CENTER for INTEGRATIVE HEALTH
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Convene.
Strategize.
Activate.

Long Term Services & Supports:

What NC Can Learn from Arizona's 1115 Waiver

VISIONARY VOICES

PRESENTED BY BRIAN LENSCH

ÅCourse Objectives:

- Review Arizona's experience with bundled managed care for individuals with I/DD
- Identify processes and areas to mitigate potential problems as North Carolina rolls out the Medicaid Transformation
- Review specific areas to measure and monitor in order to identify system concerns early on

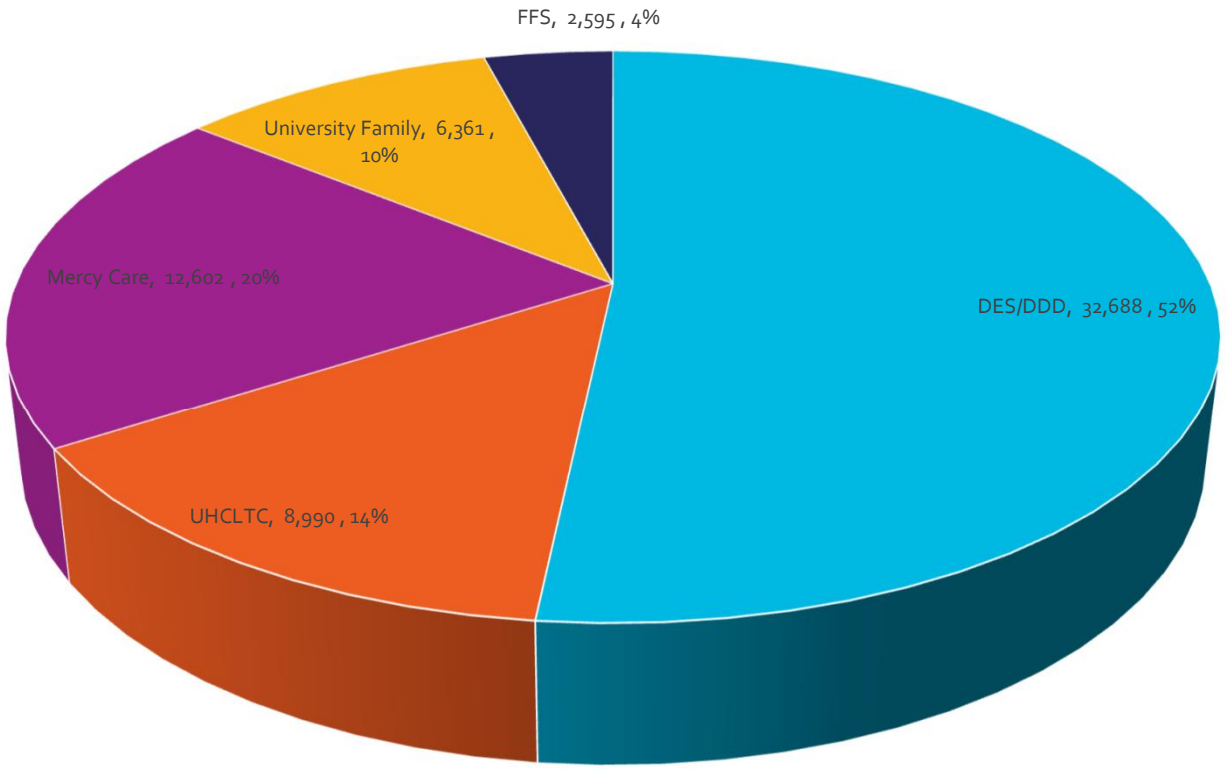
ARIZONA - MEDICAID - MANAGED CARE

- **Arizona joined the Medicaid Program in 1982 through an 1115 Research and Demonstration Waiver**
  - **Acute Care Services only**
  - **Mandatory Managed Care for everyone in Medicaid except Native Americans**

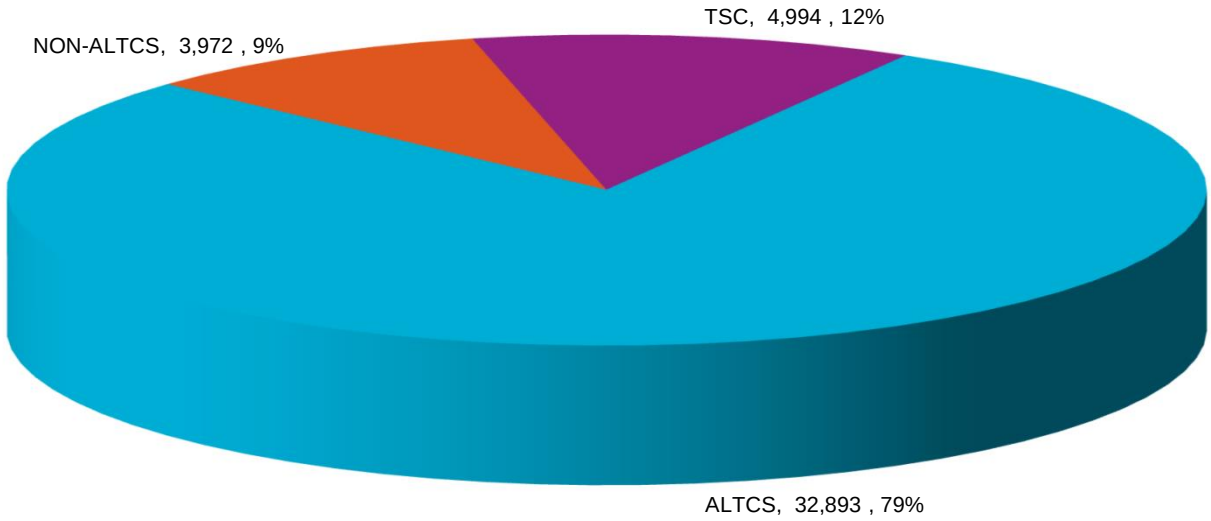
- **Arizona Long Term Care Services (ALTCS) began December 1988 as part of the 1115 Waiver**
  - **Bundled Services: Acute Care (Medical); Behavioral Health and Long Term Supports and Services (LTSS)**
  - **Preadmission Screening Tool (PAS)**
  - **Cost Effectiveness Study (CES) at the individual Level**
  - **At Risk – Blended Capitation: Per Member Per Month (PMPM)**

- **ALTCS supports three (3) populations:**
  - **Elderly**
  - **Individuals with Physical Disabilities**
  - **Individuals with Intellectual/Developmental Disabilities**

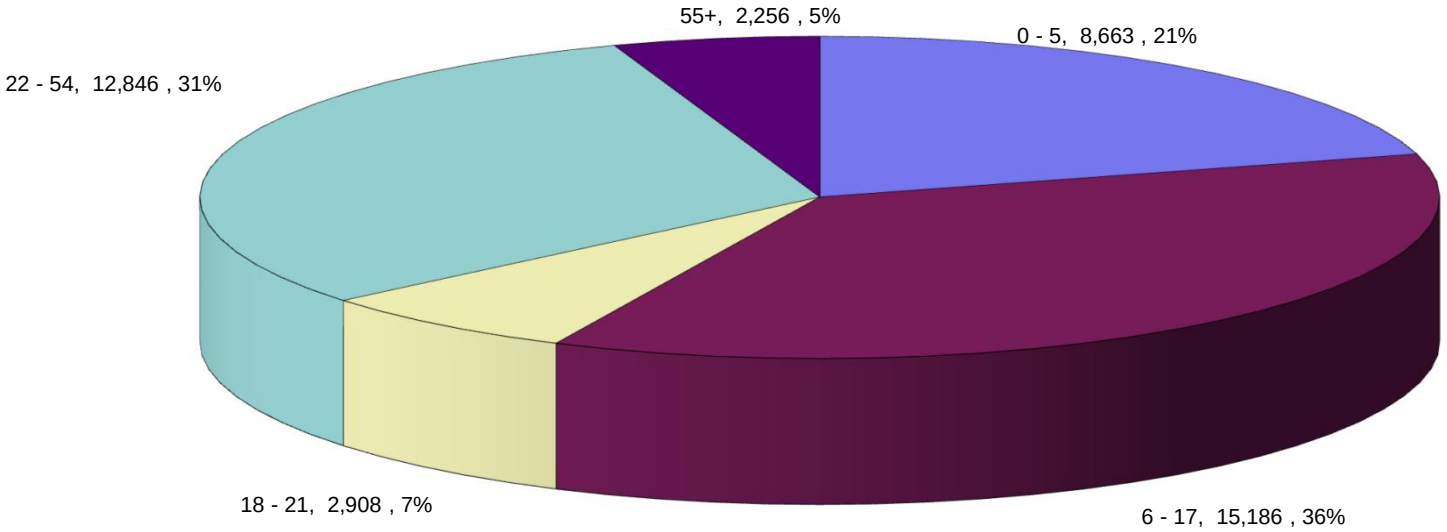
ALTCS Program
October 2018



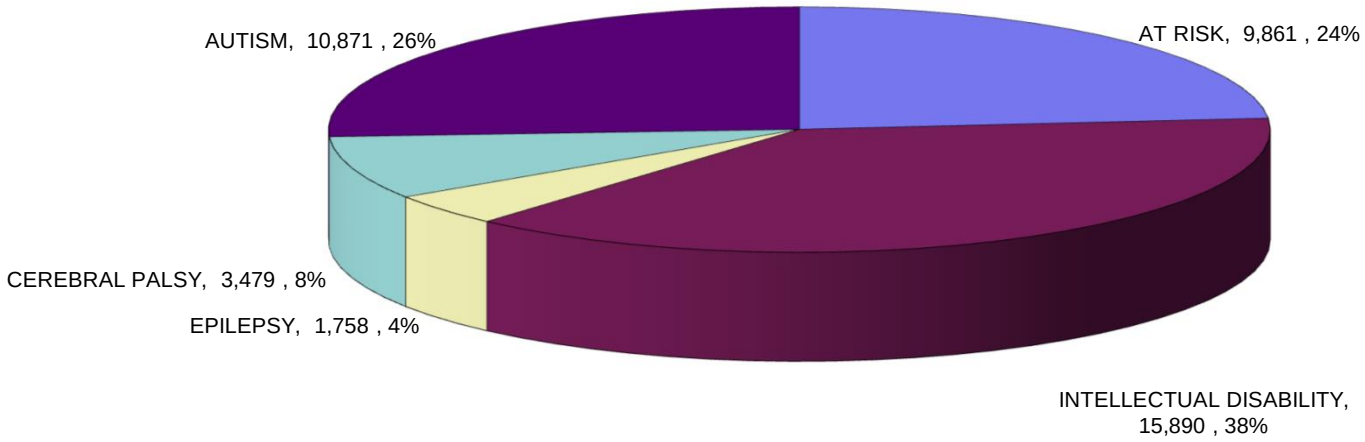
Division of Developmental Disabilities



Division of Developmental Disabilities



Division of Developmental Disabilities



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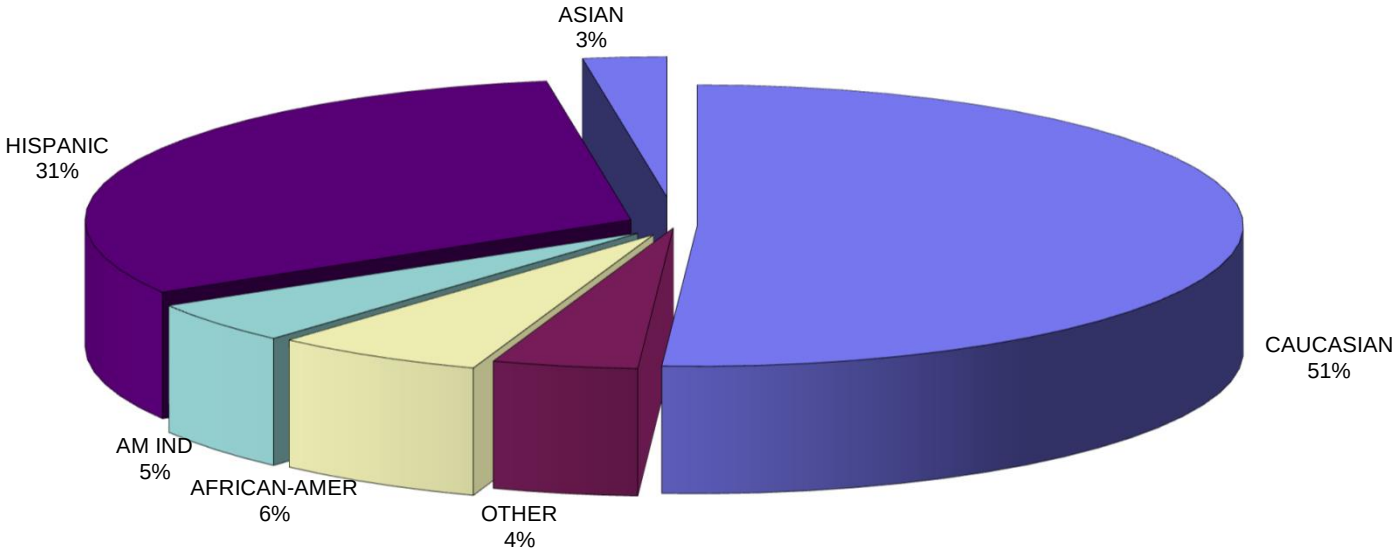

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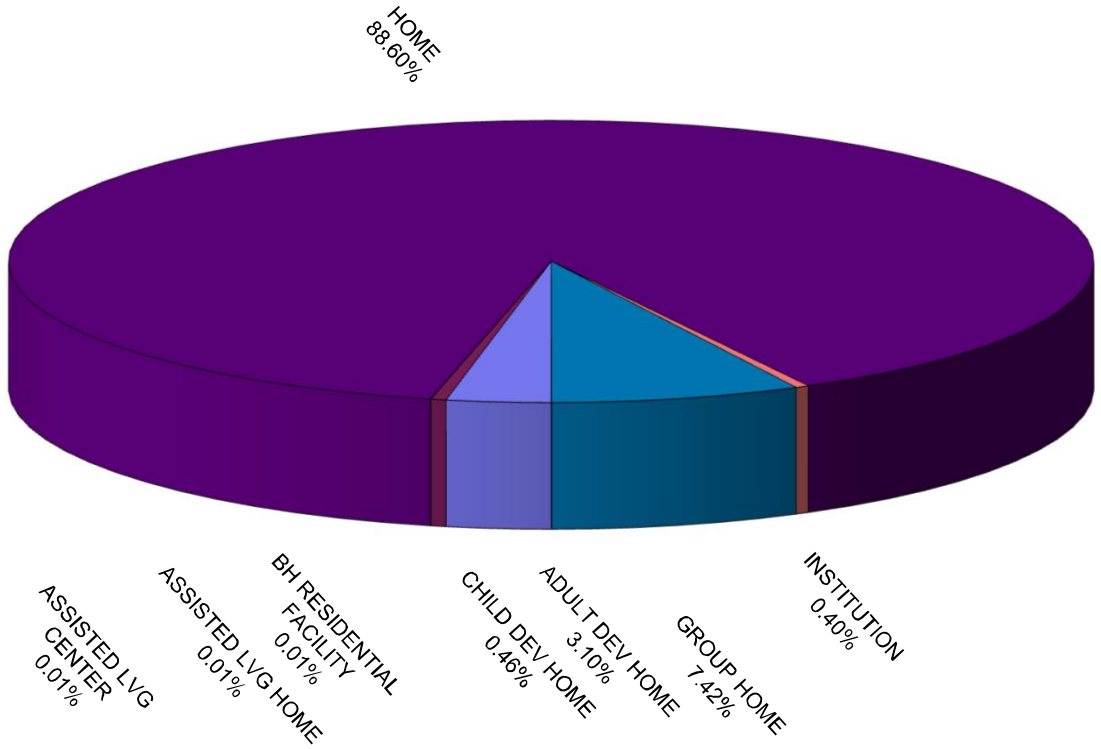


The Division of Developmental Disabilities is mandated under state legislation as the sole "Program Contractor" for individuals enrolled who have an Intellectual/Developmental Disability

ÅCAPITATION INCLUDES:

- ÅBlended cost for institutional services and Long Term Supports and Services
- Å(subtract Share of Cost collected)
- ÅCase management
- ÅAdministration
- ÅAcute Care
- ÅProvider Premium Tax
- ÅRisk and Contingency factor
- ÅBehavioral Health

	January 1, 2019
GROSS INSTITUTIONAL	$120.63
MEDICARE/TPL	($0.00)
SHARE OF COST	($4.57)
HCBS PMPM	$2,877.96
NET LTC PMPM	$2,994.02
CASE MANAGEMENT	$176.01
ADMINISTRATION	$243.17
ACUTE CARE	$603.10
PREMIUM TAX	$ 82.74
RISK & CONTINGENCIES	$ 38.14
BEHAVIORAL HEALTH	(currently provided through Single State Medicaid Agency)
NET PMPM	$4,137.17

- **ALTCS began with two capitation rates**
  1. **A rate for those members who received acute care services and case management but no HCB services**
  2. **A rate for those who received acute care services, case management and at least one HCB service**

- **The Medicaid Agency combined the two populations into one capitation for efficiency of process**

The Division of Developmental Disabilities:

- Contracts with Health Plans for acute services and sub-capitates these plans
  - The Division operates a fee-for-service program for American Indians
- Historically, the Division contracted through an Intergovernmental Agreement (IGA) for behavioral health services
- Long Term Care Services are contracted through a more typical Fee-For-Service option

Initially there were few Health Plans interested in contracting with the Division

- The Health Plans were concerned the health costs would exceed their experience in other populations
- After the first couple years, it was demonstrated that the acute care cost was actually less than the comparable Medicaid population
- There are currently three (3) Subcontracted Health Plans for the I/DD population

Long Term Care Service Providers:

- The Division contracts with “Qualified Vendors” through published rates in a fee-for-service environment
- The Division operates an independent provider network and contracts with a Fiscal Intermediary for managing payments and taxes for these providers

The Division originally released “Request for Proposals (RFP)” for LTSS

- This was the historical process for procuring services by the Division.
- New providers interested in providing the covered services had to wait for the next annual RFP before they could begin their operations

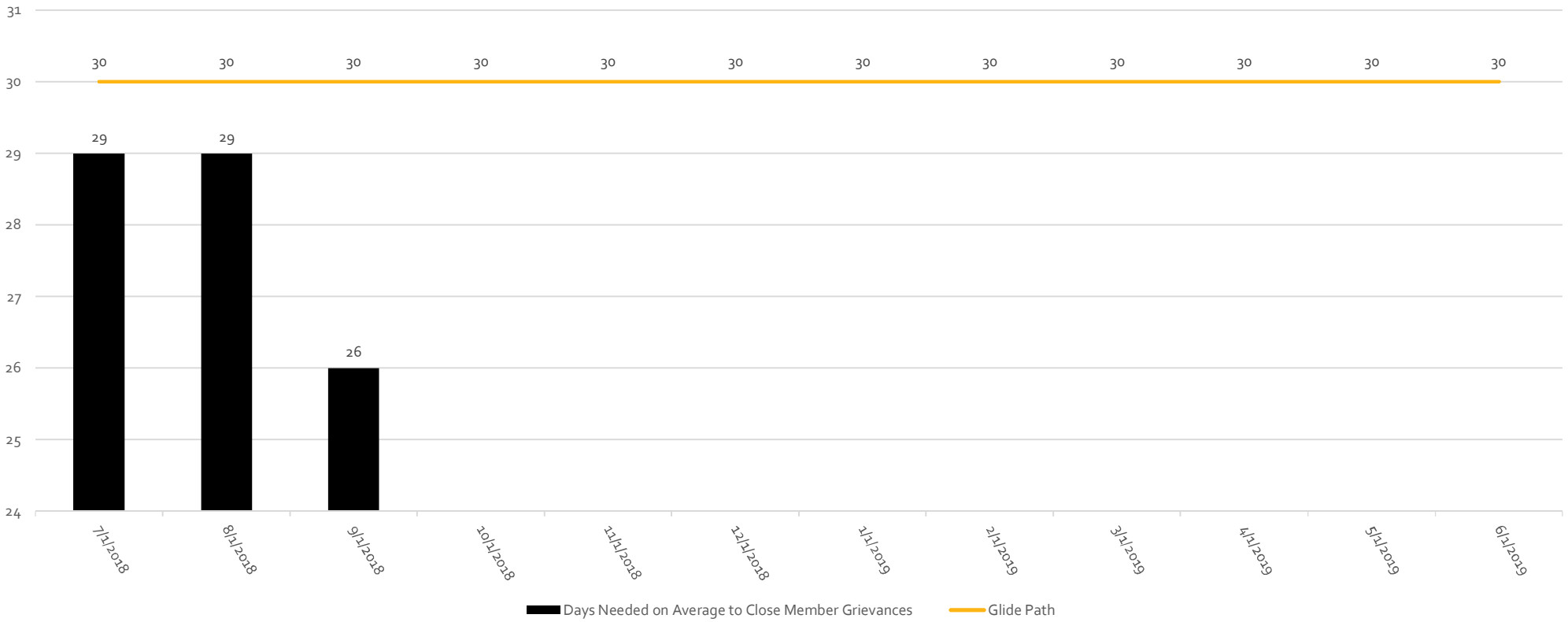
The Division now has an “Open & Continuous” contracting process

- Applicants can begin the contract process at any time by submitting required documentation electronically.
- After review processes are completed, an award for service(s) is made to the “Qualified Vendor”

GRIEVANCES & APPEALS

- Initial grievances and appeals may go through the Health Plan(s)
- All denial of services go through the Division to adjudicate
- The Division makes all final decisions for the MCO level
- The State Medicaid Agency manages all state fair hearings

DAYS NEEDED ON AVG TO CLOSE MEMBER GRIEVANCES



PROCESSES - POTENTIAL ISSUES

United States Government Accountability Office

GAO

Report to the Ranking Member, Committee on Finance, U.S. Senate

August 2018

MEDICAID HOME- AND COMMUNITY-BASED SERVICES

Selected States' Program Structures and Challenges Providing Services

GAO-18-628

Blended Rates create financial incentive toward Home and Community Based Settings (HCBS)[1]

[1]Page 9, GAO-18-628, October 01, 2018

"State and MCO officials also reported that complex conditions that affect beneficiaries' behavior, such as co-occurring developmental disabilities and behavioral health conditions, dementia, and traumatic brain injury can also create challenges for providing HCBS, particularly when beneficiaries display aggressive or other challenging behaviors." [3]

[3]Page 11, GAO-18-628, October 01, 2018

"...selected states and MCOs we interviewed said that they have responded to the challenge of serving HCBS beneficiaries with complex medical or behavioral health needs by (1) supporting the development of locations in the community to serve individuals with specific complex needs, (2) training providers, and (3) increasing care coordination." [3]

[3]Page 11, GAO-18-628, October 01, 2018

"We have previously reported that although MLTSS can provide states with the opportunity to enhance and encourage the provision of HCBS, oversight at the state and federal levels is critical to ensure that individuals with LTSS needs are able to obtain needed care in a timely fashion." [2]

[2]Page 10, GAO-18-628, October 01, 2018

LESSONS LEARNED

- **Establish what constitutes eligible settings: own home, family home, licensed settings. No "unlicensed" settings**

- **Ensure financial viability and experience of providers, open and continuous provider contract system**

Arizona developed specialized processes to support individuals who require ventilator services in community settings:

1. **Specialized Nurse case management and oversight of the program**
2. **Develop specialized Child and Adult Developmental Homes (similar to foster settings) when they could no longer be supported in their family setting**
3. **Short term stabilization post hospitalization**

Arizona developed a "joint step down facility" for individuals with co-occurring Intellectual/Developmental Disabilities and behavioral health challenges who are discharged from inpatient behavioral health institutions:

1. **Behavioral Health Provider scheduled and paid for trained staff for support/back-up**
2. **HCBS Provider rented the setting, scheduled and paid for staff providing habilitation services and general management of the setting**

Arizona developed a specialized unit to evaluate and procure contractors statewide for individuals to have augmentative communication devices.

Arizona developed a specialized unit to evaluate, develop home modification plans and procure contractors statewide for individuals to have improved access and independence in their home (whether owned or rented)

Conflict of Interest in Medicaid Authorities

Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
January 2016

CMS Webinar presented by

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the next 6 slides are from this webinar

CASE MANAGEMENT IS…

- A "key" or "linchpin" service in the world of long term supports and services (LTSS)
- Both the human services system *and* the individual/family rely on case management.
  - The "system" needs case management to keep the program running.
  - The individual and family need case management to help them build and sustain their lives.

CASE MANAGEMENT SYSTEM FUNCTIONS

(some of which work for individuals as well)

- Oversee provider performance
- Operate front line on quality compliance/outcomes/safety
- Uphold key Medicaid requirements, such as:
  - Informed choice and freedom of choice
  - Assuring rights
- Assure compliance with regulations
  - Keep the required records, which…
  - Keeps the money flowing by supporting activities such as:
    - Level of care screens
    - CMS required annual reviews
    - Assuring people keep financial eligibility for Medicaid
    - Assuring individuals plans match billing, etc.

Individual and Family Functions

- On behalf of the individual and family, case managers:
  - Engage in high quality, person-centered planning that keeps the full focus on the person.
  - Serve as the front line for information and assistance.
  - Provide a source of knowledgeable and thoughtful strategies to help individuals make decisions about what is important *to* them and *for* them.
  - Help individuals and families "navigate" the system.
  - Serve as the front person for addressing problems related to outcomes and quality.

REQUISITES FOR GOOD CASE MANAGEMENT

- Case managers are only as strong as the skills, support, technical assistance, and authority they have.
- Therefore:
  - Case management standards, values, and expectations must be clear and consistent.
  - The state must provide continuous training and oversight.

REQUISITES FOR GOOD CASE MANAGEMENT

- Caseload sizes that match scope of responsibility and account for the level of support individuals will need.
- Accessible supervision and consultation.
- Freedom from budget decisions—using resource allocation so that the person and case manager already know the budget and can just get to work.

REQUISITES FOR GOOD CASE MANAGEMENT

- Responsibility *and* authority
  - Case managers must be able to act as the conduit between state authorities and the providers & individuals who receive services
  - Case managers must receive adequate support from their supervisors and the state.
  - When case managers are seen as "just" another kind of service provider, they cannot effectively exercise authority.

- **Ensure Support Coordination/case management system has adequate training and defined roles:**
  - **Conflict free case management**
  - **Hear stakeholder voice, engage them in planning/execution**
  - **Person centered planning across all domains (acute, behavioral health, LTSS, etc)**
  - **Uniform Needs Assessment processes**
  - **Follow through on service acquisition**
  - **Initial problem solving on issues**

DATA - MEASURES - MONITORING

DISTRACTED BY DATA[4]

"Identifying the right problem to be solved as a threshold step makes a big difference. Data distraction is easy to fall into because each data stream…opens so many insights that were previously inaccessible – so many that they can obscure larger, underlying issues whose solution might need a different approach altogether."

[4] ***Goldsmith, Stephen***; **Governing Magazine; http://www.governing.com/blogs/bfc/col-data-distraction-existing-processes-underlying-problems.html; October 16 2018**

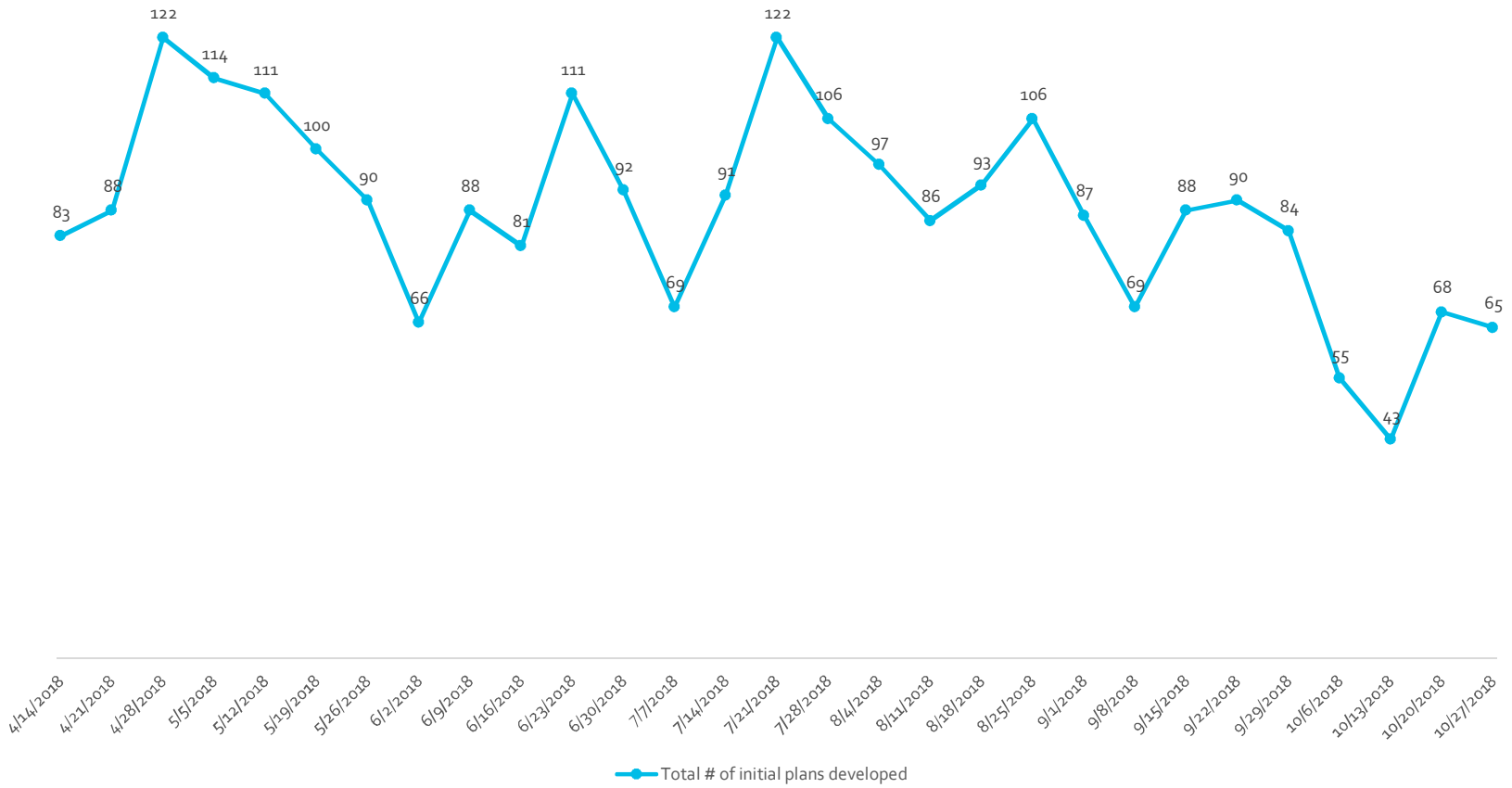
DATA

There are many areas to track/monitor

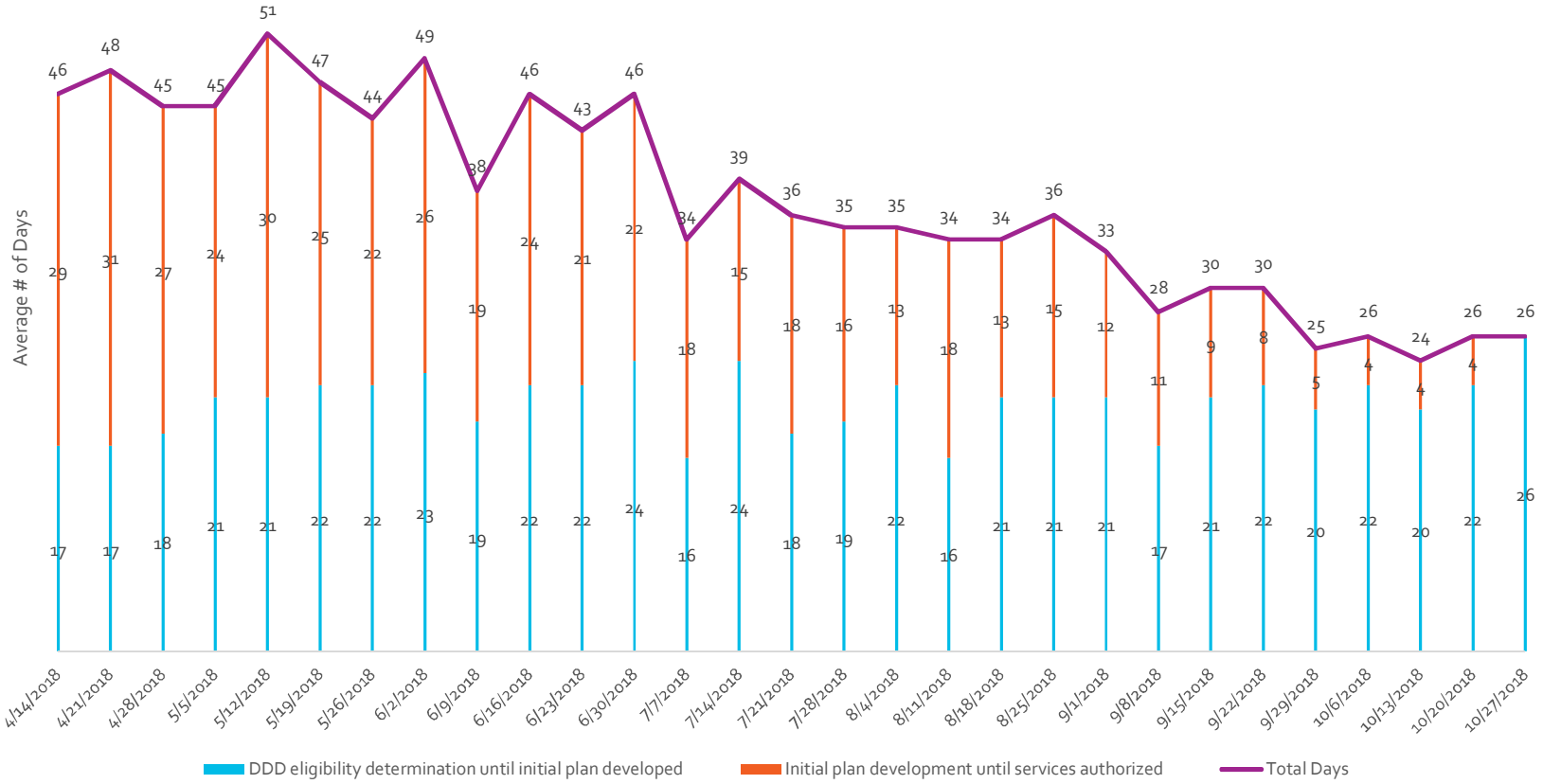
Managed Care Rules require services to be provided in a timely manner.

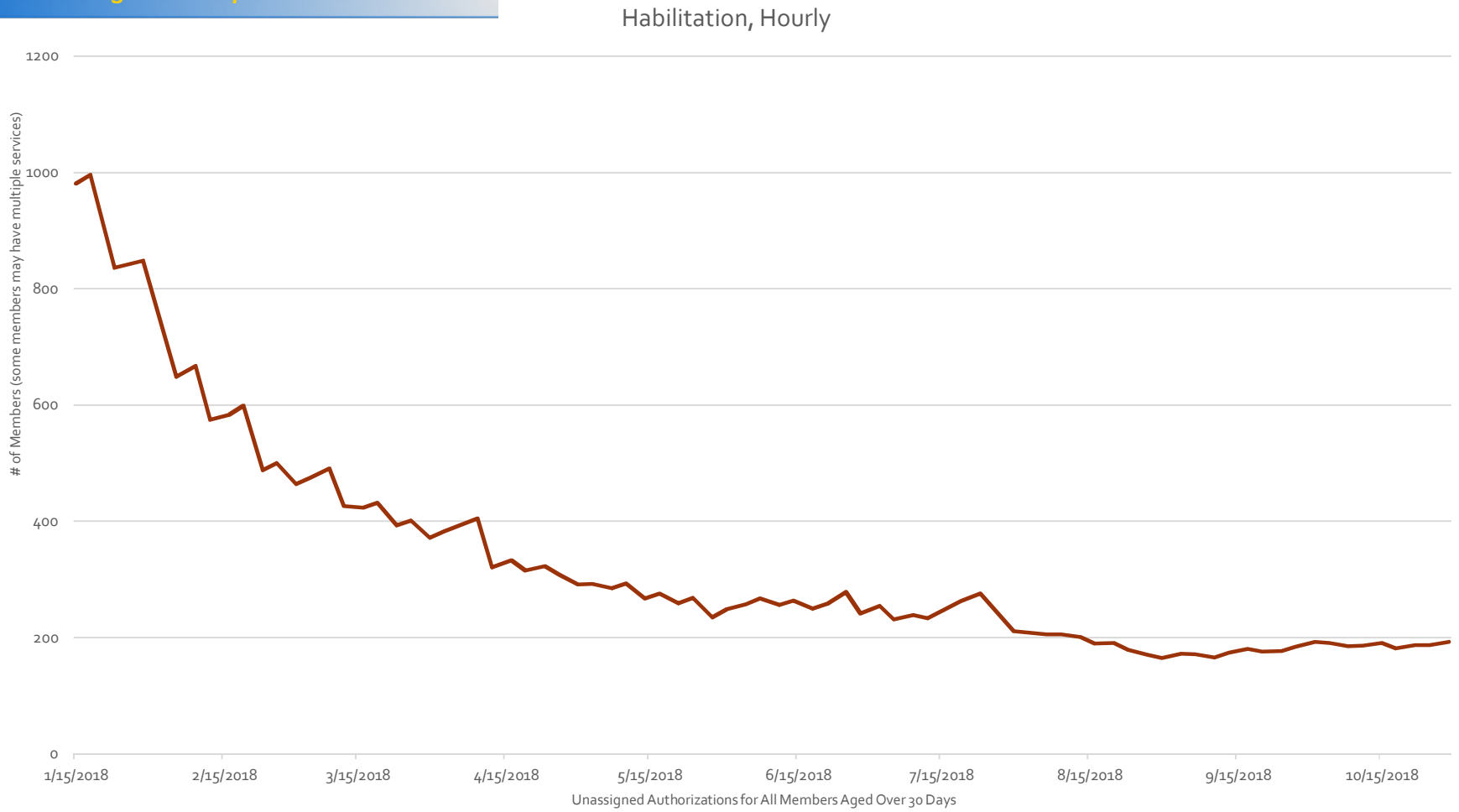
The Division has developed a metric to evaluate the timeframe for a new enrollee to have a service plan completed and then for services to be implemented

Number of Initial Plans Developed



Eligibility Determination to Service Authorization





DATA MINING

Encounters provide a wealth of information to analyze and evaluate program objectives

There are limitations that must be acknowledged or addressed:

1. **There is a lag time from when a service is provided, the claim is submitted, the claim is processed and the claim receives approved status**
2. **Some services may be provided outside the encounter environment (Community Health Services, third party coverage, Indian Health Services, etc)**

DATA MINING

Combining acute care, behavioral health and long term care service encounters requires:

- **knowledge of the data elements/systems and**
- **building inquiries into the data requires knowledge of the program.**

Sometimes there are individuals who have expertise in both however most times it requires pulling together multiple individuals with various knowledge sets

DATA MINING

Some examples of data mining:

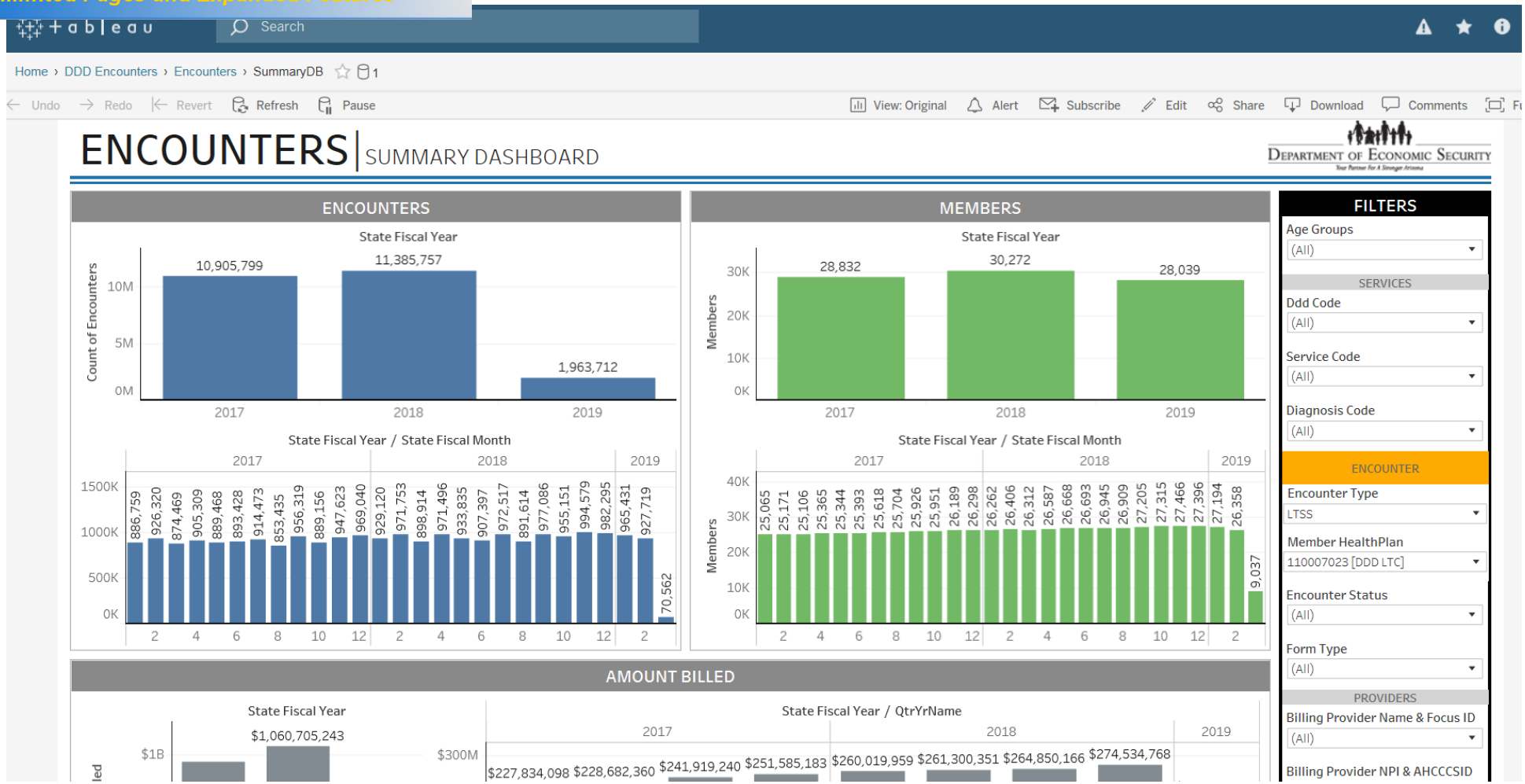
1. **Using acute and LTSS encounters to compare Personal Care utilization and hospitalizations in order to determine**
   - I. **Are there areas where Personal Care providers need additional training**
   - II. **Personal Care services are not sufficient to meet needs/mitigate hospitalizations**
   - III. **Personal Care providers not meeting expectations**

DATA MINING

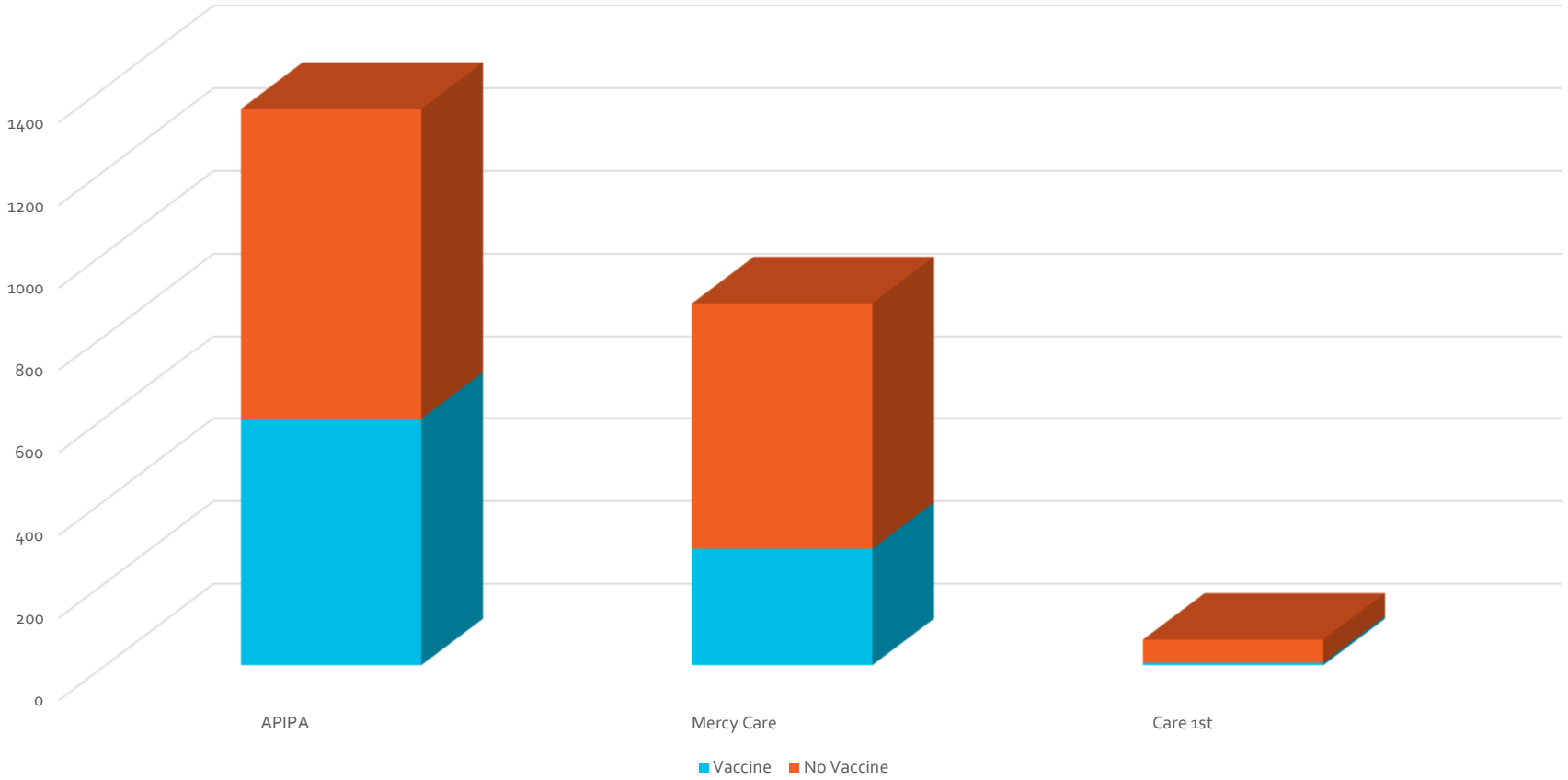
Some examples of data mining:

2. Using acute encounters:

- Review immunizations for pneumonia for appropriate groups
- Review pneumonia related hospitalization juxtaposed to immunizations



Pneumococcal Vaccine for
Health Plan Members over age 55



DATA MINING

Some examples of data mining:

3. Using acute and LTSS encounters:

- Review institutional/hospital claims overlapping LTSS claims
- Review Opioid utilization patterns by diagnosis, pharmacy jumping, etc

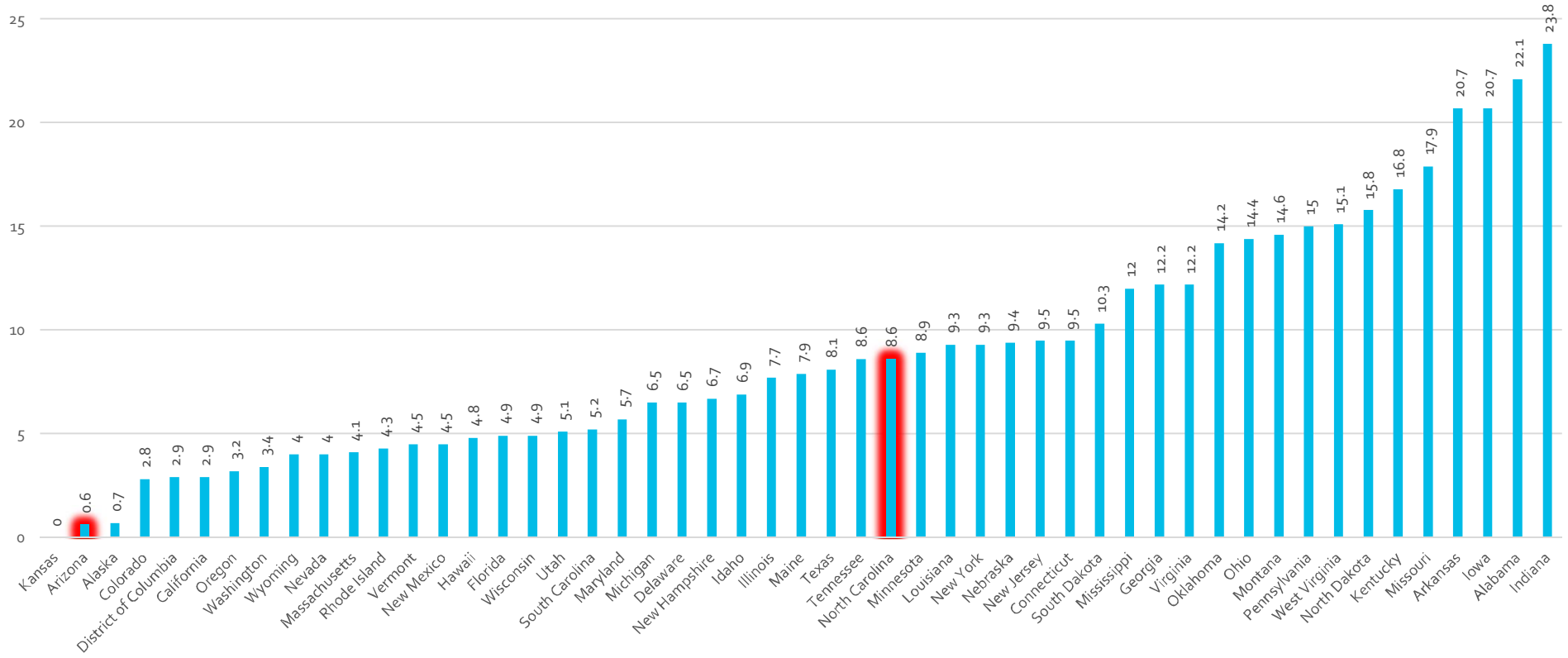
DATA MINING

Other examples of data for system analysis:

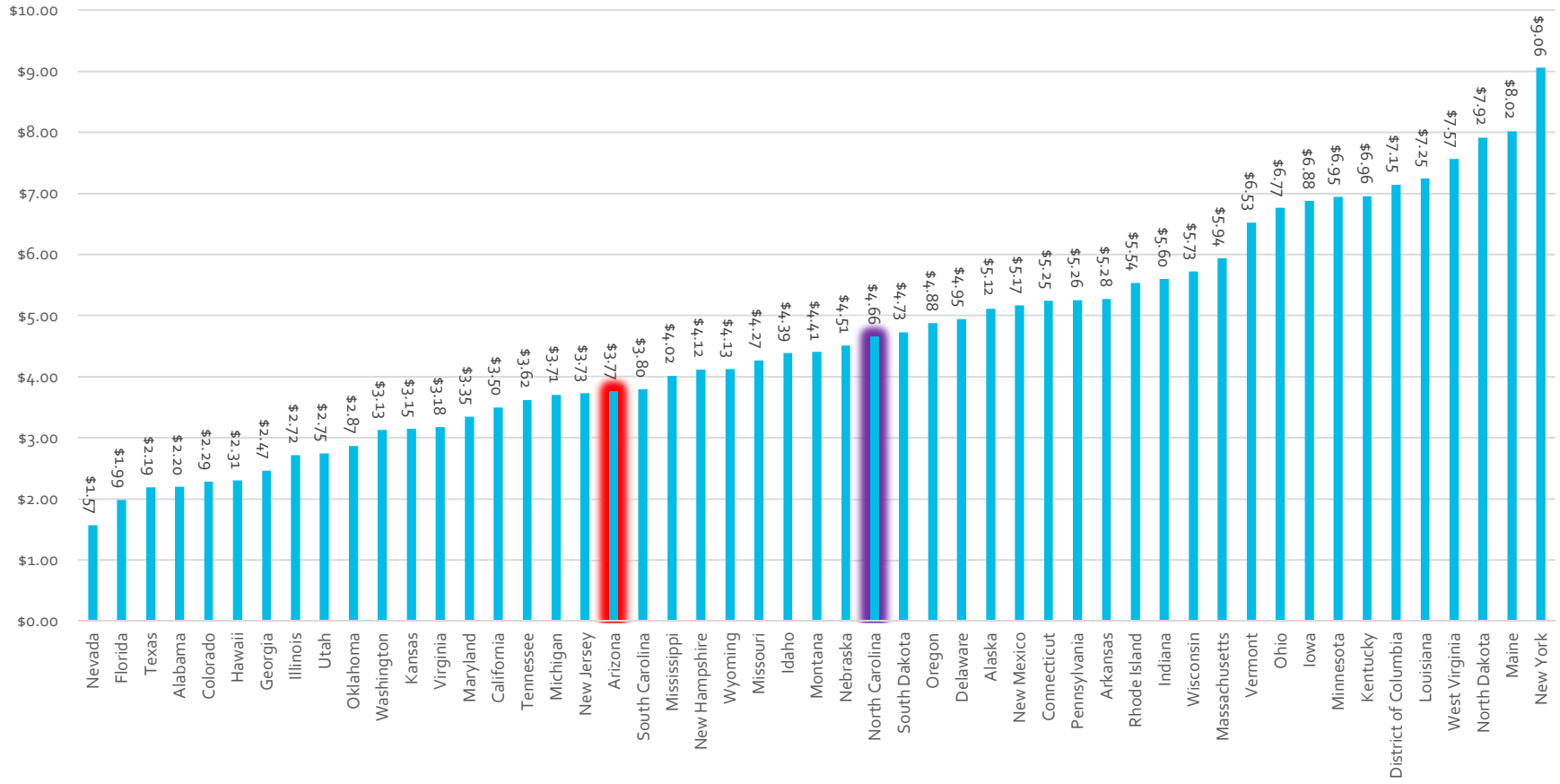
4. **National Core Indicators**
   - Surveys inform states on stakeholders view of the system
   - Create opportunity to identify areas for improvement
   - Longitudinal view of progress over time

5. **State of the States**
   - View of effort against other comparable states
   - Longitudinal view of state effort over time

State of the States 2015
Residents in Nursing Homes
(Placements per 100,000 of state's general population)



State of the States 2015
Fiscal Effort for IDD Services: Rank



MONITORING

Provider Profiling is typical in acute care environments and has application in LTSS environments as well.

- **Monitor billing by the same provider for multiple services/locations for same dates/times**
- **Extra-ordinary growth in specific services (in-home, multiple locations in state, etc)**

SOCIAL DETERMINANTS OF HEALTH NEEDS

Broadly defined as "the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life"

World Health Organization

ADDRESSING SOCIAL DETERMINANTS AND ITS IMPACT ON HEALTHCARE [5]

- "Healthcare alone accounts for only 10 to 25 percent of the variance in health over time."
- The remaining variance is shaped by:
  - Genetic factors (up to 30 percent)
  - Health behaviors (30 to 40 percent)
  - Economic factors (15 to 40 percent)
  - Physical environmental factors (5 to 10 percent)

[5]Blatt, Edward; O'Riordan, Eloise; Matejevic, Ljubisav; and Duggan, Martin; IBM Curam Research Institute; Page 5

ADDRESSING SOCIAL DETERMINANTS AND ITS IMPACT ON HEALTHCARE [5]

- **"The social determinants of health often lie outside the control of the health sector yet evidence shows that these determinants have a major impact on health."**
- **"You must be willing to be proactive in working with the other sectors that affect health."**

Use of Social Determinants of Health Codes for Member Outcomes

As part of AHCCCS' efforts in developing a streamlined method of collecting and tracking member outcomes, the use of specific ICD-10 diagnosis codes representing Social Determinants of Health has been identified as a valuable source of information that impacts member health.

The Social Determinants of Health codes identify the conditions in which people are born, grow, live, work, and age. They include factors like:

- Education
- Employment
- Physical environment
- Socioeconomic status
- Social support networks

As appropriate within their scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Any identified social determinant diagnosis codes should be provided on all claims for AHCCCS members in order to comply with state and federal coding requirements. Beginning with dates of service on and after April 1, 2018, AHCCCS will begin to monitor claims for the presence of these codes.

As of October 1, 2017, the following ICD-10 diagnosis codes are defined as Social Determinants of Health codes under ICD10. Please note that Social Determinants of Health codes may be added or updated on a quarterly basis. Providers should remain current in their thorough utilization of these codes.

ARIZONA DEMOGRAPHIC AND OUTCOME DATA SET (DUG DATA)

- AHCCCS has developed a portal for submission of data including SDOH information
- Data and information are reported to assist in monitoring and tracking the following:
  - Access and utilization of services
  - Community and stakeholder information
  - Compliance of Federal, State, and grant requirements
  - Health Disparities and inequities
  - Member summaries and outcomes
  - Quality and Medical Management activities
  - Social Determinants of Health

QUESTIONS?