



# Partnering with Managed Care Entities

## A Path to Coordination and Collaboration



Presented by:  
Caroline Carney Doebbeling, MD, MSc  
Chief Medical Officer, MDwise  
May 9, 2013

# Agenda

- Are new care models on the way?
  - Update from October
- Compare to the current Indiana landscape
  - Are CCOs and Health Homes so new after all?
- Potential opportunities
- Options for CMHCs and MCEs to partner in this new environment

# New Buzz Words?

- October discussion of CCOs and Health Homes
- Legislation to study models of care and payment for ABD and Dual Eligibles
  - Options range from managed care to CCOs to maintaining the current status

# 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 or area of the state
- 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)

# 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

# CCOs

- No outcomes
- Many health policy experts believe model is not transferable
- Five years is too short to bend the trend

# 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



# Health Home Basics

- Health home services that are required for the 90% FMAP include
  - Comprehensive care management
  - Care coordination
  - 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

# 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

# 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

# Risk Stratification for Care Select

## Average Predictions, Weighted by Eligibility

Medicaid MC All Medical Predicting Concurrent Total Risk (ID: 76)

3.82

ADCG Predicted Expenditure Range	Person Years	
	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%



# New Opportunities

- FP 13-78
- Exchanges
- CMHC Collaboration Projects

# PRTF

- RFP 13-78 for prior authorization services also includes request for UM/PA of PRTF
- MDwise has long been a leader in working with OMPP on PRTF issues
- System troubled by long-term placements, young children, failed or ill-attempted community resources
- Care Select experience and MDwise behavioral health network
  - Work hand in hand with CMHCs and DCS providers
  - Link MRO services to those with need
  - Coordinate with 1915i or other future mechanisms

# Prior Authorization

- RFP 13-78 included PA for inpatient behavioral health stays
- MDwise envisions proactive approach to behavioral health prior authorizations
  - Hospitals and providers with high quality scores
  - Coordinated reviewers with facilities to strengthen relationships
  - Care management to link with outpatient services, including MRO

# MDwise and Innovation

- Sharing of Information
- Data-driven care
- Integration projects with documented savings
- ER notifications with documented savings
- Bowen Center project
  - Presentation at Medicaid Congress
- American Senior Communities
- Telemedicine Pilots

# What About Exchanges?

## The MDwise Marketplace

# Health Insurance Exchange: Overview

- A government-managed marketplace for buying and selling health insurance
- Think of an Exchange being an Expedia, Orbitz, or Kayak but for health insurance.
  - Commoditizes Health Insurance
  - Enhanced competition through standardization and price
- The Federal government will run Indiana's Exchange



Plan Helper

Start Over

Print this page

Reset all filters

6 benefits packages (What's a benefits package?) : 41 plans

Sort plans by Benefits package

Doctor / Provider

Search for your doctor...  
Only show plans that include your doctor, nurse practitioner, hospital or health center.

Review plans. Narrow your choices. Select up to 3 plans to compare.

Monthly Cost    
 Annual Deductible    
 Annual Out of Pocket Max.    
 Doctor Visit    
 Generic Rx    
 Emergency Room    
 Hospital Stay

Annual Deductible

\$2,000 indiv. | \$4,000 fam.  
 \$1,000 indiv. | \$2,000 fam.  
 \$250 indiv. | \$500 fam.  
 No annual deductible

What's annual deductible?

Co-Insurance

Show plans with co-insurance?  
 Yes     No

What's co-insurance?

Monthly Premium

		STANDARD BENEFITS FOR ALL BRONZE LOW PLANS					
		\$2,000 (ind.) \$4,000 (fam.)	\$5,000 (ind.) \$10,000 (fam.)	annual deductible, then \$25 copay	annual deductible, then \$15 copay	annual deductible, then \$100 copay	annual deductible, then 20% co-insurance
<b>Bronze Low</b> ? <span>Close Plans</span>							
<input type="checkbox"/>	<b>CeltiCare Saver HSA</b> <b>\$954<sup>41</sup></b>	↑	↑	↑	↑	↑	↑
<input type="checkbox"/>	<b>Harvard Pilgrim Bronze HSA PPO 2000</b> <b>\$1,036<sup>83</sup></b>	↑	↑	↑	↑	↑	↑
<input type="checkbox"/>	<b>Commonwealth Advantage HMO Saver</b> <b>\$1,121<sup>23</sup></b>	↑	↑	↑	↑	↑	↑
<input type="checkbox"/>	<b>NHP Choice Optimum 2000</b> <b>\$1,124<sup>45</sup></b>	↑	↑	↑	↑	↑	↑
<input type="checkbox"/>	<b>Direct Care Rx Saver Choice 2000</b> <b>\$1,128<sup>00</sup></b> <small>SMALLER FALLON NETWORK</small>	↑	↑	↑	↑	↑	↑
<input type="checkbox"/>	<b>Select Care Rx Saver Choice 2000</b> <b>\$1,282<sup>00</sup></b>	↑	↑	↑	↑	↑	↑
<input type="checkbox"/>	<b>Access Blue</b> <b>\$1,310<sup>64</sup></b>	↑	↑	↑	↑	↑	↑

# Basic functions of Health Insurance Exchanges

- Certify and oversee Qualified Health Plans (QHPs), or plans authorized to offer coverage on Exchange.
- Facilitate enrollment in QHPs.
- Screen and enroll eligibles in Medicaid and CHIP.
- Facilitate federal subsidies and tax credits. ***New federal subsidies only available through Exchange.***
- Rate QHPs on value – based on relative quality and price.
- Public education and outreach.
- Fraud, Waste & Abuse (FW&A) Program

# Three Market Segments in the Exchange

## 1. Individual Market:

- **Begins immediately in CY 2014.**
- **Sole proprietors without employees considered Individual, not Group Insurance.**

## 2. Small Group Market:

- States define Small Group as small employers with up to 100 employees (still waiting on guidance).
- Both full and part-time employees considered in these counts.

## 3. Large Group Market:

- CY 2017: Employers with more than 100 employees may buy via Exchange.

# What does this population look like?

## Projected characteristics:

52% Male, 48% Female

52% married

Average family size = 2.6

Enrollee employed = 80%

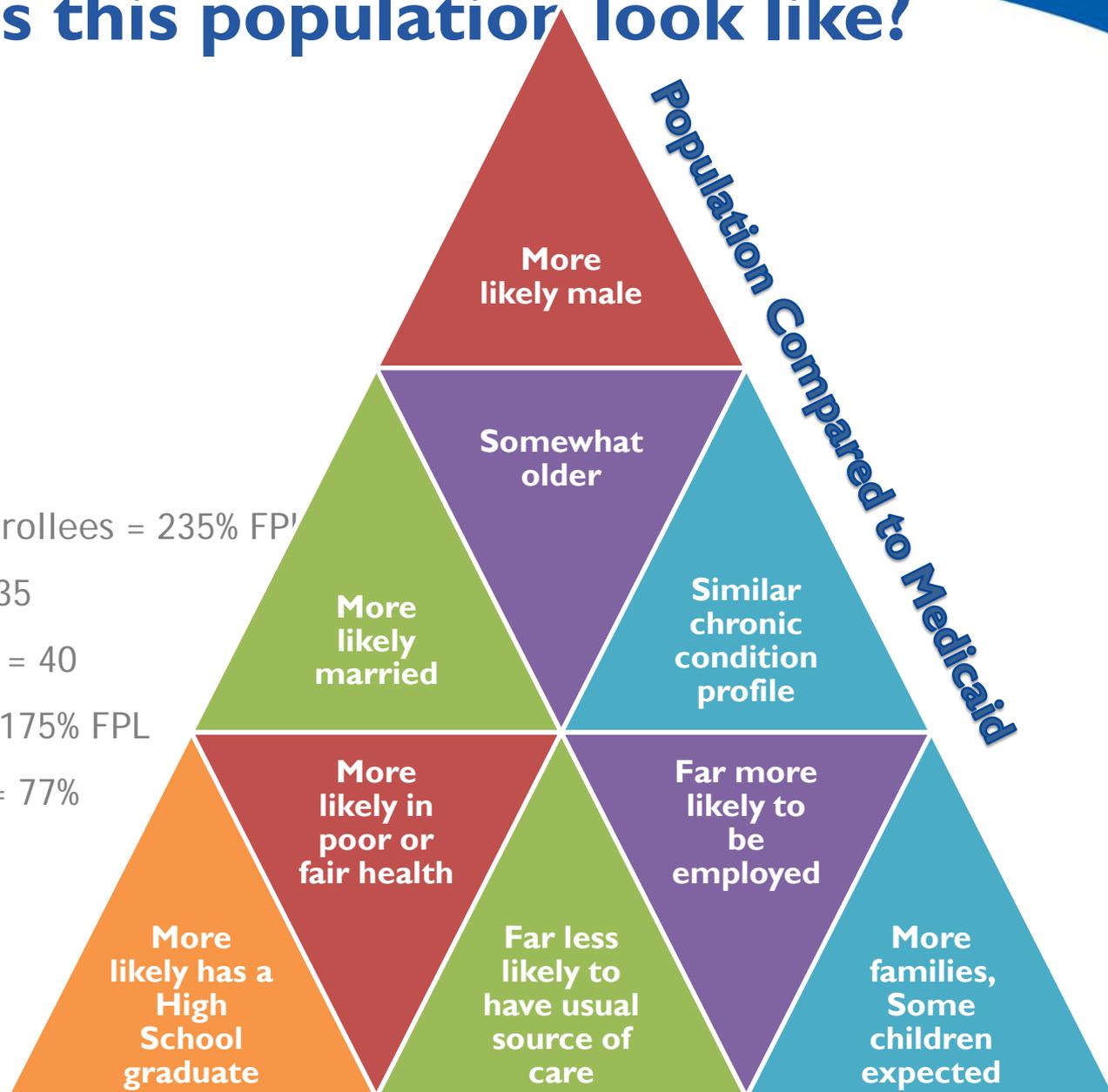
Median income of Exchange enrollees = 235% FPL

Average age of all enrollees = 35

Average age of adult enrollees = 40

Median income of uninsured = 175% FPL

High School education or less = 77%



## Qualified Health Plan

- Health plans certified to offer coverage on the Exchange
- QHPs may offer four “Metal Levels” of coverage.
  - Bronze, Silver, Gold, Platinum
  - Required to offer Gold and Silver
- QHPs must offer “essential health benefits”
- Federal rules on health plans also apply to QHPs (e.g. MLR, guaranteed issue, adjusted community rating, etc.).
- QHPs must be NCQA or URAC accredited.
- QHPs must meet requirements relating to provider networks, quality and care delivery, information and data reporting

## Essential Health Benefits

Qualified Health Plans must offer at least the “essential health benefits”:

- Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - **Mental health, substance abuse, behavioral health treatment**
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services
  - **Chronic disease management**
  - Pediatric services, including oral and vision care
- Under CMS guidance, States are given some latitude in selecting a benchmark plan to base minimum benefits. \*\* **Indiana’s benchmark plan is expected to be Anthem’s PPO Blue Access plan.**

# Provider Network Requirements

- Qualified Health Plans must demonstrate to Exchange that their provider network is adequate to “ensure a sufficient choice of providers
- QHP’s provider networks are expected to include essential community providers:
  - Examples: community health centers (FQHCs, RHCs), disproportionate share hospitals
- Community health centers (FQHCs, RHCs) must be paid at least 100% of the Medicaid prospective rate for FQHCs. No wrap-around like in Medicaid.
- QHPs may provide care through primary care medical homes

# 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
- Data management and reporting
- Utilization Management - Controlling cost trends
- Community-based programming (outreach programs)
- Experience in integrating Behavioral Health and Physical Health Services
- Claims payment



# 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 and Health Home 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 the member moves?
- 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

# 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!

