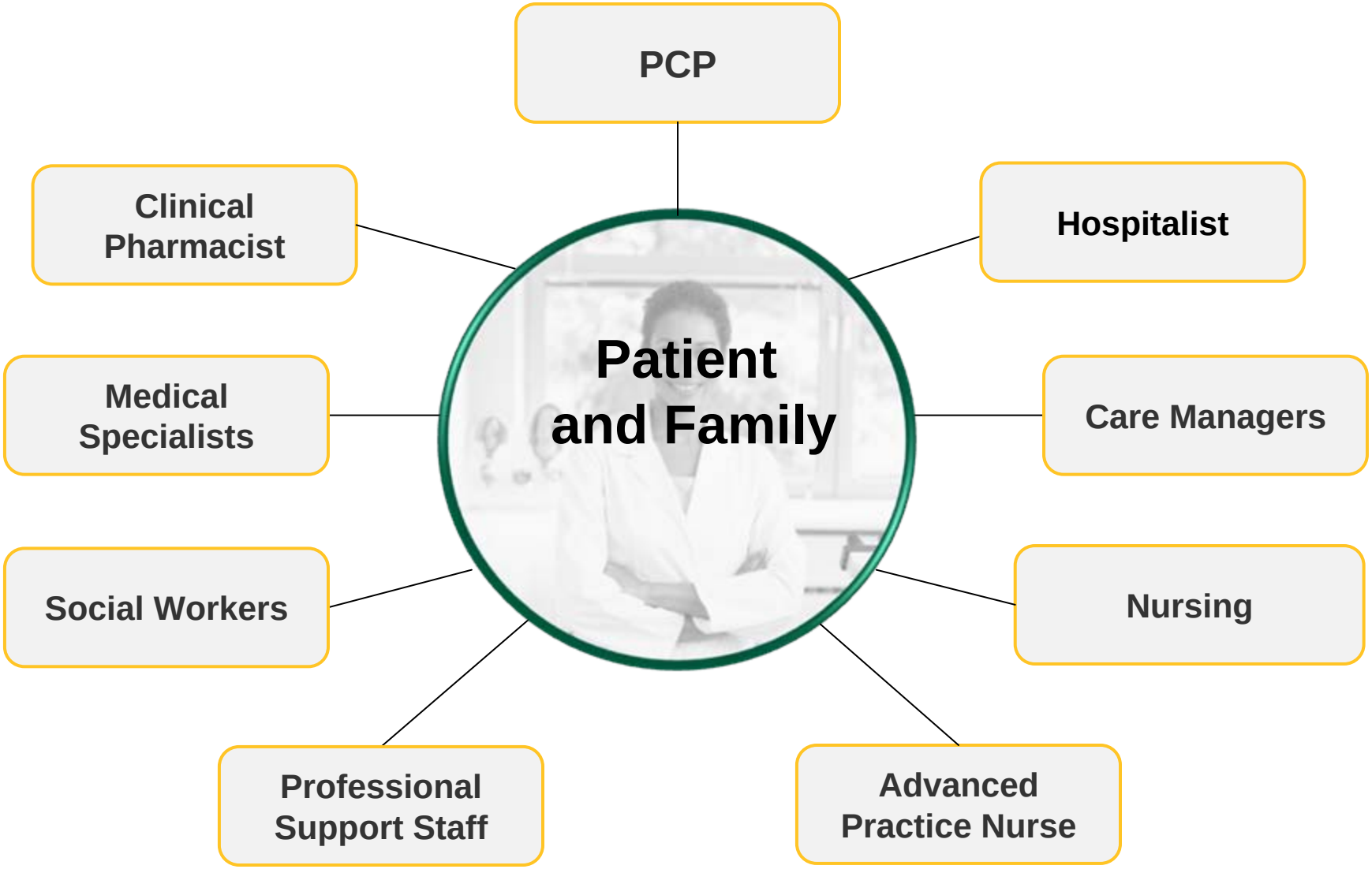
Preventive Care/Wellness Programs	Self-Management and Health Education	Complex Care and Disease Management	High-risk	Acute/ Catastrophic	End of Life
■ Define Plan of Car (“POC”), provide patient education, evaluate and monitor ■ Ambulatory EMR for documentation of care plan and goals ■ Primary Care Team (“PCT”) is responsible for patient care ■ Incorporate patient reminder technology	■ Assessment of the patient ■ PCT is responsible for patient care ■ Engage patient for health coaching and disease management ■ Define POC, with review and sign-off by the team ■ Access community services ■ Use of clinical protocols to follow	■ PCT is responsible for patient care ■ Care manager (“CM”) embedded in practice(s) patients ■ Revise and reinforce POC, provide patient education and monitor outcomes ■ Inpatient CM coordinates utilization and patient movement across the system ■ MH-CM arranges a post discharge office visit is scheduled for two to four days post discharge with the PCP – evaluate ■ Discharge office visit for patient education and medication reconciliation ■ Ambulatory EMR documentation of care plan and goals ■ Clinical protocols to follow	■ PCT is responsible ■ Specialty providers co-manage care ■ CM-Medical Assistant (“MA”) embedded ■ Define the POC, monitor outcomes with sign-off by the team ■ CM coordinate with post-acute and/or hospital clinics ■ Clinical protocols to follow	■ PCT is responsible ■ Advanced directives ■ Specialty providers co-manage care ■ CM-MA embedded in practice(s) ■ CM coordinate with the post-acute services (home health, hospice, and palliative care) ■ Clinical protocols to follow

Care Coordination Priority

Objectives

- Implement targeted care coordination services that will improve quality of care while containing costs.
  - Focus on the **"CURE"**:
    - **C**ost
    - **U**tilization
    - **R**isk Factors
    - **E**ducation
  - Establish care coordination screening
  - Newly enrolled to the organization
  - Patients with avoidable and/or high hospital admissions
  - Provider referrals
  - Polypharmarcy indicator
  - Data reports
  - Measuring the impact/effectiveness of care coordination requires consistent standards of documentation across all networks

The Interdisciplinary Care Team



The Interventions

Approaches That Impact

- Face-to-face contact with patients
  - Frequent face-to-face contact with patients (approximately once/month)
- Small enough caseload (e.g., 50 to 80)
  - With ongoing training of and feedback to care coordinators
- Rapport with physicians
  - Face-to-fact contact through co-location, regular hospital rounds, accompanying patients on physician visits, and same care coordinator for all of a physician's patients
- Strong patient education
  - Provide a strong, evidence-based patient education intervention, including how to take medications correctly and adhere to other treatment recommendations

The Interventions

Approaches That Impact (cont'd)

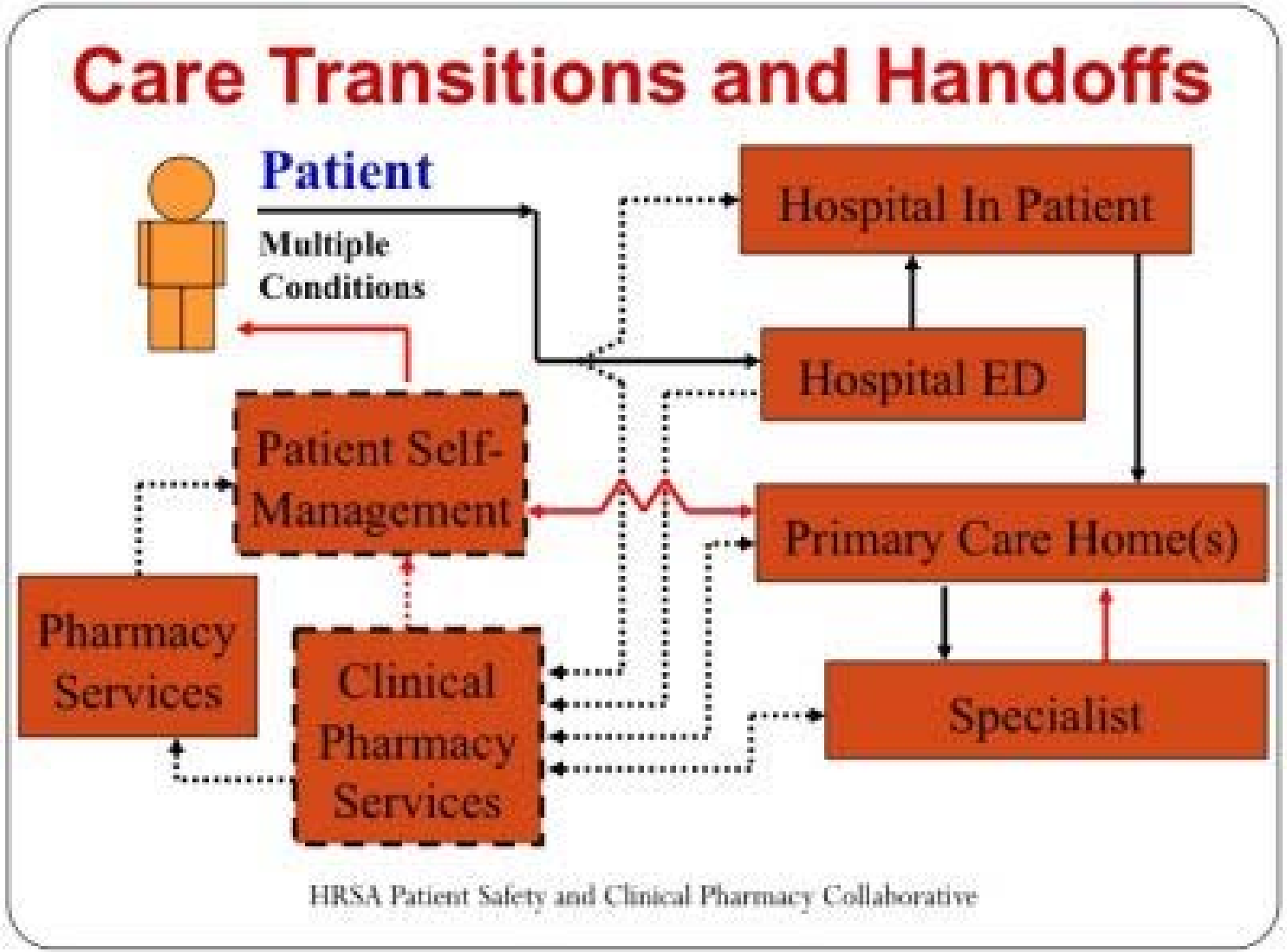
- Managing care setting transitions
  - Timely comprehensive response to care setting transitions (most notably from hospitals)
- Serve as communications hub
  - Care coordinators playing an active role as a communications hub among providers and between patients and providers
- Managing medications
  - Comprehensive medication management, involving pharmacists and/or physicians
- Addressing psychosocial issues
  - Staff with expertise in social supports for patients who need it

Interventions That Reduced Hospitalizations For High-Risk

Feature	**Among 4** programs that reduced hospitalizations	**Among 5** programs that did not
Face-to-face patient contact: more than 0.9 per month (based on data from first year of programs)	**3**	**1**
Physician engagement and cooperation Care coordinators located near physicians, attended patient appointments, or saw physicians on hospital rounds	4	1
Physician works with just 1 care coordinator	3	2
Paid physician	0	4
Care coordinator had "communications hub" role with physicians	**4**	**2**
Patient education: used behavior change model in addition to providing factual information	3	1
Transition management—care coordinators: Usually had timely notification of an admission to hospital/emergency department	**3**	**3**
Contacted patient during hospitalization	**4**	**1**
Requested copy of patient discharge instructions	**3**	**1**
Used transition protocol and monitored for consistent use	**2**	**0**
Medication management: Had information about medications from source other than patient	4	1
Consulted with pharmacist or program medical director when medication problems arose	4	2

Source: Health Affairs "Six Features of Medicare Coordinated Care Demonstration Programs that Cut Hospital Admissions of High-Risk Patients" June 2012

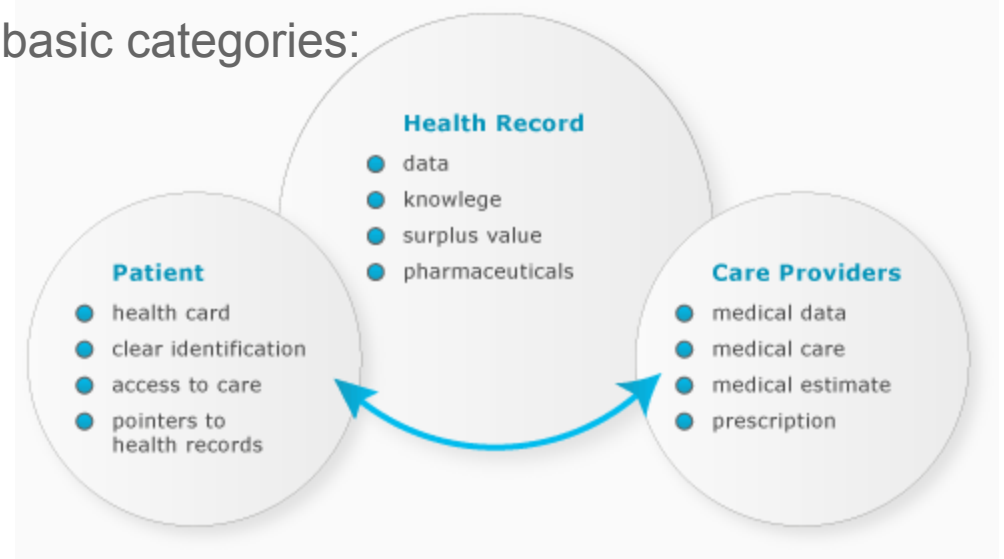
Transitions in Care



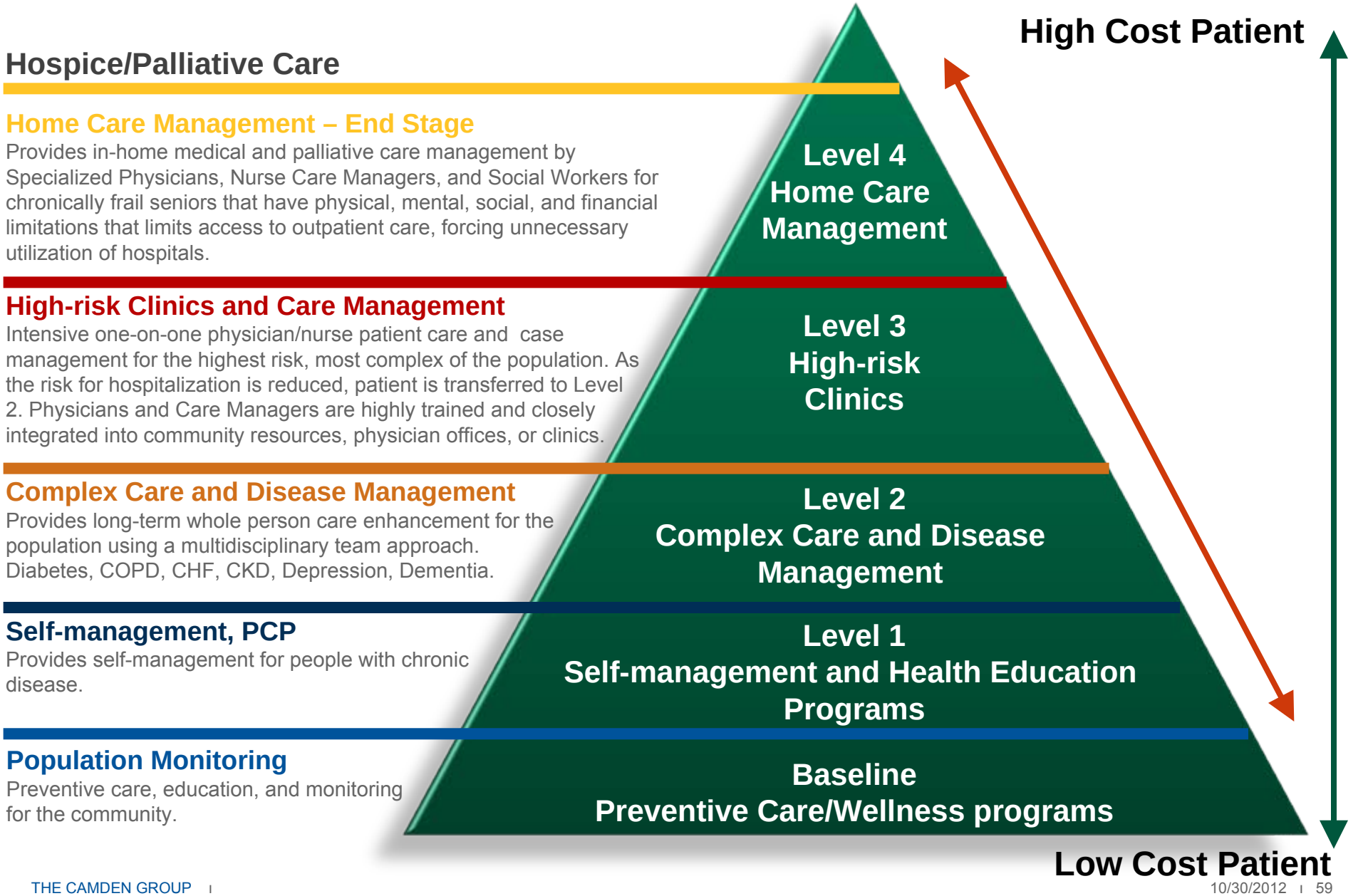
Care Transitions

Defining Process

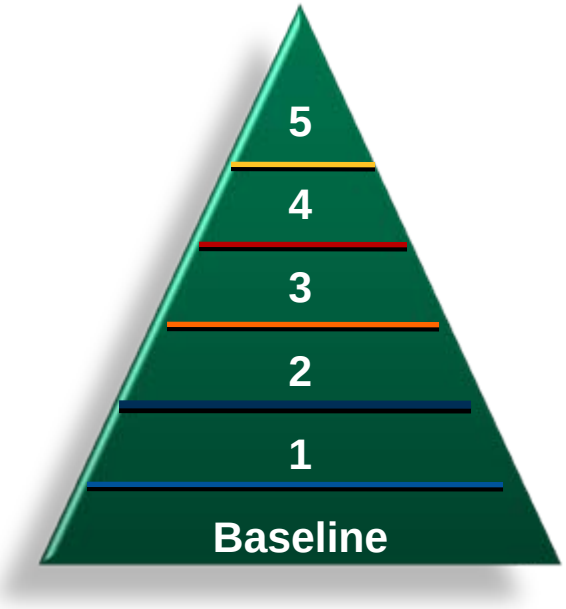
- The movement of patients between healthcare locations, providers, and/or different levels of care as their conditions and care needs change with the goal of maintaining continuity
  - Services can be broken into seven basic categories:
    1. Extended care
    2. Acute hospital care
    3. Ambulatory care
    4. Home care
    5. Outreach
    6. Wellness
    7. Housing
  - Four basic integrating mechanisms are:
    1. Care coordination, with
    2. Inter-entity planning and management
    3. Case-based financing, and
    4. Integrated information systems.



Transition Management Between Levels of Care



Strategies to Manage Care Transitions to Alternate Settings



Care Transitions Management Strategies

- Intake assessment
- Communication flow
- Discharge planning
- Medication reconciliation
- Longitudinal record documentation
- Post-discharge follow-up

PCP with Care Management Support

Escalation due to:
- Interventions
- Failed outpatient care
- Acute event

Outpatient Services

Clinics
Urgent Care
ER

Transition

Acute Care Services

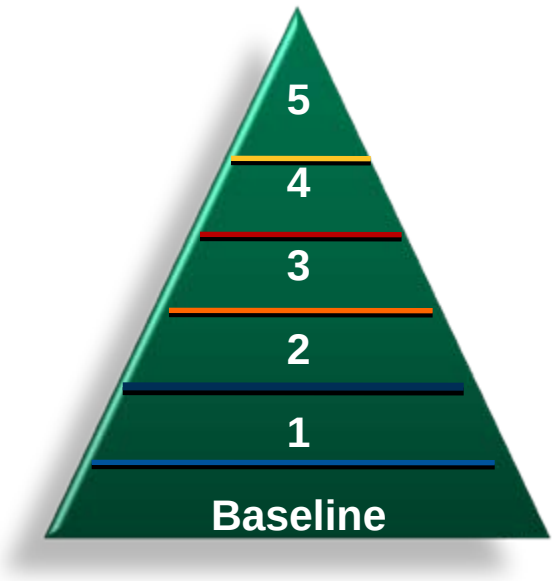
Inpatient

Transition

Post-acute Care Services

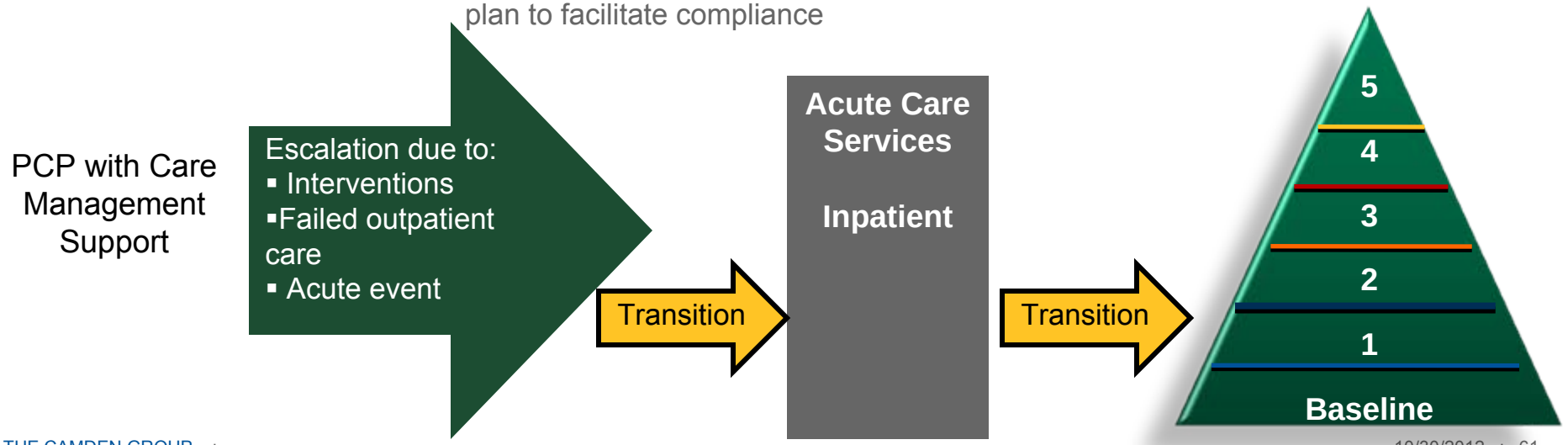
HH, SNF, LTACH, Clinics, Rehab

Care Transition Strategies to the Acute Care Setting

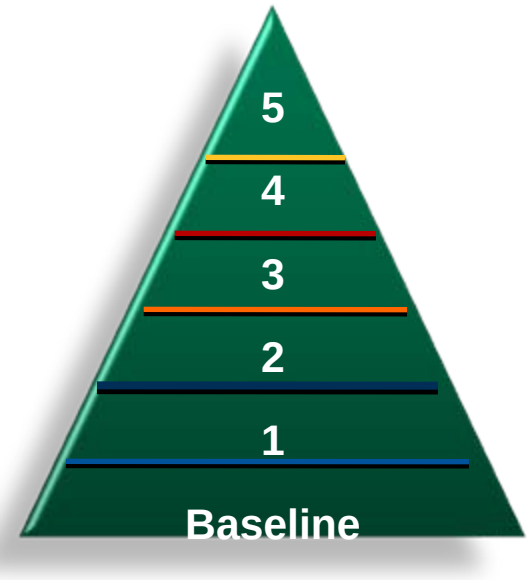


Care Transitions Management Strategies

- Patient is seen in the acute care setting (ED or direct admit)
- ED provider contacts the PCP
- PCP confirms the POC with the ED provider
- ED CM collaborates with the UR nurse to determine the level of care, and patient status
- ED provider communicates with the Hospitalist regarding the admission, diagnostics, and POC
- Hospitalist communicates all relevant information to the PCP throughout the hospitalization and in preparation for discharge; documents in the medical record
- PCP communicates with the specialist as needed
- The MH-CM coordinates with the inpatient CM to facilitate the transition to home and arranges for a post discharge office visit with the PCP within two to four days
- The MH-CM completes all required patient education and documents a follow-up plan to facilitate compliance

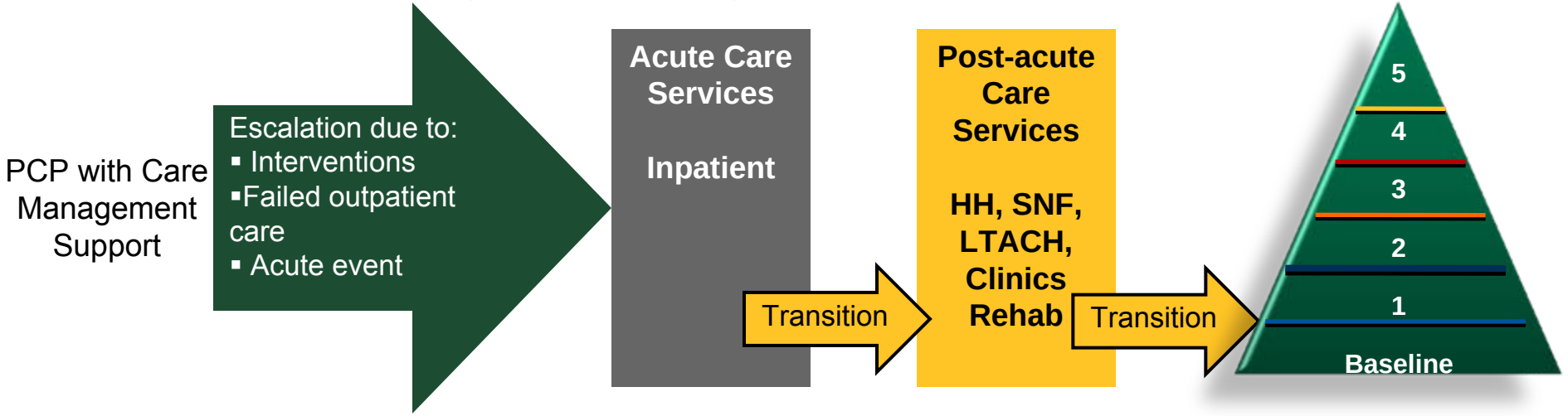


Care Transition Strategies to Acute Care and Post-acute Services



Care Transitions Management Strategies (cont'd)

- The hospitalist confirms the post acute services with the PCP
- The inpatient CM engages the patient and family to evaluate the post acute services and make a decision regarding discharge/transfer
- The utilization review ("UR") nurse confirms eligibility and obtains authorization as necessary and documents in the medical record
- The inpatient CM facilitates communication with the patient and facility regarding transfer data
- Provider communicates all relevant information to the PCP post-acute care services and documents in the medical record
- The MH-CM arranges for a post discharge office visit with the PCP within two to four days
- The MH-CM completes all required patient education and documents a follow-up plan to facilitate compliance



Discharge Planning Strategies

Identification of the Patients Needs

- All patients are entitled to a discharge plan
- Upon admission, the case management staff should screen all patients for high risk factors
  - Age
  - Diagnosis
  - Financial
  - Social history
  - Living arrangements
  - Mental status
  - Readmission
  - Abuse/Neglect
  - Substance abuse
  - Risk of harm to self or others

- Daily interdisciplinary discharge planning meetings/huddles provide an opportunity to further identify patients for evaluation
- Attendees should include nursing, medicine, therapies, case management, and other disciplines as needed

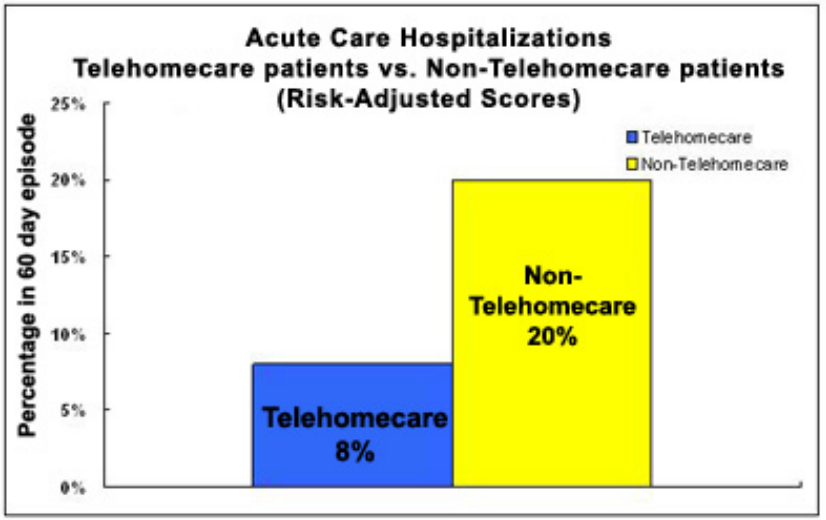
Elements of an Ideal Transition Record

- Identifies the medical home and/or transferring coordinating physician/institution
- Emergency plan contact number and person
- Patient's cognitive status
- Assessment of caregiver status
- Advanced activities, power of attorney consent
- Principle diagnostic and problem list
- Medication list (reconciliation), including immunizations, over-the-counter/herbal remedies, allergies, and drug interactions
- Prognosis and goals of care
- Ongoing treatment and diagnostic plan
- Test results/pending results
- Planned interventions, durable medical equipment, and wound care

Adaptive Care Management

Telemedicine Reduces Hospitalizations and Improves Patient Care

- FirstHealth a not-for-profit home health agency located in the south-central region of North Carolina
- Firsthealth provides comprehensive home care services to patients in six rural counties with an average daily census of 400 patients
- The Health Resources and Services Administration ("HRSA") telehealth grant, allowed FirstHealth to develop an innovative telehomecare approach to address high rates of chronic illness in the organization's service region
- Since 2009, FirstHealth has served more than 1,500 patients. As a result of the telehomecare program, acute care hospitalization for this group is at 7.9 percent while the non-telehomecare group is at 20.1 percent. In addition, patient satisfaction for the telehomecare group exceeds 90 percent, further evidence of the program's success



Creating Quality Improvement

Patient Advisory Council ("PAC")

- International Community Health Services ("ICHS") Seattle, Washington provides multilingual care to a diverse, multi-cultural population from the community, most of whom are publicly or privately insured
- ICHS successfully implemented PAC to address challenges that patients encounter when communicating about their healthcare
- The vision was for the PAC's work to enhance understanding and cooperation between patients and staff to ultimately increase overall patient satisfaction
- PAC has proven to be an effective strategy to involve patients in their healthcare and support quality improvement efforts. Since the establishment of their PAC in 2007, ICHS has identified the following key lessons:
  - Clinic staff are key to identifying good PAC members
  - Language needs and cultural barriers create challenge
  - Staff involvement is critical
  - There are always opportunities for improvement
- The effective use and focused activities of the PAC demonstrated that higher patient participation can lead to improved health outcomes and to increased quality of care

Source: U.S. Department of Health and Human Services Health Resources and Services Administration

Integrated Care for Dual Eligible

- The State of North Carolina developed and submitted to CMS the Dual Eligible Beneficiary - Integrated Delivery Model. The model is based on the premise that providing the right care, to the right person, at the right time results in better access and care.
- A model where private homes are the default setting of care and the investment of public funds acknowledges the:
  - Individual differences in what constitutes “quality of life”
  - Preventive services and high quality care are essential
  - Realization that with variation in goals there is variation in the type of community resources needed

Source: North Carolina State Demonstration to Integrate Care for Dual Eligible Individuals

Measures of Success

- Better healthcare– Improve individual patient experiences of care along the IOM six domains of quality: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity
- Outcomes – focus on the overall health by addressing underlying causes of poor health, such as: physical inactivity, behavioral risk factors, lack of preventive care, and poor nutrition.
- Reduced costs– lowering the total cost of care

Duals – Opportunities & Challenges
CA Prospective

Jeff Flick

National Vice President, Government Programs

HealthCare Partners

Why We're in Business…

Mission

HCP partners with our patients to live life to the fullest by providing outstanding healthcare and supporting our physicians to excel in the healing arts

Vision

HCP will be the role model for integrated and coordinated care, leading the transformation of the national healthcare delivery system to assure quality, access and affordable care for all

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Medical Group and Affiliated Physicians

How We Do Business…

Values

The Common Good

- We will enhance the common good by committing resources to build an organization that meets the needs of the people and communities we serve

Compassionate Healing

- We will be patient-centered and serve our patients as we would guests in our own house

Dignity

- We respect the inherent value and worth of every life we touch

Excellence

- We will always strive for the highest quality outcomes and service to our patients and customers

Leadership

- The way we conduct business and serve our customers will be the standard by which other healthcare systems are judged. All of our staff will ensure that quality patient care is at the heart of all our business decisions.
- Physicians will maintain leadership roles in our organization

Stewardship

- We all share the responsibility for the organization's resources

Integrity

- We conduct ourselves with the highest ethics and compliance with applicable laws and regulations

Learning

- We continually improve our systems, our service, and ourselves through learning

Accountability

- We have input into the decision-making process and are therefore responsible for our results

Collaborative Teamwork

- We strive to work cooperatively with people to achieve our common goals and our vision

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HCP Current Market Footprint

California

- Nearly 500,000 commercial and over 100,000 senior members in Metro LA. 525 employed physicians in 66 locations and over 4,100 under contract.

Florida

- Over 48,000 senior members and 4,000 commercial members in central and South Florida. 60 employed physicians in 41 locations and over 2,800 under contract.

Nevada

- 36,000 senior and 37,000 commercial members under global or partial capitation in Metro LV. 130 employed physicians in 52 locations and 1,400 under contract.

New Mexico

- 180,000 patients including 26,000 managed Medicare members.

Largest Private Medical Group in each of HCP's Current Markets

Variety of physician and hospital payment arrangements

- All employed physicians paid salary with incentives
- Many contracted physicians are either exclusive or semi-exclusive / HCP
- Wide range of hospital payment arrangements
- Contracted PCP's paid combination of capitation and FFS plus bonus (based on acuity and quality outcomes)
- Contracted specialists paid capitation and discounted FFS
- Full range of language capabilities

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HCP Experience with Dual Eligibles

- **Significant experience with duals – 14,000 full-risk members/patients in LA and OC**

- **Believe passively enrolled duals will be MORE challenging**
  - Coordinating care for those who have not chosen coordinated care

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Managing Complex Populations

- **130 employed hospitalists and SNFists**
  - Management of hospital days, hospital admissions and readmissions
- **Staff and IPA platforms for primary and specialty care**
- **Network of Comprehensive Care Centers**
- **24-hour patient support and fully staffed patient support center. We don't close - service available around the clock**
- **Conveniently located urgent care centers – some open 24/7**
- **Highly sophisticated IT infrastructure with decision-support capability**
- **Extensive care management and disease management programs – all time tested and highly effective**

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HCP Faces Challenge Ahead!

Even with track record of success with over 100,000 full risk seniors and all the tools in place to assist HCP with the management of complex populations…

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Improvements Up Ahead

- **Preparing for influx of passively enrolled dual eligibles**
- **Implementing significant care improvements**
- **Redesign of clinical protocols and processes**
- **New focus and way of thinking regarding this population**
  - Patients will have different attitude towards care
  - Patients will remain high users of high-cost care in the absence of new and improved clinical model
  - Patients will have not experienced HCP model of care

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Improvements Up Ahead – Patient Communication

- **Enhanced “Stickiness” factor**
- **More timely and comprehensive patient outreach**
- **Connectivity with patients centers on health risk assessments**
- **Introduce patients to goals of coordinated care**
- **Conduct immediate physical exams**

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Improvements Up Ahead – Program Redesign

- Rebuilding palliative and supportive care programs to bring up the standard for this population
- Development of new programs to support Alzheimer's patients and patients with cognitive healthcare challenges
- Redesign of programs for patients with serious & persistent mental behavioral health challenges

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Improvements Up Ahead – Process Redesign

- **Building flexibility into our referral process to access specialist care**
  - With no adverse effects on quality or efficiency
- **HCP has capital structure to learn and invest in a new LTSS business**

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LTSS

- **HCP believes 38% of the total cost for servicing dual eligibles is directly tied to LTSS**

- **In CA, anticipate 90% of 1st year LTSS costs will be spent:**
  - IHSS Services
  - Custodial Care in Nursing Homes

  - **Drastic changes and improvements will be necessary in the management of LTSS.**

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LTSS – IHSS Changes and Improvements

- **Most IHSS staff have no formal training, HCP would like to incorporate caregivers into the medical care management team**
  - IHSS Staff is frequently disengaged from medical care
- **IHSS**
  - Staff is often family members, friends of the patient
  - 430,000 individuals – with the patients supervising the IHSS workers
  - **Health plans/physicians looking to bring change coordinating these activities with the medical care team**
- **Physician engagement is needed to fundamentally improve IHSS – physicians have the relationships with patients**

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LTSS – Custodial Care Changes and Improvements

- **Develop strong nursing home diversion programs**
- **Health plans/physicians moving the focus away from institutional care and into home and community alternatives**
- **Again, Needs to be focus of physicians due to relationships with patients**
  - Physician engagement essential – physicians must drive the change
- **HCP has discussed with hospitalists**
  - Happy to engage once a nursing home alternative is established
  - Extremely difficult – good alternatives must be identified and tested

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Current State…

- **HCP is currently not 100% prepared – we still have work to do.**

- **Even sophisticated groups like HCP - don't have enough knowledge, personnel, correct protocols, tested alternatives or important tools to effectively coordinate care for this population.**

- **Working hard to establish all that is necessary by June 2013**
  - Will be significant challenge, despite the strong base from which we are building.

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Rates that Make Sense

- **Perhaps the most important ingredient – rational long term rate structure with appropriate risk adjustment**

- **HCP has the capital and the DNA to make the investments – however, there must be a strong multi-year business case to support the investment**

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Strong Business Case

- **HCP is planning to take full risk for medical cost – and substantial risk for LTSS**
- **Critically important that incentives are aligned with HCP and its health plan partners. We never want one party to benefit at the expense of the other.**
- **Operating losses in 1st year – highly probable**
- **Hundreds of thousands of patients rely on HCP to provide exceptional, coordinated care today**
- **Cannot risk services to existing patients**
- **Rates for the duals will need to support the investment**

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Current State of Mind

- **Good news is that California is one of the states leading this effort to bring fully coordinated and accountable care to this population**
  - HCP and other high-performing provider organizations are well established in this market
  - In a large part of CA there are firm foundations to build upon
- **HCP values health plan partners, but this challenge will require fully engaged physicians**
- **Success will stem from engaged physicians with access to sophisticated infrastructure operating with properly aligned incentives**

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