Building a healthier future for all Arkansans

Long term services and supports (LTSS) workgroup

October 25, 2012

Objectives for today and what's coming up

Objectives for today

- Provide context on Payment Improvement Initiative to ground our work in the effort
- Share overview of Long Term Services and Supports (LTSS) population and care usage
- Gather feedback on challenges and potential opportunities within LTSS
- Introduce concepts of episode-based care and health home model

Role of workgroup: we want real input and collaboration

Workgroups: we are looking for…

- Input on the client care journey and experience
- Input on system inefficiencies and improvement potential, and/or existing attributes to accentuate or protect
- Feedback and discussion on payment model design
- Feedback on practical implementation challenges to overcome

Format for today

- We want your active participation and feedback
- Flow: we will present some materials and will then turn to group discussion and comments
- Videoconference participants should feel free to speak up (we will also pause at points to ask for input from other sites)
- Please always speak directly into the microphone so that those in other sites can hear your comments

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Today, we face major health care challenges in Arkansas

- **The health status of Arkansans is poor**, the state is ranked at or near the bottom of all states on national health indicators, such as heart disease and diabetes
- **The health care system is hard for patients to navigate**, and it does not reward providers who work as a team to coordinate care for patients
- **Health care spending is growing unsustainably:**
  - Insurance premiums doubled for employers and families in past 10 years (adding to uninsured population)
  - Large projected budget shortfalls for Medicaid

Our vision to improve care for Arkansas is a comprehensive, patient- and client- centered delivery system

Focus today

Objectives

For patients and clients

- Improve the health of the population
- Enhance the patient experience of care
- Enable patients to take an active role in their care

For providers

- Reward providers for high quality, efficient care
- Reduce or control the cost of care

How care is delivered

Population-based care

- Medical homes
- Health homes

Episode-based care

- Acute, procedures or defined conditions

Four aspects of broader program

- **Results-based payment and reporting**
- **Health care workforce development**
- **Consumer engagement and personal responsibility**
- **Health information technology (HIT) adoption**

Payers recognize the value of working together to improve our system, with close involvement from other stakeholders

Coordinated multi-payer leadership…

- Creates **consistent incentives** and standardized reporting rules and tools
- Enables **change in practice** patterns as program applies to many patients
- Generates enough scale to justify investments in **new infrastructure** and operational models
- Helps **motivate patients** to play a larger role in their health and health care

1 Center for Medicare and Medicaid Services

Medicaid and private insurers believe paying for results, not just individual services, is the best option to improve quality and control costs

✓ Transition to payment system that **rewards value and patient health outcomes** by aligning financial incentives

✗ **Reduce payment levels for all providers** regardless of their quality of care or efficiency in managing costs

✗ **Pass growing costs on to consumers** through higher premiums, deductibles and co-pays (private payers), or higher taxes (Medicaid)

✗ **Intensify payer intervention in decisions though managed care or elimination of** expensive services (e.g. through prior authorizations) based on restrictive guidelines

✗ **Eliminate coverage of** expensive services or eligibility

Contents

List of Medicaid LTSS programs in Arkansas

Community based
Facility based

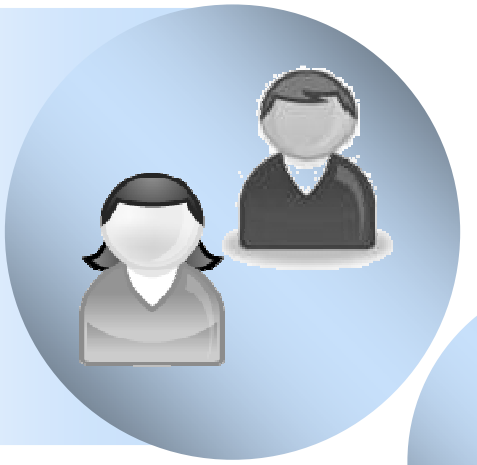
	Eligibility assessment	Age range	Services that are provided
Personal care		▪ Any age	▪ Personal care / grooming ▪ Meals and diet ▪ Household chores
ElderChoices	▪ DAAS registered nurse	▪ 65 +	▪ Adult family homes ▪ Homemaker ▪ Chores ▪ Home delivered meals ▪ Emergency response ▪ Adult Day Care ▪ Respite ▪ Companion services
Independent Choices	▪ DAAS registered nurse	▪ 18 +	▪ Provides counseling services and a monthly allowance for: – Personal assistance – Products and services that increase independence
Alternatives for adults with physical disabilities	▪ DAAS registered nurse	▪ 21 - 64	▪ Attendant care ▪ Environmental accessibility adaptations ▪ Case management
Living Choices	▪ DAAS registered nurse	▪ 21 +	▪ Assisted living facility that provides: – Attendant care – Therapeutic social activity – Medication oversight/ administration – Some nursing services – Transport
Nursing homes	▪ Provider assessment	▪ Any age	▪ All nursing home support and services

Note: Does not include PACE or other demonstration programs
SOURCE: DHS website

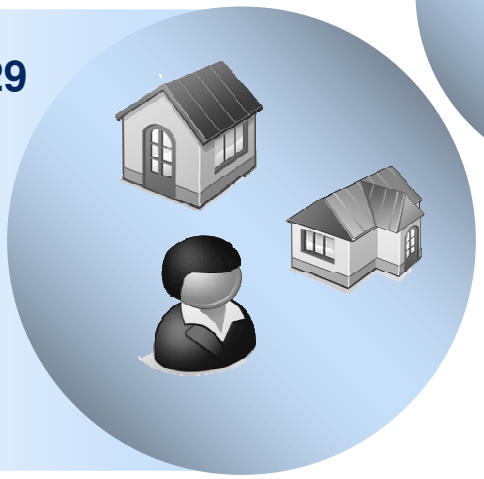
Basic facts about Medicaid LTSS population in Arkansas

PRELIMINARY

Nursing home residents **~12,000**
Waiver recipients **~11,000**
Personal care



Nursing homes **229**
Assisted Living Facilities **77**
Waiver providers **>2300**[2]
Adult day care facilities **26**



Total LTSS expenditures **$900 M**
Total Medicaid "halo[1]" expenditures (does not include Medicare) **$150 M**

Core spend:

- LTSS services delivered to the client

Halo spend:

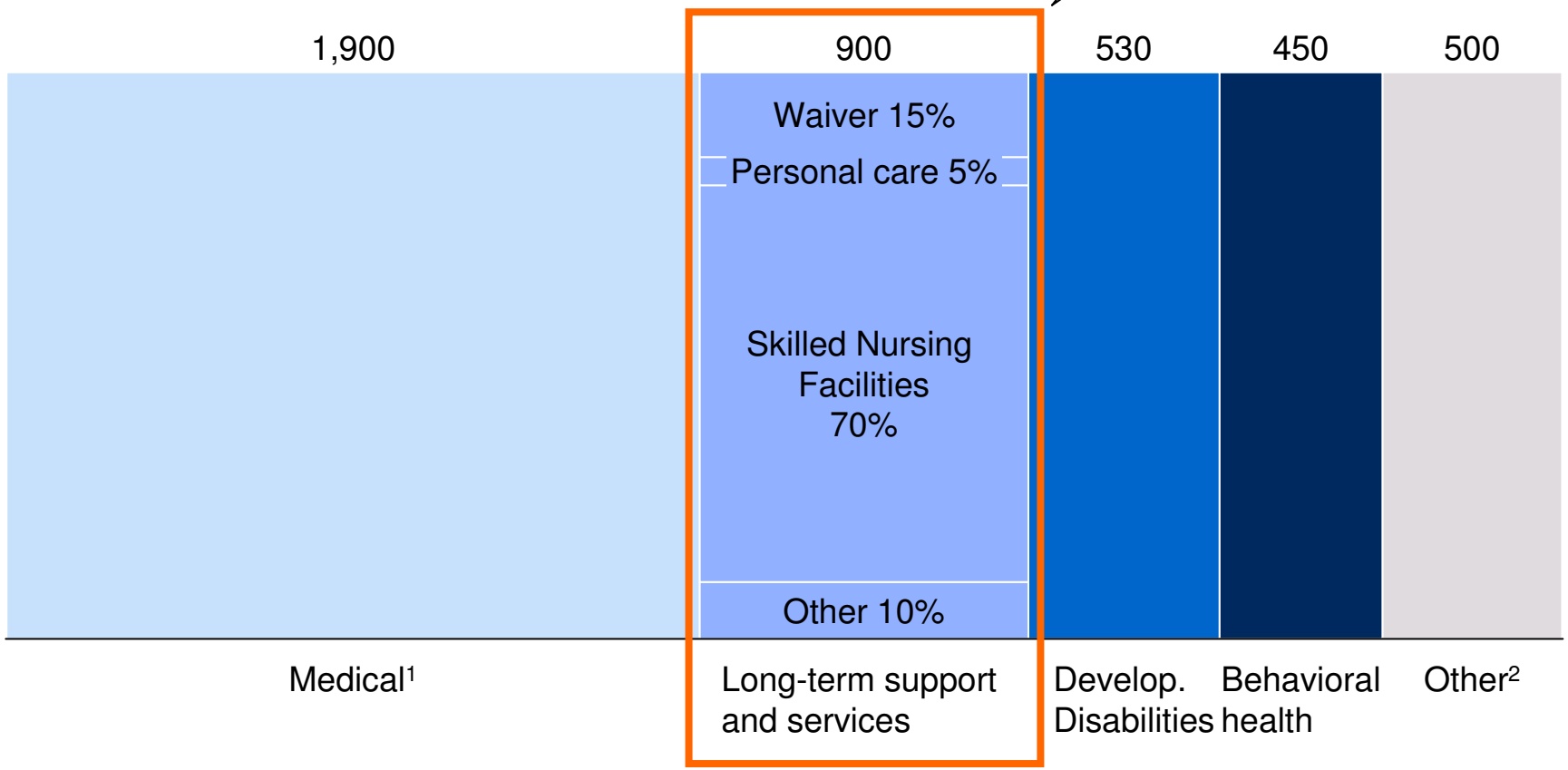
- Includes non-LTSS health services (e.g., medical, behavioral health services) delivered LTSS clients

1 Includes all Medicaid expenditures for services not provided by LTSS provider, e.g., medical, behavioral health, pharmacy. Does not include Third-Party Liability or Medicare expenditures.
2 >300 agency providers and >2000 consumer directed providers
NOTE: Does not include populations in Developmental Disabilities (DD) or Behavioral Health (BH) facilities. Waiver programs include: ElderChoices, Adults and Physical Disabilities, Assisted living, Independent Choices. Does not include Personal Care.
SOURCE: SFY2011 Medicaid claims data, SFY2012 Office of Long Term Care fact sheet

LTSS represents 21% of total Medicaid spend and 24% of Medicaid growth

PRELIMINARY

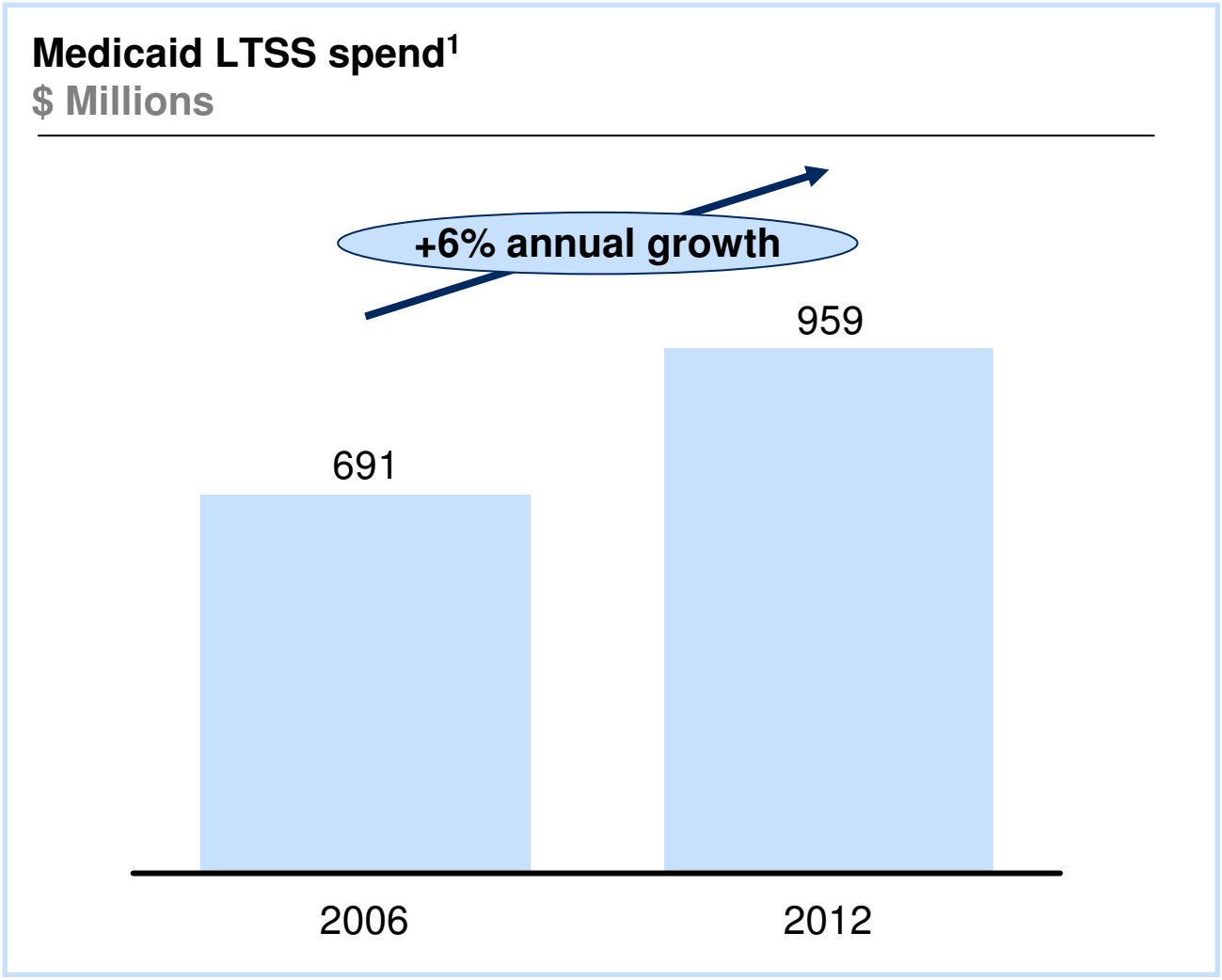
Medicaid spend by area, includes cost settlements, total = $4,380M
$ million, (% of total)



1 Medical includes physician, hospital and other primary medical services
2 Other includes Medicare buy-in program, medical equipment, ambulance services, and managed care fees/waivers

SOURCE: SFY 2011 Medicaid financial data

Medicaid LTSS spend has grown 6% annually for the past 6 years



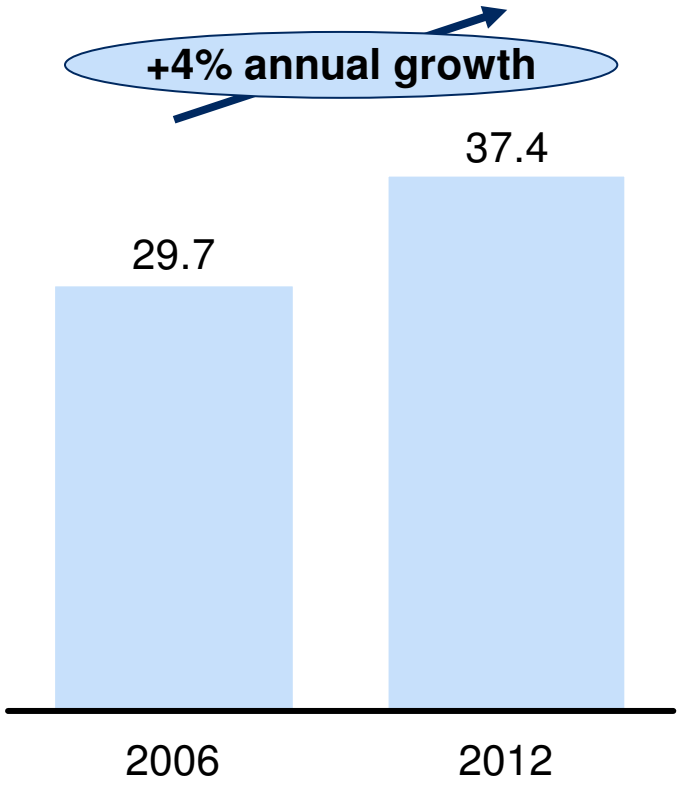
1 Includes Aged, Disabled, Children & Families, and Other populations, with Other comprised of Adoption, Foster Care and ARHealthnetworks

SOURCE: SFY 2006-2012 Medicaid financial data

Among the Aged population, hospital services spend has grown 4% annually, while physician services spend has remained constant

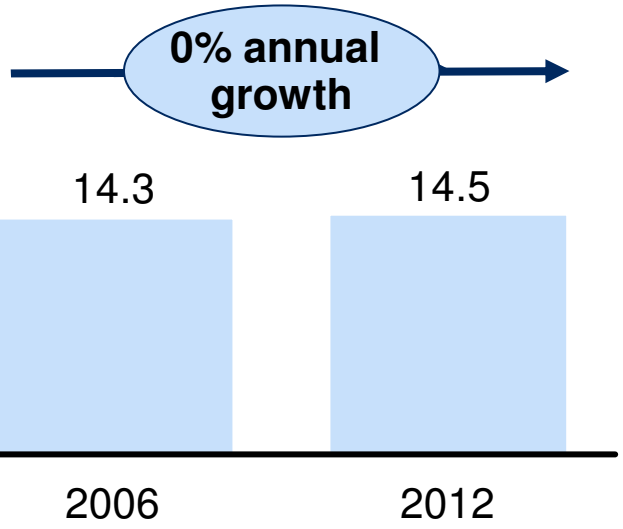
Medicaid hospital services spend for the Aged population[1]

$ Millions



Medicaid physician services spend for the Aged population[1]

$ Millions

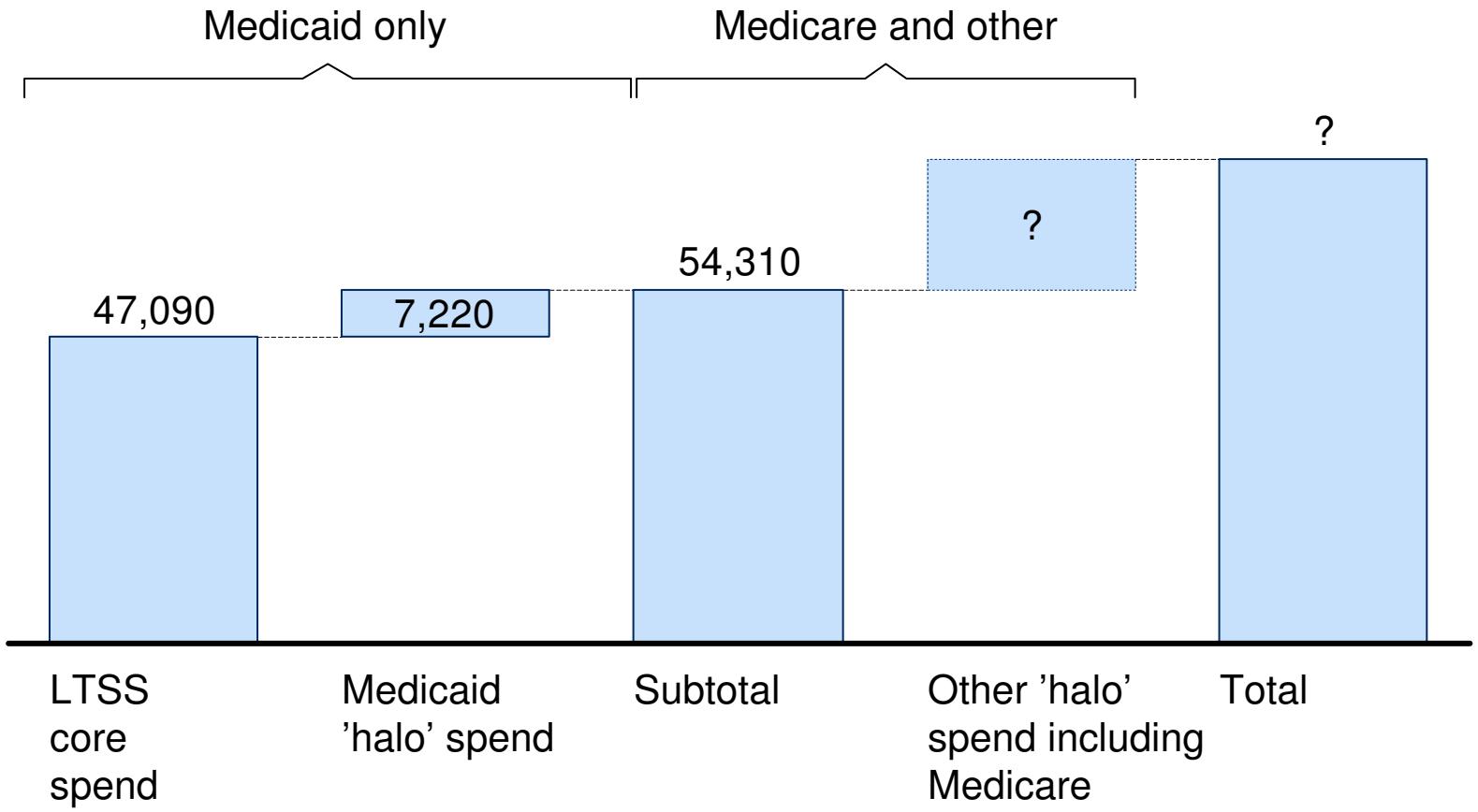


1 Aged population includes SSI Aged and Medically Needy Aged populations
SOURCE: SFY 2006-2012 Medicaid financial data

To fully capture spend, we need to understand dual eligible costs that do not show up in Medicaid claims

Per capita spend on LTSS population and other services[1]

Dollars

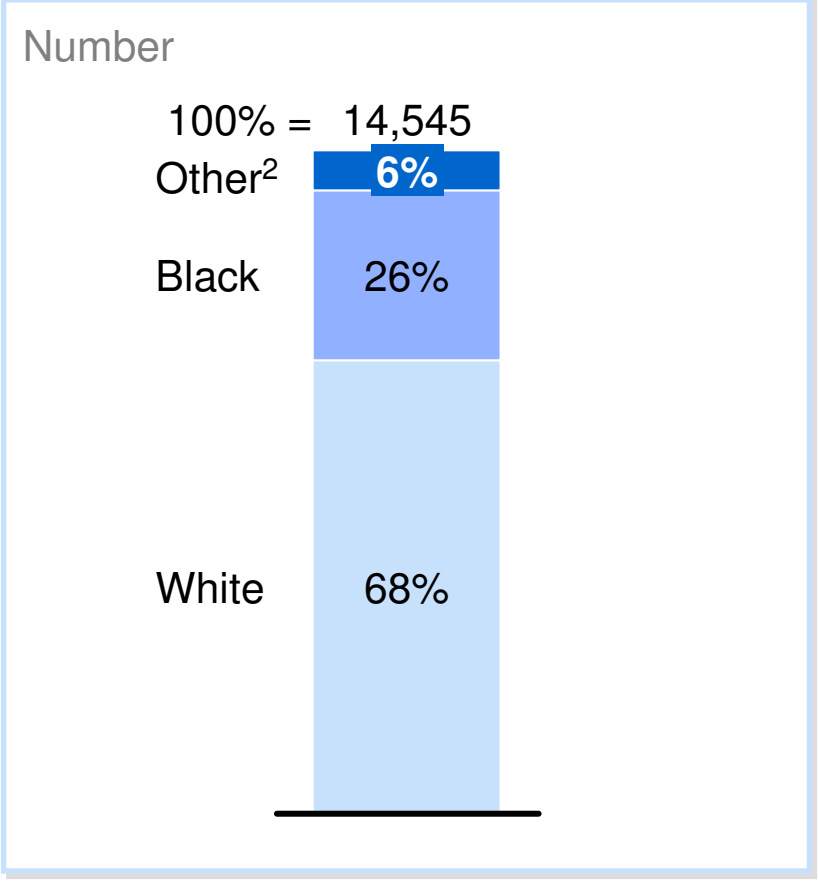


1 Does not include third party liability or pharmacy

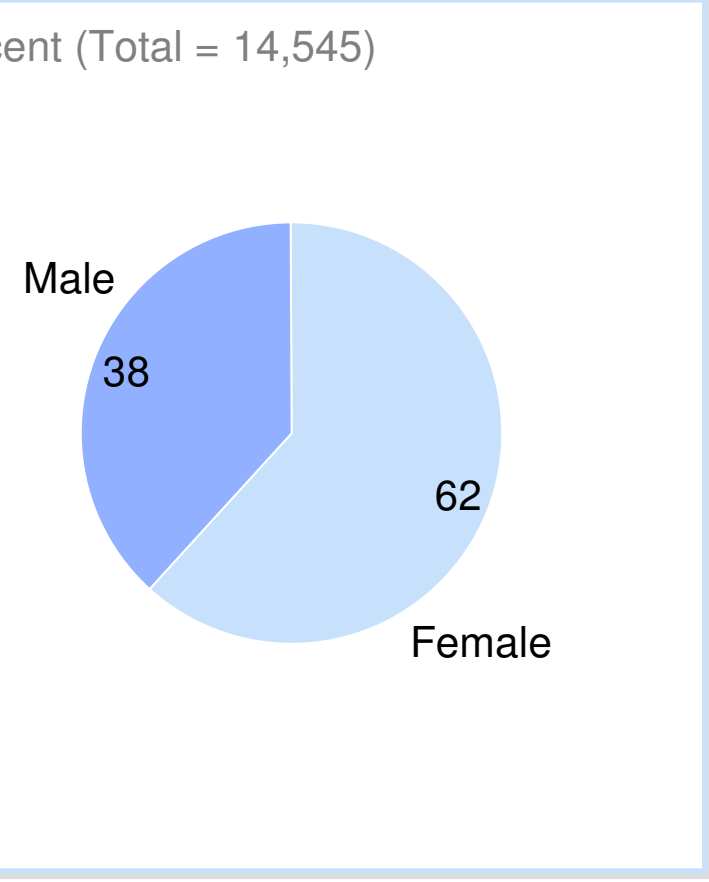
SOURCE: Medicaid claims data for claims incurred in SFY 2010 and SFY 2011

Community-based services[1] client demographics

Distribution of community-based services clients by ethnicity



Distribution of community-based services clients by gender

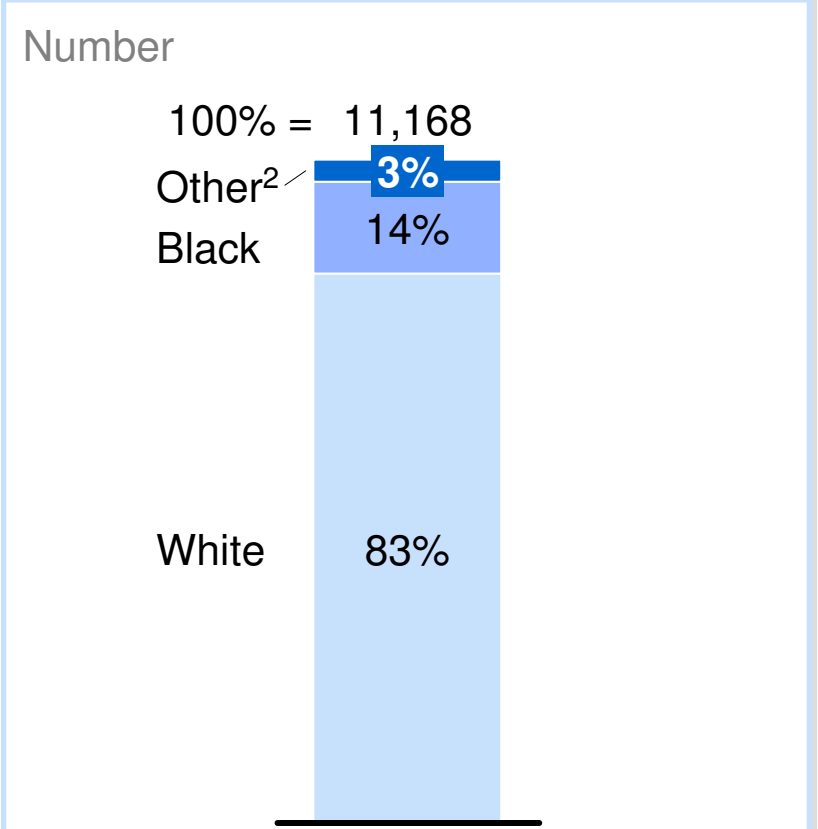


1 Includes Elder Choices, IndependentChoices and Alternatives for adults with physical disabilities (AAPD)
2 Other includes: Hispanic, Asian, Native American, Native Hawaiian and Other Pacific Islander, and more than one race
NOTE: SFY 2011 estimates
NOTE: 2011 US Census indicates that 80.1% of the Arkansas population is White, 15.6% is Black or African American, and 4.3% falls under Other. Females represent 50.9% of the population.

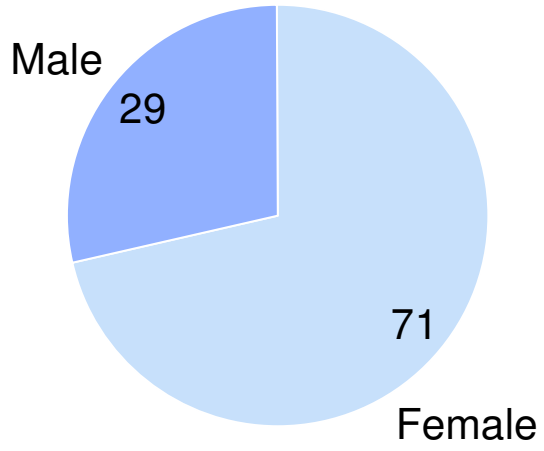
SOURCE: ADHS 2011 Statistical Report

Facility-based services[1] client demographics

Distribution of facility-based services clients by ethnicity



Distribution of community-based services clients by gender

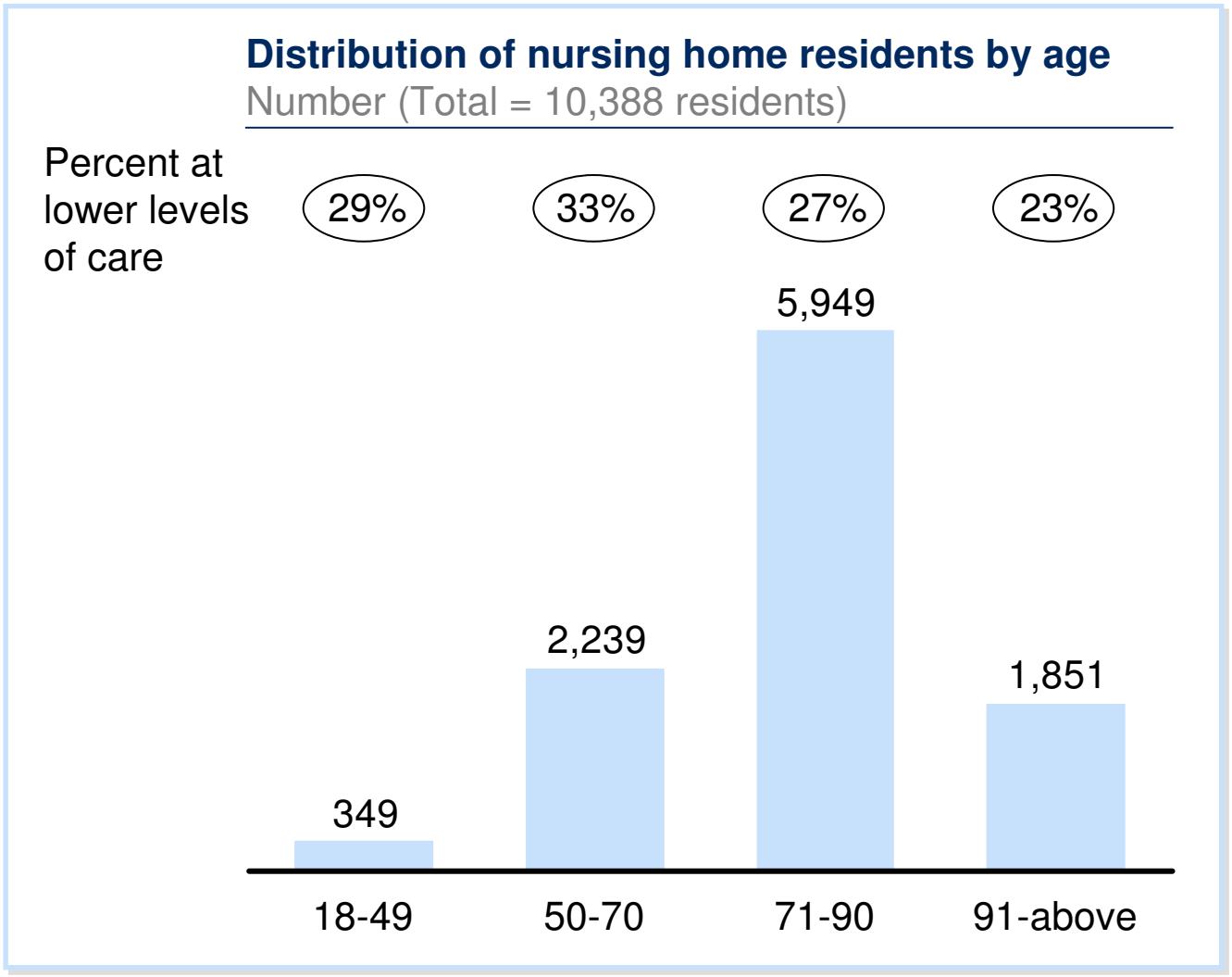


Details on nursing home residents to follow

1 Includes Assisted living choices and Nursing homes
2 Other includes: Hispanic, Asian, Native American, Native Hawaiian and Other Pacific Islander, and more than one race
NOTE: SFY 2011 estimates for Assisted living choices numbers. Time period for Nursing home numbers = July 1, 2011 to September 30, 2011. Total sample = 186 nursing homes, 10,388 residents. Does not include Intermediate care facilities for people with mental retardation (ICFMRs)
NOTE: 2011 US Census indicates that 80.1% of the Arkansas population is White, 15.6% is Black or African American, and 4.3% falls under Other. Females represent 50.9% of the population.

SOURCE: ADHS 2011 Statistical Report. Q Source Management for Medicaid Quality Initiatives and Technical Support (MMQI), Arkansas Long Term Care MDS/RUG Project.

The majority of nursing home residents are between the ages of 71 and 90



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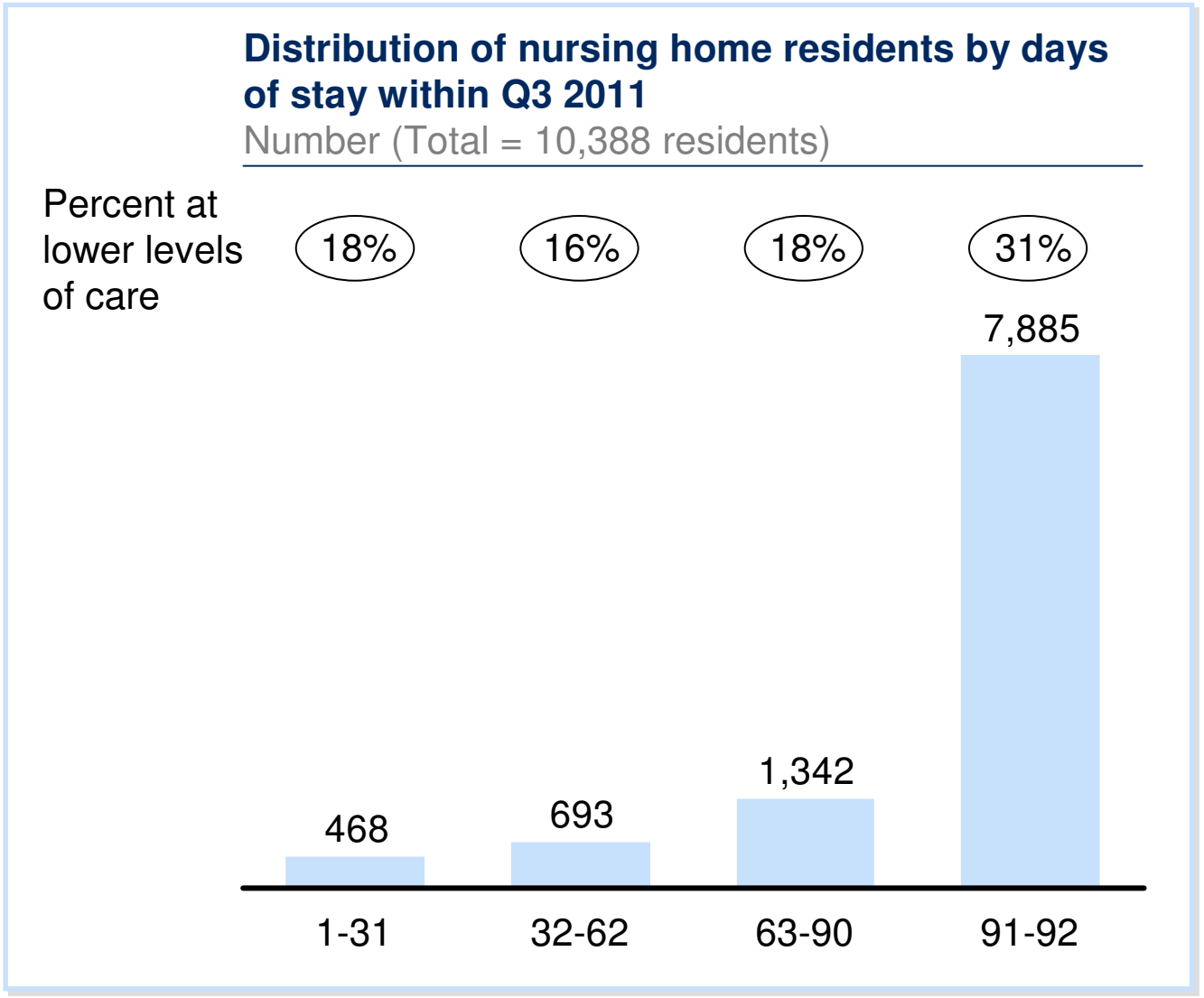
Nursing home stays vary in duration



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Initial view of challenges within current LTSS system

PRELIMINARY

Matching level of care to need	▪ Eligibility and budgeting decisions should reflect client needs
Removing adverse incentives	▪ Incentives should reward positive care planning and appropriate staffing levels
Coordinating care	▪ Some clients have high costs outside of the LTSS system (e.g., medical costs) ▪ Performance on case management should be consistent across providers and clients
Helping people get to the right setting of care	▪ Clients need to make setting of care decisions with a full understanding of long term supports and services
Ensuring a diverse array of providers	▪ Match array of providers with client needs and preferences

Potential sources of value in LTSS

PRELIMINARY

1. **Care may not always be reflective of need**
2. **Channels for care coordination exist but may not address full array of services or be available in all settings of care**
3. **Setting of care drives types of services provided**

Potential approaches to capturing sources of value in LTSS

PRELIMINARY

Potential sources of value in long term care	Possible approaches to address
1 **Care may not always be reflective of need**	▪ Develop an assessment-based episode so that payment matches needs for care over an entire period, underpinned by a comprehensive assessment
2 **Channels for care coordination exist but may not address full array of services or be available in all settings of care**	▪ Use health homes to align financial incentives to support the coordination of care and management of client treatment
3 **Setting of care drives types of services provided**	▪ Match setting of care to client needs and preferences

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The assessment-based episode model is designed to align services with client needs and preferences and reward high-quality, cost-effective care

The goal	▪ **Customized needs- and preferences-based care** for all clients based on a comprehensive assessment, focusing resources and time on the highest-impact services
Accountability	▪ A **lead provider** is designated as accountable for assessed levels of care across the episode
Incentives	▪ **High-quality, cost efficient care** is rewarded beyond current reimbursement, based on the average cost and total quality of care across each episode

Goals of the health home

PRELIMINARY

To deliver integrated care coordination in a manner that facilitates quality care and positive outcomes through:

Providing care coordination

- Providing clients with integrated care coordination within and across LTSS, medical health, behavioral health and other systems

Managing core care delivery

- Ensuring effective LTSS treatment, including pharmacy effects

How can we design health home criteria and corresponding payment model to achieve these goals?

Introduction to a health home

What a health home is…	What a health home is not…
▪ Extra support for people who need an increased level of care coordination or who face greater challenges in navigating the healthcare system ▪ Enhanced support for clients have needs in multiple areas, including LTSS, housing, justice system, etc. ▪ Opportunity to promote quality in the core provision of LTSS ▪ Encourage providers to work in teams to improve outcomes for the clients ▪ A way of aligning payment with evidence-informed, team-based care, and health outcomes	▪ NOT necessarily a direct provider of medical services ▪ NOT a gatekeeper restricting a client's choice of providers ▪ NOT a physical "house" where all health home activities take place

Timetable going forward - what to expect

PRELIMINARY

Key milestones	Description	Activities to begin
▪ **Episode and health home model development**	▪ Elements for episode and health home defined (i.e., target population, scope of services, lead provider, quality metrics) ▪ Provider requirements and payment mechanics designed ▪ Feedback gathered from stakeholders to inform Arkansas-specific model and assessment approach ▪ Educational workgroups and townhalls to answer questions	Ongoing
▪ **Assessment launch**	▪ Training provided to independent assessors ▪ Initial assessments begun with select populations	As soon as possible (by Q1 2013)
▪ **Reporting period / data collection for both episode and health home**	▪ Data collection and refinement ▪ Reports available to providers in order to establish baseline historical performance	2nd Half 2013
▪ **Feedback period**	▪ Formal/informal opportunities for feedback and experience to date ▪ Refinements to version 1.0 design	Q4 2013
▪ **Performance period begins**	▪ Episodic payment begins (design / timing may vary by level of LTSS services)	Late 2013
	▪ Performance-related health home payments introduced	Q1 2014