Approaches to Integrated Long-Term Care

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Overview

- Evercare Background
- Key Elements of LTC Integration
- The Care Management model
- State Experience in Integrated LTC
Our mission is to optimize the health and well-being of aging, vulnerable and chronically ill individuals

- Evercare is focused on serving older & disabled individuals
  - More than 65% are dual eligible
  - Have multiple chronic illnesses
  - Need assistance with multiple ADLs and IADLs
  - Represent the costliest:
    - 5% of Medicare beneficiaries generating 50% of Medicare costs
    - 19% of Medicaid beneficiaries generating 35% of Medicaid costs
- These individuals are:
  - Generally poorly served by the current health care system
  - The fastest-growing and most costly population segment
Evercare National LTC Experience

- Serving 71,000 elderly and disabled Medicaid beneficiaries through 7 programs in 6 states
  - Arizona Long Term Care System (ALTCS)
  - Florida Long Term Care Programs
    - Nursing Home Community Diversion Program
    - Frail / Elderly Program
  - Massachusetts Senior Care Options (SCO);
  - Minnesota Senior Health Options (MSHO)
  - Texas STAR+PLUS Program
  - Washington Medicaid/Medicare Integration Program

- Serving 30,000 beneficiaries in Medicare Advantage Special Needs Plans for nursing facility residents

- Serving 66,000 beneficiaries in Medicare Advantage Special Needs Plans for dual eligibles and individuals with chronic illnesses in the community
Integrating LTC Services

**Current System**

**HCBS Waivers**
- Home/Personal Care
- Assisted Living
- Adult Day Care/Other

**Medicaid**
- Nursing Home Care
- Medicare Cost Sharing
- Other Acute

**Behavioral**

**Medicare**
- Acute Care
- Some Home Health
- Some equipment
- Medicare Part D

**Integrated LTC Program**

**Medicaid Services**
- Home & community based services
- Nursing Home Care
- Behavioral Health
- Acute services

**Medicare Services**
- Acute Care
- Medicare Part D
- Other Medicare
Options for Medicare/Medicaid Integration

- Three Party Integration Model
  - MSHO/MASS SCO/WI Partnership

- Plan Level Integration
  - TX STAR+PLUS/ AZ ALTCS

- Capitated Wraparound Model
  - NY Medicaid Advantage

- Buy-In Wraparound Model

Most Comprehensive

Least Comprehensive
## State LTC Programs

<table>
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<tr>
<th>FUNDING</th>
<th>POPULATION</th>
<th>AGE</th>
<th>BENEFITS</th>
<th>ENROLLMENT</th>
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* In Minnesota, Dual Eligibles are required to enroll in a managed care plan, and they have the option to voluntarily enroll in the integrated MSHO model.
Persons in need of care coordination

• 50% of people die in hospital outside of Hospice
• Poor palliation services
• Maybe functioning well, but no reserve secondary to age
• Sudden event is catastrophic

• 5+ chronic conditions = 2/3 Medicare costs
• Biggest cost = biggest opportunity for improvement
• Single condition but very high impact, e.g. quadriplegia, advanced Alzheimer’s Disease
What binds these diverse groups

The care process should essentially be the same for all four groups. These principles are:

- Individualized
- Comprehensive
- Coordinate
- Continuous

Current care system is designed for acute care

- Fragmentation among numerous providers
- Poor transitions across care settings
- Lack of systematic approach to prevention and early identification of change
Care Management Model

- holistic
- consumer-centered
- continuous
- collaborative
- focus on preventive care
- evidence-based
Clinical Model Evolution

- Frail, Elderly in Nursing Homes
- Care One Clinical Platform
- Ovations Data Mart
- Galaxy
- Community-Based Long-Term Care Medicaid
- Community-Based Medicare via Special Needs Plans (dual eligibles)
- Medicare Advantage
- Hospice/palliative care
- Retirement Community
- ESRD
- AARP Medicare Supplement

Reaching people regardless of living setting or payer
Evercare Care Management Model

- Evercare’s care management approach is designed to provide individuals with timely, medically necessary health care services in the least restrictive setting and most appropriate setting.

- Comprehensive risk assessments and care management level assignment based on severity and need.

- Comprehensive care plan development, implementation, monitoring and evaluation of status.

- Coordination of services and funding.

- Holistic, team approach with PCP, patient and family

- Focus on prevention, early intervention and quality of life.

- Emphasis on teaching members self management techniques.
Clinical Recruiting, Training, Development and Management

- Hiring experienced clinicians and giving them the support they need is essential to the best outcomes for our members:
  - Clinical Service Managers, Health Service Directors and Medical Directors in all regions assist the front line clinicians with the day to day management of their members
  - The CareOne clinical system supports the management of the member by maintaining continuity of information, documenting care plans, proactively identifying members at risk, and tracking interventions (immunizations, pharmacy, care plan reinforcement, family interactions)

- In 2003 Evercare Established the Evercare University to ensure our clinicians are able to advance their skill level in relevant areas for our members:
  - Early Identification of Change in Condition
  - Geriatric Psychology
  - Interacting with Members and Caregivers
  - Advanced Care Planning
Evercare Nursing Home Program

- Founded in 1987 by two nurse practitioners in Minnesota

- Approved by HCFA as a federal demonstration project in 1994

- Today, Evercare cares for over 37,000 permanent nursing home residents in 18 states
  - 6 Demo Sites
    - Arizona, Colorado, Florida, Georgia, Maryland, Massachusetts
  - Additional sites:
  - Partner with over 700 nursing homes, 2000 primary care physicians, and employ 400 nurse practitioners
Enhance primary care services to reduce avoidable acute care hospitalizations

- Nurse Practitioners are assigned to work with nursing homes and physicians and carry a case load of 85-95 members (a fraction of normal NP case load) which results in:
  - Increased visits for residents
  - Emphasis on proactive care and preventive care
  - Early identification of change in condition
  - Increased communication with resident, family, nursing staff and PCP
  - Formal and informal education to nursing staff

- Align financial and clinical incentives with nursing facilities and physicians to facilitate treatment in place
- Comprehensive and continuous advanced care planning and family communication are essential in the care of this population.
Overall Goal:
- Keep people out of next stage.
- Optimize care within stage

Primary Goal

Main Interventions
- Prevention and Screening
- Education
- (Patient, Family, Physician)
- Reminder system

Care Enhancement Vehicle
- Mail
- Web
- Telephone

Primary prevention
- of chronic illness

Managing chronic illness

Primary and secondary prevention
- Disease management
- Functional early warning system
- Medication management

Evercare 9 step model

Dying in dignity in their choice

Compassionate end of life care
- Holistic care plan
- Bereavement
- Palliation
- Family education

II. Vulnerable
- 2-3 Chronic Illnesses

Managing chronic illness

III. High Risk
- 4+ Chronic Illnesses

Multiple Chronic Illness:
- Holistic care to prevent acute events and maintain functional independence

IV. Terminal
- End of Life

Healthy
- 0-1 Chronic Illnesses

Primary prevention
- of chronic illness

Prevention and Screening
- Education
- (Patient, Family, Physician)
- Reminder system

In Person Care Mgmt
- Telephone

In Person Care Mgmt
- Telephone

In Person Care Mgmt
- Telephone
Critical Elements that Support Independence

Medical Care
- Chronic care management
- Medication and poly-pharmacy management
- Maximizing functional ability preventing premature decline
- Appropriate transitioning across settings
- Early identification of change of condition
- Behavioral Health

Home Supports
- Sufficient and well trained homecare workforce
- Medical supplies and equipment
- Housing modifications
- Emergency alert call systems
- Care Coordinator
- Caregiver support
- Respite care
- Medical transportation

Social Services
- Adult Protective Services
- Licensing and certification
- Training
- Behavioral Health
- Information and referral
- Independent living centers
- Aging & Disability Resource Centers

Community Infrastructure
- Accessible and affordable housing
- Communities designed with universal design principles
- Accessible public transportation
- Meals on Wheels
- Transportation
- Housing
- Volunteer systems support
Integrated LTC
Program Outcomes

**Access**

- In Arizona, Community placement rate rose from 5% to 63% over 17 years.

- Texas STAR+PLUS increased clients receiving personal care by 31% and adult day care by 38%.

**Satisfaction**

- ALTCS 2001 Consumer Satisfaction Survey:
  - 93% were satisfied overall with their care manager
  - 95% were satisfied with their HCBS caregiver
  - 90% were satisfied that the care manager involved the respondent in care decision-making

- In Minnesota, 94% of families of nursing home residents would recommend their MSHO care coordinator to others.
Integrated LTC Program Outcomes

**Quality**

- Texas STAR+PLUS reduced hospitalizations by 22% and ER visits by 38% \(^5\)
- Florida Nursing Home Diversion clients had much lower probability of entering a nursing home compared to clients in FFS Medicaid programs \(^6\)

**Cost-Effectiveness**

- In 1993, the ALTCS program saved $111.1 million compared to FFS Medicaid costs \(^7\)
- Texas STAR+PLUS
  - Total savings of $78 million – an 8% reduction in Houston Metro \(^8\)
- Florida LTC Diversion Program diverted clients from entering a nursing homes saving the state $10,000 to $15,000 per client per year \(^9\)
Citations

1) State of Arizona Claims Data
2) Sema K. Aydede, PhD, “The Impact of Care Coordination on the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Patients”, Institute for Child Health Policy, September 2003.
4) “2004 Consumer Assessment of Health Care: MSHO Nursing Home Population”. Minnesota Health Data Institute, August 2004
5) Same as #2
9) Elizabeth Shenkman, PhD. “STAR+PLUS Enrollees’ Satisfaction with Their Health Care.” Institute for Child Health Policy, University of Florida, October 2003.
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