Medicaid Home Care: Adjusting to the Changes Successfully

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Agenda

- Introductions
- Managed Care Overview
- Challenges & Opportunities
- Preparing for Change
- Q & A
New Paradigm

- A longstanding barrier to coordinating care for Medicare–Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. CMS is interested in testing models across the country in programs that collectively serve up to 2 million Medicare–Medicaid enrollees.

- The combination of Long–term care AND acute care risk makes it essential that health plan dual eligible members live safely and healthfully at home as long as possible.

Primary Managed Care Initiatives

- Medicare and Medicaid Alignment Initiative (MMAI) aka Dual Eligible Demonstration
  - State and CMMS contract
  - Includes Long –Term and Acute Care
  - Very few carve outs approved by CMS
  - More opportunity to coordinate care for better outcomes /lower costs.

- Medicaid Managed Care
  - State driven effort requiring CMS approval
  - Typically services/populations phased in
  - More carve out populations
  - Fewer levers for MCOs to achieve better quality lower cost
  - Informal or backdoor Duals Program
Financial Alignment Demonstrations to Enhance Cost Effectiveness and Quality for Dual Eligible

March 2010
ACA establishes the “Duals Office”

April 2011
CMS awards 10 states $1 million each to develop proposals to integrate care

July 2011
CMS announces Financial Alignment Demonstration (FAD)

Spring – Summer 2012:
26 states submitted proposals to participate in FAD

2010 2011 2012+

Fall 2011
39 states—including all 15 that won grants—submit letters of intent to participate in FAD

August 2012-Ongoing
States prepare for implementation of 2013 and 2014 FADs, including plan procurement, signing MOUs with CMS, and entering into three-way contracts with plans and CMS

Why now

- State budget deficits
- Growth in Medicaid spending
- Current LTSS spending trends are unsustainable
- ACA: State incentives to develop new service delivery and payment models
  - financial alignment, medical homes, waiver changes
- Current system issues
  - Low rates, Institutional bias, inflexible service packages, little incentive for oversight, etc.
**Why Dual Eligible**

Concentration of Health Care Spending in the U.S. Population, 2007

MMAI focuses on the top 5% in terms of resource utilization

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2007

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**Potential Benefits to Homecare**

- Bridging social model and medical model homecare
- Accelerated rebalancing through global budgets
- Improved integration between acute care and home care
- More flexible benefit packages
- Better consumer care/satisfaction
The current system "silos" care with little communication between the pre and post-acute disciplines resulting in a lack of continuity which means great opportunity to improve outcomes.

Existing infrastructure fails to manage the Member along the pre-acute continuum.

MCO have limited experience in Home Care and less in HCBS.

Process is moving very quickly in some states.

Transitioning providers from fee-for-service to capitated systems.

Network adequacy, particularly Medicaid Home Health.

What happens to existing community-based organizations.

Ensuring that important HCBS features are not lost in integration with acute care.
Challenges (continued)

- Change from “status quo” operations
- Working with multiple and varied plans
- Redundant Requirements (States and MCOs)
- Who is responsibility for quality and oversight
- Client education – confused clients can blame provider for changes in services

Opportunities

- Rebalancing from higher cost institutional and acute care should favor in-home care, Home Health and other HCBS
- Providers focused on outcomes and alignment will win
- Opportunity for “risk based” contracting
- Lowering acute costs (gain share opportunity)
Opportunities (continued)

- NH diversion or community reintegration programs highly desired
- Hospital re-admission reduction programs
- Self-Directed Care oversight, training and support opportunities
- Network integration (horizontal and vertical)

Payment Models

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<tr>
<th>FFS</th>
<th>Case Rate</th>
<th>Sub Cap</th>
<th>PMPM</th>
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<tr>
<td>Per hour or per unit</td>
<td>Paid flat rate for each</td>
<td>Lump sum payment for a population or</td>
<td>Per Member payment for the total</td>
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<td>reimbursement for all</td>
<td>client referred for a</td>
<td>Per Member monthly payment for a subset</td>
<td>population</td>
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<td>authorized services</td>
<td>defined set of services</td>
<td>of capitated services</td>
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<td>provided</td>
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<tr>
<td>Little to no risk</td>
<td>Could be further</td>
<td>Would require historical evaluation</td>
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<td></td>
<td>stratified by client</td>
<td>of the population</td>
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<td>HCBS Provider is paid for</td>
<td>“DRG -Like” reimbursement</td>
<td>HCBS Providers would need to develop</td>
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<td>all services provided</td>
<td>- Moderate risk</td>
<td>a system for service authorizations</td>
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<td></td>
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<td>and Case Management</td>
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Case Management and coordination with MCO is critical.
Prepare for change

• Be proactive and involved
• Many opportunities for stakeholder input
• Help educate the plans constructively
• Not likely carve out
• Align your concerns in context with concerns of other providers and advocacy groups
• Know where the political landmines are located

Prepare for change (continued)

• Prepare throughout organization
  • Reimbursement
    • Billing
    • Authorization management
  • Information Technology
    • Data deliverable on outcomes
    • Health Information Exchange – HIPPA Compliant transaction set
      • 270/271 Eligibility, 277/278 Authorization, 835 Claims.
      • Growing EVV utilization
  • Contracts –
    • Boiler plate network contracts and credentialing not tailored to Home Care
Prepare for change (continued)

- Could see rate pressure
- Will see utilization pressure
- Be prepared to drive and demonstrate your outcomes (prove value and cost-effectiveness)
- Most states have assured no changes for up to a year but plans will ultimately select networks based on outcomes, technology capacity, market share and service area.

Summary

The stakes are high to CMS, States and MCOs
- Lower costs and better outcomes
- Member satisfaction
- Provider acceptance

Winners will align with interest of the Plans
- Keep members at home and stratify on risk profile
- Technology enabled with real-time connection to plan
- Early identification and coordinated intervention
Questions