Partnering with Managed Care Entities

A Path to Coordinated Care

Presented by:
Katherine Wentworth, JD
Chief Operating Officer, MDwise
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Agenda

- Review new care models in Medicaid managed care
  - Coordinated Care Organizations
  - Health Homes
- Compare to the current Indiana landscape
  - Are CCOs and Health Homes so new after all?
- Discuss covered populations and their unique health care needs
  - Experience of Care Select as comparison
  - Lessons learned
- Options for CMHCs and MCEs to partner in this new environment

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Health Homes & Coordinated Care Organizations – the new buzz words

New models being proposed for better integrated care:

- Affordable Care Act allows States to establish person-centered "health homes" to integrate services for the individual and are hoped to produce improved outcomes for beneficiaries and better services
- Oregon has launched a program for Coordinated Care Organizations (CCOs) - community-based not-for-profits responsible for coordinating mental health, physical health and dental care
- Other states have used the ACO concept to include Medicaid enrollees into CCOs

** Indiana is looking at options for new programs for the aged, blind and disabled (and possibly dual eligibles) … what will they choose? **

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Goals behind Health Homes and CCOs

- Affordable Care Act set up funding streams for new programs that are hoped to:
  - Integrate care across systems
    - Physical
    - Mental
    - Dental
  - Provide treatment of the whole person
    - Social needs such as housing, in addition to medical
  - Improve care while reducing or maintaining costs
- Similar concept called a CCO model established per deal with HHS and Oregon

Coordinated Care Organizations (CCOs): Definitions

- Network of all types of health care providers
  - Physical health, mental health, addictions, dental
- Agreement to work together in local community
- Serve persons covered by all Medicaid programs
- Focused on prevention & chronic disease management
- Founding principles:
  - Care will be better coordinated
  - Budget flexibility to cover services not covered by Medicaid (e.g. air conditioner)

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CCO Criteria

- Coordinate physical, mental health and chemical dependency services, oral health care
- Encourage prevention and health through alternative payments to providers
- Engage community member/health care providers in improving health of community
- Address regional, cultural, socioeconomic and racial disparities in health care
- Manage financial risk, establish financial reserves, meet minimum financial requirements
- Operate within a global budget

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CCO Governance Structure

Required by Oregon State Law

- Locally defined membership (can differ CCO by CCO)
- Must include representation from all major components of the health care delivery system
  - Entities or organizations that share in financial risk
  - At least two health care providers in active practice
  - **Primary care** physician or nurse-practitioner
  - **Mental health or chemical dependency** treatment provider
  - At least two community members
  - At least one member of **Community Advisory Council**

Community Advisory Council

- Majority of members must be consumers
- Must include representative from each county government in service area
- Duties include Community Health Improvement Plan and reporting on progress
- Community Health Improvement plan must be approved by Oregon Department of Health

Mental Health Care in CCO

- Goal: Continuity of care
- Most FFS clients in Oregon use a managed mental health organization (MMHO) for mental health care
- Starting in September, mental health care moved into CCO as well (CCO will essentially act as an MHO)
- On Nov. 1 clients will be fully enrolled into a CCO that includes physical and mental health care

CCO Exemptions

- Clients with Third Party Liability (TPL)
- Tribal clients who choose not to enroll
- Clients who are eligible for both Medicaid and Medicare (Dual Eligibles) who choose not to enroll
- Clients who request a third trimester pregnancy exemption through December 2012

CCOs: Funding and Accountability

- CCO budget parameters
  - One global budget (versus open-ended federal match %)
  - Budget grows at a fixed rate
  - CCO board is accountable for health outcomes
- Oregon
  - Agreement with federal government to reduce projected state and federal Medicaid spending by $11 billion over 10 years.
  - Oregon will lower the cost curve two percentage points in the next two years.
  - Up-front investment of $1.9 billion from the U.S. Dept. of Health and Human Services over five years to support coordinated care model.
  - OHA and CCOs will be held to high standards for health outcomes.

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Current Status - Oregon

- Today at least 13 operational, three pending CCOs
- Some in competing markets/counties
- Service areas can be self-defined (counties, partial counties, zip codes) – and not all counties are covered yet
- All managed care members and newly enrolled FFS members roll into CCOs if there is one in area
- "collaboration" between existing MCEs to finance operations
- Variable in size, member composition
- Required to work with State Dept. of Health
- Vision to transform the *whole* health care system in Oregon, including state employees, commercial insured

CCOs vs. Indiana MCEs/CMOs

CCO	MCE/CMO
CCO is responsible for coordination of all services, including medical, behavioral, and dental	Indiana includes medical, behavioral, and therapies in managed care. (HHW carves out pharmacy, dental, MRO, PRTF)
Global budget for all care	HHW: Capitation rate pmpm Care Select: FFS for all services, CMO fee ($12/PMPM for health plan)
Community decides how to spend global budget and reimburse providers for services Community must agree on who gets paid how much for what type of service	Covered services set by OMPP, paid at Indiana Medicaid fee schedule or can be paid a negotiated %/different rate
Development of performance measurements against which payment is determined	Pay for performance measures based on HEDIS measures or measures defined by OMPP
Accountable for addressing avoidable population differences in health care outcomes	Care coordination/care management are key to success, measured by State, NCQA standards
Data collection, quality programs required	Data collection, quality programs required

Health Homes
ACA section 2703

- A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner.
- This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital.
- Health records are shared (either electronically or paper) among providers so that services are not duplicated or neglected.
- The health home services are provided through a network of organizations – providers, health plans and community-based organizations.
- When all the services are considered collectively they become a virtual "Health Home."

Health Home Basics

- Person-centered systems of care that facilitate access to and coordination of care
  - Primary and acute physical health services
  - Behavioral health care, and
  - Long-term community-based services and supports
- Expands on the traditional medical home models
  - Additional linkages and enhancing coordination and integration of medical and behavioral health care
- The model has two aims:
  - to improve health care quality, clinical outcomes, and the patient care experience
  - Reducing per capita costs through more cost-effective care

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Health Home Basics

- Health home services that are required for the 90% FMAP include
  - Comprehensive care management
  - Care coordination and
  - Health promotion and preventive care
  - Chronic disease management
  - Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
  - Individual and family support
  - Referral to community and social support services, if relevant
  - Long term supports and services
  - Use of health information technology (HIT) to link services

Health Home Basics

- Must develop a care plan for each individual that coordinates and integrates all clinical and non-clinical services and supports required to address the person's health-related needs
- Must use HIT to link services, facilitate communication between and among providers, the individual, and caregivers, and provide feedback to practices
- Must establish a continuous quality improvement program
- Must collect and report data that support the evaluation of health homes

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Health Home Required Data

- CMS recommends that states collect individual-level data to permit comparative analyses of the effect of the health home model across Medicaid sub-populations, as well as comparisons between those who do and do not receive health home services
  - Avoidable hospital readmissions
  - Calculate savings due to improved care coordination and disease management
  - Monitor the use of HIT
  - Emergency department visits
  - Skilled nursing facility admissions

Health Homes and Quality

- CMS will provide further guidance on quality requirements
  - Develop a core set of quality measures for assessing health homes
- Until then, states are expected to define the measures they will use to capture
  - Clinical outcomes,
  - Experience of care outcomes
  - Quality of care outcomes

Health Homes vs. Indiana MCEs/CMOs

Health Home	MCE/CMO
Health Home is responsible for coordination of medical and behavioral services	Indiana includes medical, behavioral, and therapies in managed care. Services coordinated through care management and utilization management
Health home receives 90/10 match for services; funding otherwise remains the same	HHW: Capitation rate pmpm Care Select: FFS for all services, CMO fee ($12/PMPM for health plan); 90/10 match not applicable
Health home decides who will provide care management; expectation that all members have integrated care plans	MCEs and CMOs stratify members to different levels of intervention based on need and risk
Development of performance measurements	Pay for performance measures based on HEDIS measures or measures defined by OMPP
Accountable for meeting performance and quality standards	Care coordination/care management are key to success, measured by State, NCQA standards
Data collection, quality programs required	Data collection, quality programs required

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Who might be covered?

- Unknown yet which Medicaid populations Indiana might target in a potential Health Home/CCO model
  - Aged, blind, disabled
  - Duals?
  - Waiver populations?
  - Long term care?
- A portion of ABD members are currently in Care Select
- Experience from Care Select might provide guidance to understand challenges ahead
  - Chief diagnoses
  - Use of medications
  - Risk profile

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Current Care Select Program

- October 2010 – OMPP redesigned program
- Must be ABD + one of the following
- State defined conditions to be enrolled in Care Select
  - Asthma
  - Diabetes (DM)
  - Congestive Heart Failure (CHF)
  - Coronary Artery Disease (CAD)
  - Chronic Kidney Disease (non-dialysis)
  - Severe Mental Illness (SMI)
  - Serious Emotional Disturbance (SED)
  - Depression
  - Co-morbidity/combination of Diabetes (DM) and hypertension (HTN)
  - **AND … Co-morbidities/combinations of any of these disease conditions**

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Care Select Conditions

N= Persons with Condition	9/25/2010 N=39,076	% total	Post 10/1/2010 N=19,500	% total
Infectious HIV/AIDS	8,249 344	21% 1%	4,624 199	24% 1%
Malignant Neoplasm	3,617	9%	2,316	12%
Diabetes	6,043	15%	4,901	25%
Liver ESLD Chronic Hepatitis	2,376 229 403	6%	1,718 183 295	9%
Gastrointestinal	12,661	32%	7,902	41%

Care Select Conditions

N= Persons with Condition	9/25/2010 N=39,076	% total	Post 10/1/2010 N= 19,500	% total
Endocrine/Metabolic	13,550	35%	9,124	47%
Musculoskeletal and Connective Tissue	16,712	43%	10,865	56%
Hematological , including Coagulopathies	4,828	12%	3,107	16%
Cognitive Dementia	2,350	6%	767 524	4%
Substance Abuse	7,440	19%	5,712	29%

Care Select Conditions

N= Persons with Condition	9/25/2010 N=39,076	% total	Post 10/1/2010 N=19,500	% total
Mental Disorders Schizophrenia MDD/Bipolar Depression	17,345 2,239 6,299 3,149	44%	12,743 1,836 5,000 2,511	65%
Developmental Disability	8,958	23%	4,829	25%
Neurological Quadriplegia Paraplegia	8,942 606 276	23%	5,178 132 83	27%
Cardio-Respiratory Arrest Ventilator Dependent	2,160 396	6% 1%	1,383 160	7% 1%

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Care Select Conditions

N= Persons with Condition	9/25/2010 N=39,076	% total	Post 10/1/2010 N=19,500	% total
Cardiac CHF Hypertension	12,705 2,500 8,110	33%	8,798 1,872 5,697	45%
Cerebro-vascular	3,013	8%	1,611	8%
Vascular	3,831	10%	2,655	14%
Lung Cystic Fibrosis COPD Asthma	13,489 58 5,202 3,610	35% 0.1%	9,117 41 4,110 2,638	47% 1%
Eyes	14,839	38%	8,591	44%

Care Select Conditions

N= Persons with Condition	9/25/2010 N=39,076	%total	Post 10/1/2010 N=19,500	%total
Urinary Kidney Transplant Renal Failure	8,578 73 1,410	22%	4,941 39 1,017	25%
Genital	5,485	14%	3,554	18%
Pregnancy	682	2%	395	2%
Skin Decubitus	10,259 414	26%	5,987 193	31%
Injury Head injury	12,418 473	32% 1%	7,663 243	39% 1%

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Pharmacy Complexity and Cost - One Year Spend for Anti-Psychotics

Antipsychotics		
	GEODON 60 MG CAPSULE	$538,320
	GEODON 80 MG CAPSULE	$1,144,579
	ABILIFY 30 MG TABLET	$911,231
	ABILIFY 20 MG TABLET	$1,343,281
	ABILIFY 15 MG TABLET	$910,412
	ABILIFY 10 MG TABLET	$1,335,512
	ABILIFY 5 MG TABLET	$1,526,446
	ABILIFY 2 MG TABLET	$403,105
	SEROQUEL XR 300 MG TABLET	$672,329
	SEROQUEL XR 400 MG TABLET	$583,801
	SEROQUEL 100 MG TABLET	$444,842
	SEROQUEL 200 MG TABLET	$808,123
	SEROQUEL 300 MG TABLET	$1,378,147
	SEROQUEL 400 MG TABLET	$1,100,944
	ZYPREXA 10 MG TABLET	$514,670
	ZYPREXA 20 MG TABLET	$902,921
	ZYPREXA 15 MG TABLET	$586,557
	RISPERDAL CONSTA 50 MG SYR	$498,583
	INVEGA ER 6 MG TABLET	$874,843
	INVEGA ER 9 MG TABLET	$526,644
		$17,005,290

Pharmacy Complexity and Cost
Most Commonly Prescribed Medications

Pain		
	Hydrocodone or Oxycodone	99,682
	Tramodol	12,706
	Cyclobenzaprine	5,793
	Methadone	4,670

Risk Stratification for Care Select

Average Predictions, Weighted by Eligibility	
Medicaid MC All Medical Predicting Concurrent Total Risk (ID: 76)	**3.82**

Membership 10/5/10	Person Years	
ADCG Predicted Expenditure Range	Number	Percent
Very Low Risk	478	2.89%
Low Risk	3,109	18.84%
Moderate Risk	2,945	17.84%
High Risk	6,241	37.82%
Very High Risk	3,731	22.61%
Total	16,502	100.00%

Care Select: Lessons Learned

- It takes a village
- It takes comprehensive systems
- It takes time to shift a trend, and some trends just can't be shifted
- Outliers, orphan conditions matter
- Some costs cannot be defrayed, so need to direct care management where it can be most effective
- It takes expertise in many areas – from customer service to certified care managers to provider relations and outreach staff

Indiana MCEs and CMOs - Why Partner?

- CMHCs have a lot to offer to MCEs
- CMHCs serve as central site of care for many members who don't seek medical care from PMP
- CMHCs have community partnerships to provide needed services not covered by Medicaid
  - Supportive housing
- CMHCs treat family units
  - Must know home environment in order to understand barriers to good outcomes
- CMHCs coordinate behavioral and addiction care

Indiana MCEs and CMOs - Why Partner?

MCEs bring a lot to the table as well -

- Health Information Technology
- NCQA Accreditation
- Quality Outcomes and Measurement (tracking HEDIS and CAHPS)
- Community-based provider networks driving care decisions
  - Behavioral Health, DME, long-term care, transportation, etc.
- Member Grievances and Appeals
- Provider Grievances and Appeals
- Right Choices Program (RCP) management
- Utilization Management - Controlling cost trends
- Community-based programming (outreach programs)
- Experience in integrating Behavioral Health and Physical Health Services

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MCEs & Health Information Technology (HIT)

- MCE HIT Systems
  - Linkages with Indiana Health Information Exchange(IHIE)
    - All MCE data feeds IHIE today
  - Data linkages between all provider types
    - Pharmacy fills, ED visits
  - Care management systems
    - Software systems and templates to collect all needed information and bring to single screen, along with utilization
    - Stratification tools
  - Utilization management systems
    - Built in standard criteria
    - Esp. important in controlling costs in CCO environment

MCEs & Data and Reporting

- IT and data analysts to meet State and Federal reporting requirements
- Quality tracking
- Financial spend by categories
- Risk scoring
- Utilization
- Fraud and Abuse

Resources to Bridge among Health Homes

- Health Homes will manage their own patient data … but what happens when they move?
- Members churn in and out of MCEs/CMOs today – this is likely to happen in a Health Home model as well
  - Transient population
  - Federal member choice rules
- MCE data infrastructure could provide umbrella to bridge from Health Home to Health Home with a common information source
- MCEs bring care management expertise for medically complex members

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Future Partnerships
MCEs & Health Home Models

- One possible model:
- Marry the best attributes of both entities
  - MCEs/CMOs infrastructure remains with financial risk
    - Development of contracting arrangements to link providers of all types
    - Care management services provided centrally *and* in community
  - MCEs/CMOs provide administrative services
    - Health home assumes development of care management, responsible for outcomes
  - MCOs maintain provider networks and referral sources for specialty care
  - CMHCs are the face to the member in the community
    - Serve as new "PMPs"
    - Coordinate community partners, creating safety net for members

Questions? Thank you!