

Schaller Anderson, Incorporated

Mercy Care Advantage

**Medicare Advantage Special
Needs Plan for Beneficiaries
eligible for Medicare and Medicaid
(Dual Eligibles)**

December 2007



SCHALLER ANDERSON



MERCY CARE ADVANTAGE

At a Glance

- Southwest Catholic Health Network - Medicaid contractor in the state of Arizona since 1985
- Managed and Operated by Schaller Anderson
 - 8 Medicaid Contractors in Arizona
 - 5 have dual eligible special needs plans (SNPs)
- State Contract – Capitated per member per month (pmpm)
 - Average dual eligible capitation (\$150)
 - Average dual eligible enrolled in the Long Term Care Program (\$1400-\$2200)



Mercy Care Advantage Special Needs Plan: Dual Eligible

- Effective January 1, 2006
- Dual Eligible Enrollment (as of 11/1/2007)
 - 13,815 Members
- Service Area – 3 counties



Mercy Care Advantage

- Prior to the SNP Model
 - Arizona beneficiaries received services through separate managed care systems or
 - FFS Medicare and Medicaid Managed care systems
- Roadblocks
 - Provider network issues
 - Cost sharing responsibility disputes
 - Prior authorization requirements conflicts
 - Unable to obtain sufficient data for quality initiatives
- Provider Confusion
- Member Confusion



Mercy Care Advantage

- Capitated Wrap Around Model
 - Contract with CMS: Medicare Advantage SNP
 - CMS Oversight
 - Contract with Arizona: Medicaid
 - State Medicaid Program oversight
 - Provides the Medicaid Benefit
 - Also provides acute and long term care
 - Capitated by both CMS and State



Integrated Advantages

- Coordinated Care Program through one health plan
- Link key data (claims, pharmacy, lab, procedures, DME, Behavioral health, referrals PCP access, care management tools)
- Use predictive modeling to target care management interventions
- Pharmacy adherence / Medication Management
- Care Plans accessible to members and to providers
- Tool for Providers



Mercy Care Advantage Integration

- Models the MCA program to integrate the Medicare and Medicaid benefits
- Case management
- Identical Provider Networks
- One billing by providers
 - COB done internally
- Aligns Incentives with stakeholders
- LTC Members and High-risk acute members assigned to a case manager
 - Assist with community resources
 - Coordinating with case workers if necessary
- Navigates Mental and Behavioral Health Services
- Predictive Pathways



Program Components

- Health Risk Assessment
- Medical Home for Each Beneficiary
- Community-Based Model
- Predictive Modeling Stratification
- Identification of Gaps in Care and Service
- Evidenced-Based Guidelines Drive Interventions
- Individualized Care Plans
- Behavioral / Physical Integration
- Analytic Services
- Provider Engagement
- Health Coaching / Education



ALTCS PROGRAM – Prior to 1/2006

- 80% of ALTCS members – Dual eligibles
- Medicaid (ALTCS) Program not financially responsible for hospital/medical costs
- Programs Focus was keeping members at lower placement levels
 - Home
 - Alternative residential setting vs SNF



ALTCS Programs: 1/2006 Special Needs MA Plan

- Program is now financially responsible for hospital/medical costs
- Enhanced and upgraded clinical oversight of ALTCS model
 - Upgrading and adding RN Manager Position
 - RN manager Position
 - RN Supervisor
 - Reorganized RN Team
 - Regular Meetings with acute medical case management
 - Identifies potential overlapping service models
 - Develop reports for coordination of care with both programs
 - Data comparison



Mercy Care Integration

- Specific Activities for integrated medical management
 - Identification of high risk members:
 - Through Predictive Pathways (PPM)
 - ALTCS Case Management Referral through quarterly assessments
 - Audit by RN Manager of case management notes looking for members more complex medical conditions
 - Interdisciplinary Team Review of High Risk Cases each week for Plan development:
 - Medical Director
 - Behavioral health Medical Director
 - RN Manager
 - Behavioral health Coordinator
 - RN Supervisor
 - ALTCS Case Manager



Mercy Care Integration

- Case Manager Role now includes
 - Tracking of 2 and 5 day follow up calls after discharge
 - Skin Integrity screening document to the ALTCS Case Management Assessment Tool
 - Fall Risk assessment program done in member's home two (2) times a year
 - Added criteria when home health nursing must be added to the care plan.
 - Added additional training to ALTCS Case Management program



Medicare/Medicaid Integration Outcomes

- Reduced Acute Admits
- Reduced Readmits
- Reduced ED Visits
- Decreased Length of Stay (LOS)
- Increased Medication Adherence
- Personal Goal Achievement
- Enhanced Patient Satisfaction
- Enhanced Quality of Life
- Enhanced or Stable Functional Status



Mercy Care Advantage Success Stories

- **67 yr old Female**: DX Parkinson's Disease
 - Enrolled in a different Medicare Advantage Plan
 - Medicaid Plan – Mercy Care Long Term Care Plan
 - Hospitalized in 2005 for bowel obstruction
 - Discharged to home health
 - Nursing Services denied by former MA Plan
 - Coordination between Plans challenging for providers / confusing for member
 - Patient moved and changed physicians
 - Non-Par with MA Plan
 - 2006 Enrolled in Mercy Care Advantage
 - Mercy Care Advantage and Mercy Care LTC
 - Less confusion for member/family



Additional Case Studies:

48 yr old Beneficiary – HIV Positive for 9 years (dual eligible)

- Originally enrolled in Mercy Care Medicaid / Medicare FFS
- Difficulty obtaining medications – confusion of Part D enrollment
 - Went several days without medication
 - ER Room and 5-day Hospital stay
- Enrolled in Mercy Care Advantage
 - All medications received timely
 - No hospitalizations

88 yr old beneficiary – CHF, Diabetes and Dementia

- Resident of LTC - 2 years
- 2005: 2 hospital admits
 - Returned to SNF 31 days / 33 days
- 2006 Managed by Nurse Practitioner
 - One hospital stay – followed by only 19 days of skilled care
 - Another SNF stay for 4 days (without hospitalization)



Call for Integration

- CMS encourages plans to work with state Medicaid agencies
 - Integration can occur at different levels
 - Quality programs can be part of the state contract and mirror the Medicare initiatives
 - State can rely on Medicare mandatory EQR activities
 - Integrated reporting processes
- Enrollment activity can be streamlined
- Grievance/Appeals
 - Although essential state and federal protections must remain intact
- Cost savings with coordinated medical management
- Good for the member and the provider community
- Good for both state and federal health programs and quality initiatives

