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Complex Care Management Model Design

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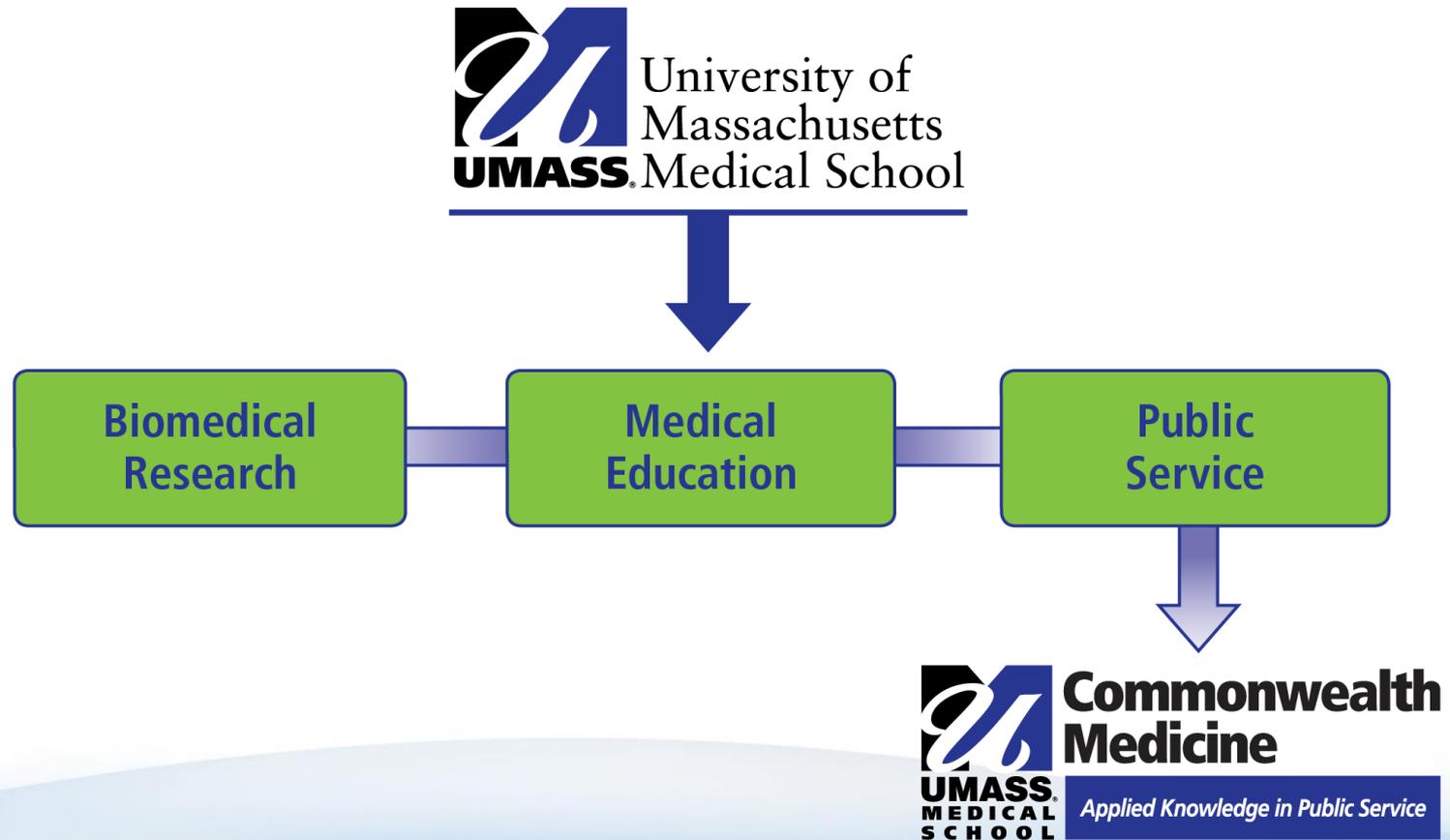
*Overview for Managing Long Term Support
Services for Complex Populations Summit*

October 25, 2016



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Who We Are



Essential Steps in Model Design

- Step One: Identify the population
- Step Two: Determine the risk factors
- Step Three: Identify interventions
- Step Four: Develop Plan of Care
- Step Five: Monitor Outcomes
- Step Six: Continuous improvement

Medicaid Focused Complex Care Management

- Medicaid Administrative activity
- Focused on a defined population of medically complex individuals requiring skilled interventions
- Involves the facilitation of Medicaid funded long term services and supports (LTSS) to enable individuals to remain in the community and avoid institutionalization

Goals

- Provide LTSS benefit coordination of Medicaid State Plan services
- Streamline and simplify the prior authorization (PA) process by establishing a single point of entry to Medicaid LTSS
- Ensure that Medicaid is the payer of last resort for services by coordinating the LTSS needs of Individuals with those available from other insurance or other payers
 - including services provided by state/local agencies

Program Eligibility

- All individuals who require continuous skilled nursing services
- No age requirement
- Individuals must
 - Require a nurse visit of > 2 continuous hours of nursing services in the home
 - Have certain categories of Medicaid insurance

Member Characteristics

- Typical Primary Diagnoses:
 - Cerebral Palsy
 - Congenital Malformations
 - Neuromuscular Disease
 - Neurologic Disorders
 - Genetic Disorders
 - Trauma
- Age Range:
 - 0-97 years old
- Other:
 - Severe Developmental Delays
 - Guardianship Issues
 - School Issues
 - End of Life Issues

Process

- Step One: Referral to program
- Step Two: Telephone Screening
- Step Three: Comprehensive in-person assessment completed by RN
- Step Four: Develop Service Record (AKA Plan of Care)
- Step Five: Monitor Individual and Utilization Regularly
- Step Six: Adjust Service Record as needed

Single Point of Entry

- Once services authorized, nurse care manager becomes the primary contact for the Individual/Caregiver for ongoing LTSS needs and any issues that may arise
- Nurse care manager is responsive to Individual's ongoing needs
 - Quick authorization of increased services during acute illness
 - Assist Individual/Caregiver to locate nurse providers
 - Referral to other state/local agencies
 - Connection to benefits support, including assistance with premium payments and other insurers
 - Attendance at hospital and facility discharge planning meetings to facilitate discharge
- Ongoing support through telephone calls and annual in-person reassessments (or more frequently if needed)

Single Point of Entry (cont.)

- Nurse care manager works in collaboration with Allied Health professionals
 - Occupational Therapists, Pharmacists, Physical Therapists, Rehabilitation Counselors, Respiratory Therapists, Social Workers, Speech Therapists
- Allied Health professionals provide ongoing support, including:
 - Clinical knowledge and decision making for other LTSS authorizations
 - Durable Medical Equipment, Orthotics & Prosthetics, Oxygen/Respiratory Equipment & Supplies, Therapy Services
 - Functional assessment for personal care services, home and community accessibility and other LTSS needs
 - Identification of communication needs
 - Collaboration with other community providers to identify and coordinate other support needs

Outcomes

- Member Survey
 - 2014 Surveyed a sampling of individuals in the program for at least 6 months (N-667)
 - Response rate 45.3%
 - Survey designed to assess perceptions across number of areas including needs assessment, communication with and coordination of services, interaction with allied health specialists and overall perceptions of the care approach.

- 91% overall satisfaction with care coordination
- Majority indicated assessment process which drives nursing authorization is thorough and clear
- 89% report the care coordination has resulted in having a positive impact on a person’s life
- 83% report it would be at least “somewhat difficult” to stay at home without this support
- Cost Avoidance
 - FY 04-16 > \$84M

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Questions