PARTNERSHIPS IN INTEGRATED CARE:
A FEDERAL AND STATE PERSPECTIVE ON THE PROBLEMS AND OPPORTUNITIES BETWEEN MCOS & AGING & DISABILITY NETWORKS

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A Federal & State Perspective on Partnerships in Integrated Care
The Challenge of an Aging America

• By 2020 1 out of 5 persons will be over 65 years old
• 85+ population fastest growing segment of elder population
• Chronic Disease
  – Medicare beneficiaries with 2+ chronic diseases comprise 63% of total population.
  – 21% of beneficiaries have 5+ chronic conditions with 26% also had functional impairment.
  – 95% of Medicare spending is on chronic conditions
  – The challenge of an aging America no longer cared for at home
  – Institutional-Biased Care
  – HCBS Care & LTSS
Fragmented Programs of Care and Reimbursement

Health & LTC Program & Delivery System SILOS
- Primary Care
- Specialist
- ERs
- Hospitals
- Pharmacy
- Behavioral Health
- Sub-Acute
- HCBS & LTSS
- ALF
- SNF

Health & LTC Financing SILOS
- Medicare Funds
- Medicaid Funds
- Pharmacy Part D
- Medicaid Waiver Funds
- Other Funds
Health & Long Term Care

Today’s Model of Care

• Fragmented care
• More illness
• Premature death
• Institutionalization
• High Cost of Care

Tomorrow’s Model of Care

• Improved health outcomes
• Reduce acute care episodes & Provider Accountability
• Reduced death & injury
• More Choices in Settings of Care
• Reduced overall cost & improved efficiency
Strains of Existing HCBS Networks:
The Brownie Dependency

Today’s Care Challenges
- Fragmentation in access & care delivery
- Overwhelming communication
- Institutional-bias
- LTSS & HCBS systems & Funding silos

Tomorrow’s Value Proposition
- Care Coordination & Service Integration (SPOE)
- Patient/Member-centric Communication
- Comprehensive Applications & Assessments
- Choices of all Settings of Care with Rebalanced Approaches toward HCBC LTSS
- Integrated Financing and Care Models & Consumer-Directed Integrated Options
The Demand from State and Federal Budget Issues

- Better value and better care
- New business model
  - More efficient
  - Consumer focused
  - Increased accountability
  - Rewards innovation
  - Stimulates creativity

*Not just bending the cost curve, but improving quality & outcomes for our members*
Significant State/Federal Initiatives

• “Stars Aligning” for the Aging & Disability Networks
• Cost savings to State through Rebalancing & sharing in Medicare savings
• More choices for frail to age in place with increased HCBS funding
• More LTSS service options & reduction or elimination of waiting lists
• More patient-centric care, patient satisfaction & Caregiver support
• Increased Quality Assurance, Oversight & Transparency
Aging & Disability Network Opportunities

• Leveraging experienced community networks of HCBS/LTSS Providers
• Expanded Coordination interoperability & responsibility—Acute>Behavioral>LTC
• Focus on need to build upon HCBS infrastructure & increased capacity

*Hitting the reset button to participate in new emerging integrated models with multiple partners including health plans to improve clients health outcomes & quality of care*
The Need to Leverage Existing State and Local Resources

• MMLTSS: New integrated model of LTC
  – Focus on appropriate setting for services & supports
    • Combines Aging and Disability
    • Similar basic needs but acknowledges differences
    • Intervention in critical pathways
    • Includes HCBS/LTSS as well as Institutional Based Care
    • Options for Diversion & Transition
    • Requires multiple partnerships & interdisciplinary collaborations to achieve integration of care
    • Acute > Behavioral > Long Term Care
    • Public, private, community-based & individuals
    • Requires effective use of data & technology
    • Web-based resource database
    • Data & Information exchange protocols across health & LTC
    • Cost effectiveness aligning financial incentives
Independent Living Systems

• Involvement with the aging network and service providers combined with knowledge and practice of managed care; that translates into building effective and efficient networks, care models and systems
• Experienced approach of network development by working with historical providers such as aging network agencies
• Systems designed for real time connectivity and adapted to program specific requirements that enable contracting entities to effectively manage at risk health and LTC
• ILS is willing to share or take global risk for LTC or full benefits costs
• Systems built on experience with special populations through data that incorporates utilization, HRA, and stratification for more effective care coordination and complex care management
• PASS® (Care Transitions) has added competency for Nursing Home Diversion and transition from nursing home back to home
Examples of Successful Partnerships

- CCTP partnerships in NY, IL, & FL
- California partnership MLTC/CBOs and Aging Network
- CMS 14 state care transition pilot
  - QIO – ILS – FL AAA, DOEA
- Ohio hospitals and Ohio association of AAAs – 10B
- Tennessee TennCare Collaboration
- Michigan Association of AAAs & 10 individual AAAs
- New York MLTC
- Planned agreements with associations in 20 additional states
Duals: A Study in Complexity
What Drives Medicaid and Medicare Health Care Changes?

- Poorly managed, uncoordinated care for the most complex and fragile patients
- Equally fragile state budgets
- A search for a winning theme to improve quality and care while reducing cost and resisting the chance for more overwhelming regulatory burdens
Massachusetts, California, Florida, Kansas, Kentucky, New Jersey...
Forced Consolidation Across All Players
The First Barrier: Them vs. Us
The Second Barrier: Us vs. Us
The Third Barrier: Them vs. Them
Collective Challenge

COST
10% drives 30% COST
Collective Challenge

Demographics
Require Wheelchairs

45%
Collective Challenge

Chronic Conditions
32.6% obese drive 9.7% higher cost

12% late effect CVD

50% have multiple chronic conditions

6.1% paralysis or quadriplegia

13.9% spinal cord injuries

10.9% multiple sclerosis
Collective Challenge

Inefficient Use of Information
10% of patients with a SAAM score at 45 or more
Collective Challenge

Fragmented Services
Requires plan of care that reflects 10% of your members
Collective Challenge

Financial & Policy Complexity
Dealing With The Challenges

- There are few actuarial models for this complex population of TA, TBI, MI, DD patients- TANF models will not be useful.
- Managed Care Organizations will seek to find “risk consumers” to share the “cost” of the learning experience.
- At some point we must learn a new winning theme of Sustainability
A Solution for Health Care
Questions?
Home & Community Based Services

Humana
Success

Members get Services
and
Providers get paid Success
MCO Opportunities

• Proactivity vs. Reactivity
• Internal understanding of Long Term Service Support (LTSS)
  – Consumer/Participant Direction
  – Fiscal Employment Agent
  – Modification vs. Remodeling/Repairs
• Need acceptance and understanding of ‘Social’ vs. ‘Medical’ model
  – Housing
  – Caregiver and Family
• Integrated Case Management/Care Coordination
• Accurately measuring and managing illness and wellness of fragile population
Long-Term Care: Model Overview

**NURSING HOME**
- Prevent or Delay Nursing Home placement

**HOSPITAL**
- Prevent unnecessary hospitalization

**HOME & COMMUNITY**
- Reduce hospitalization of nursing home residents
- Reduce short term stay and ensure proper transition
- Identify individuals for community placement
- Ensure proper discharge and care transition

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**Assessment Tool**
Main entry point into LTC system. Identify member needs and determine eligibility.

Services/supports in home or other community-based settings:
- Must meet facility based level of care
- Services include: Case Management, Homemaker, Personal Care, Home Health Aide, DME, Adult Day Health, Habilitation, and Respite.
- May include: Non-medical Transportation, DME, Meal Service, Home Modifications, Adult Day Care, etc. Varies by state.
Duals & Integrated Program
Model of Care
Duals & Integrated Program Model of Care

- Not the traditional silo management approach
- Comprehensive
- Complete Continuum of Care

Case Management

Physician Services

Hospital Services

Case Management

Behavioral Health

Case Management

HCBS / LTSS
Duals & Integrated Program Model of Care

- Not the traditional silo management approach
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Physician Services

Hospital Services

Behavioral Health

HCBS / LTSS

COMPREHENSIVE MODEL OF CARE
Duals & Integrated Program
Model of Care

- Comprehensive Assessments
- Individualized Care Plans
- Holistic Ongoing Case Management
Duals & Integrated Program Model of Care

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Patient Centered Model

Case Management Team

Patient & Caregiver

Medicare & Medicaid

HCBS

LTSS

BHS

SPC

PCP

HHS
Partnerships for Successful Management

ILS Model of Care

Care Management: Aging Network Lead Agencies

Coordination of Care: Participant Directed Care

Care Transitions: Area Agencies on Aging

Rebalancing: HCBS Network

Community Support: Social Services & Outreach
Thank You

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