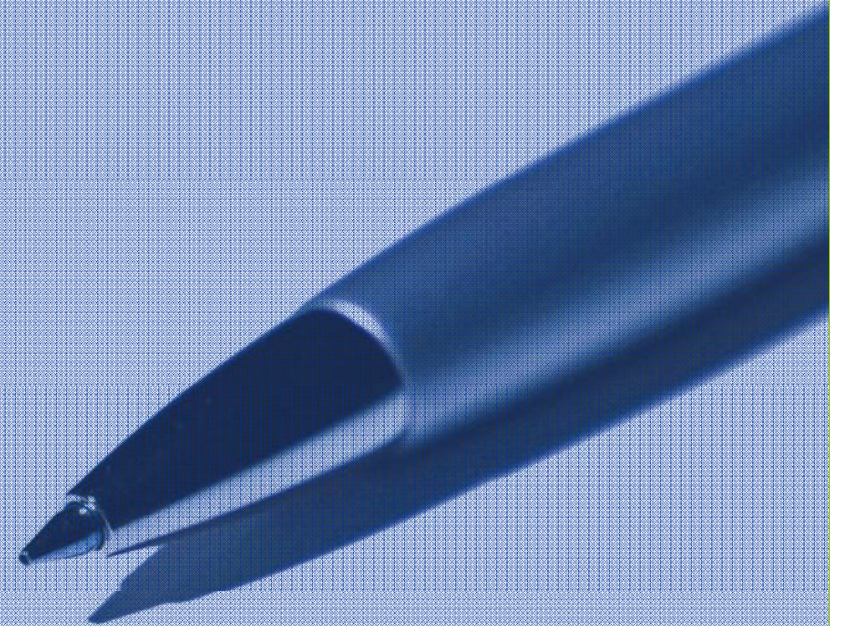


MaineCare Services



MaineCare Services

*An Office of the
Department of Health and Human Services*

John E. Baldacci, Governor

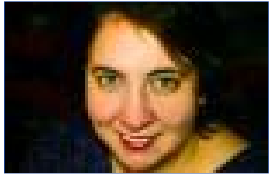
Brenda M. Harvey, Commissioner

Developing Medicaid Care Management

August 2009

Presenters

Robin Chacon



Project Manager, MIHMS
Robin.Chacon@ maine.gov

Pamela Fromelt



**Specialist Leader Medical
Management, Deloitte
Consulting**
pfromelt@deloitte.com

Bharat Chaturvedi



Manager, Deloitte Consulting
bchaturvedi@deloitte.com

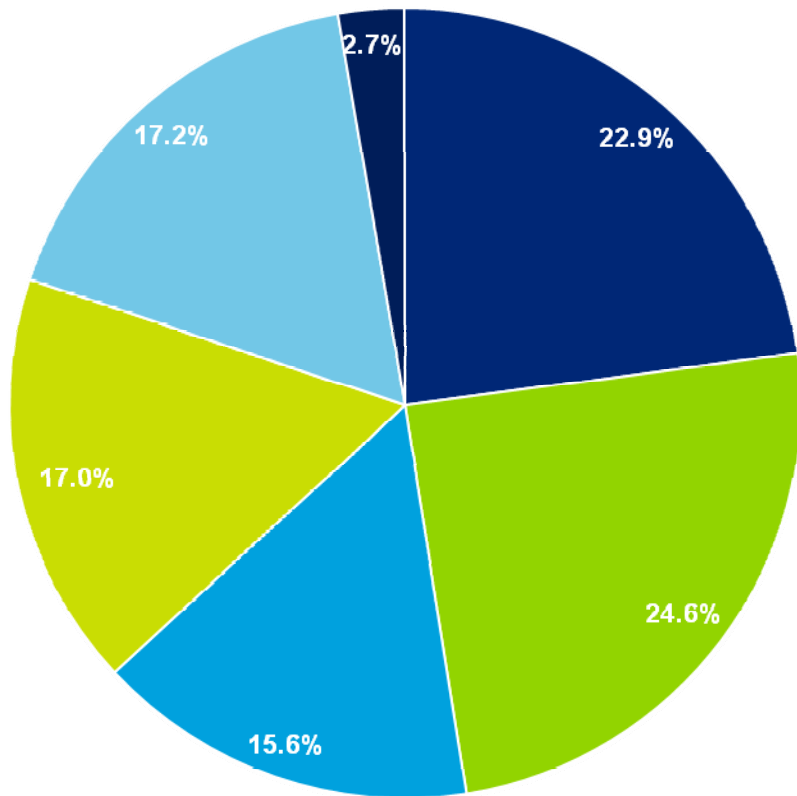
Agenda

- Overview – Maine Medicaid Population
- Maine Manage Care Vision
- Achieving the Vision and Developing the Model
- Who Will Be Managed By Care Management
- Care Management has to Address the Continuum of Care Needs
- Care Management Must Have Sustainable Processes
- Integration is Critical to Medicaid Care Management
- Integration with Eligibility - Example
- Data Flow Model
- Appendix A

Overview – Maine Medicaid Population

Over 60% of the dollars are spent by 10% of the Medicaid population. Focusing on transactions will not fix the problem

Percentage of Total Paid Dollars by Percentile Group



■ Top 1% ■ 2-5% ■ 5-10% ■ 10-20% ■ 20-50% ■ Bottom 50%

Source: MaineCare

Focus on High Risk, High Cost Members can Change Maine's Overall Medical Spending

- The top 1% account for 22.9% of the total paid dollars
- The top 5% account for 47.5% of the total paid dollars
- The top 10% account for 63.1% of the total paid dollars
- The bottom 50% account for 2.7% of the total paid dollars

Maine Care Management Vision

The implementation of a new claims system created an opportunity to develop a meaningful, hands-on care management program

Drivers

- Claims Payment Focused
- Unreliable Data
- Transaction-Driven
- Prior Authorization Delays
- Lack of Nationally Recognized Criteria/Guidelines
- Siloed Programs and Services
- Reactive Interventions
- Minimal Evaluation of Program Effectiveness

**Data-Driven
Decisions
to Address
Gaps in
Care and
Member
Needs**

Future State

- Member-Focused
- Data-Driven Decisions
- Health and Wellness Promotion
- Disease Prevention
- Supportive Care Management
- Medical/Behavioral Health Integration
- Anticipatory Interventions
- Evidenced-Based Guidelines Available and Applied Consistently
- Provider-Member Shared Decision-making

Maine Manage Care Program - Overview

Achieving the Vision and Developing the Model

Once “Future State” was defined, MaineCare created its vision of care management integrating other internal State departments and existing contracted vendors

Tenants of the Vision

Integrate and leverage other available services to provide the best member experience and outcomes

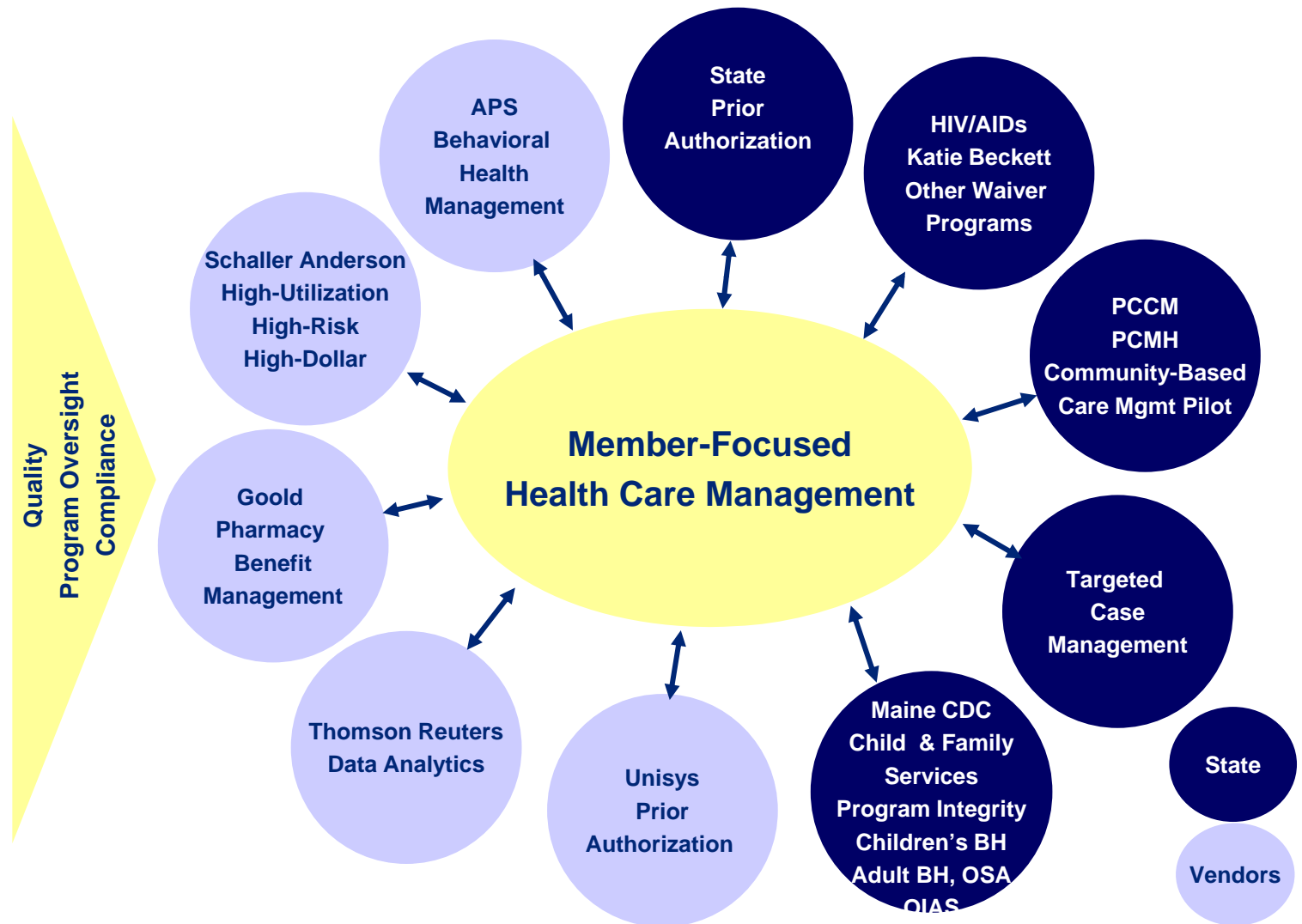
Provide direct care management services for some members

Partner with industry-recognized experts to deliver care management services for some members

Facilitate linkages with State and community services to avoid redundancies

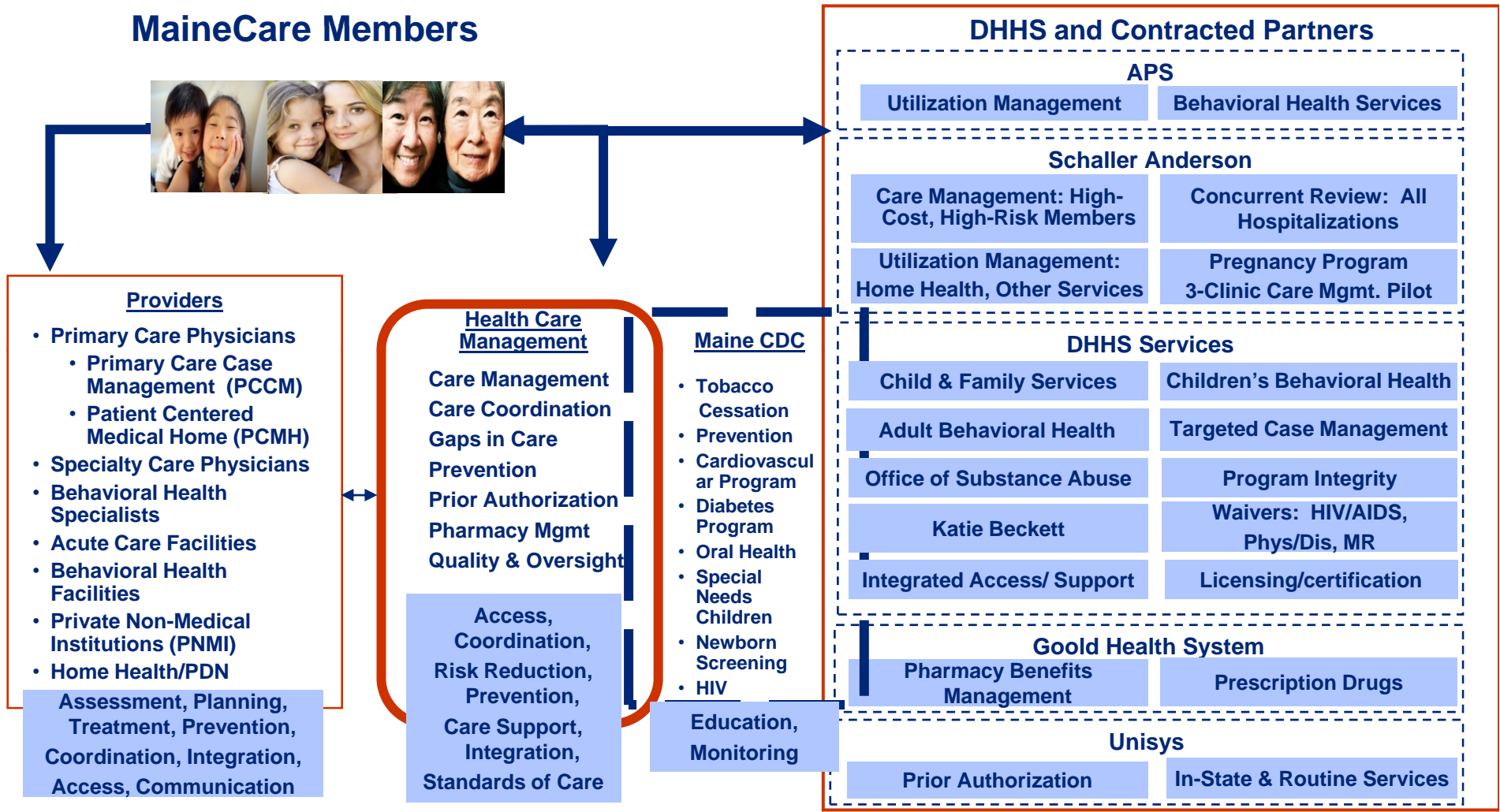
Advocate for members by integrating quality, compliance, and oversight throughout services and programs

Focus on actions and results designed to improve cost, quality, and access



Achieving the Vision and Developing the Model

MaineCare Members



Data Sources, Tools, and Technology Supporting the Integrated Clinical Model



Who Will Be Managed by Care Management

The “Future State” model must address the needs of all MaineCare members

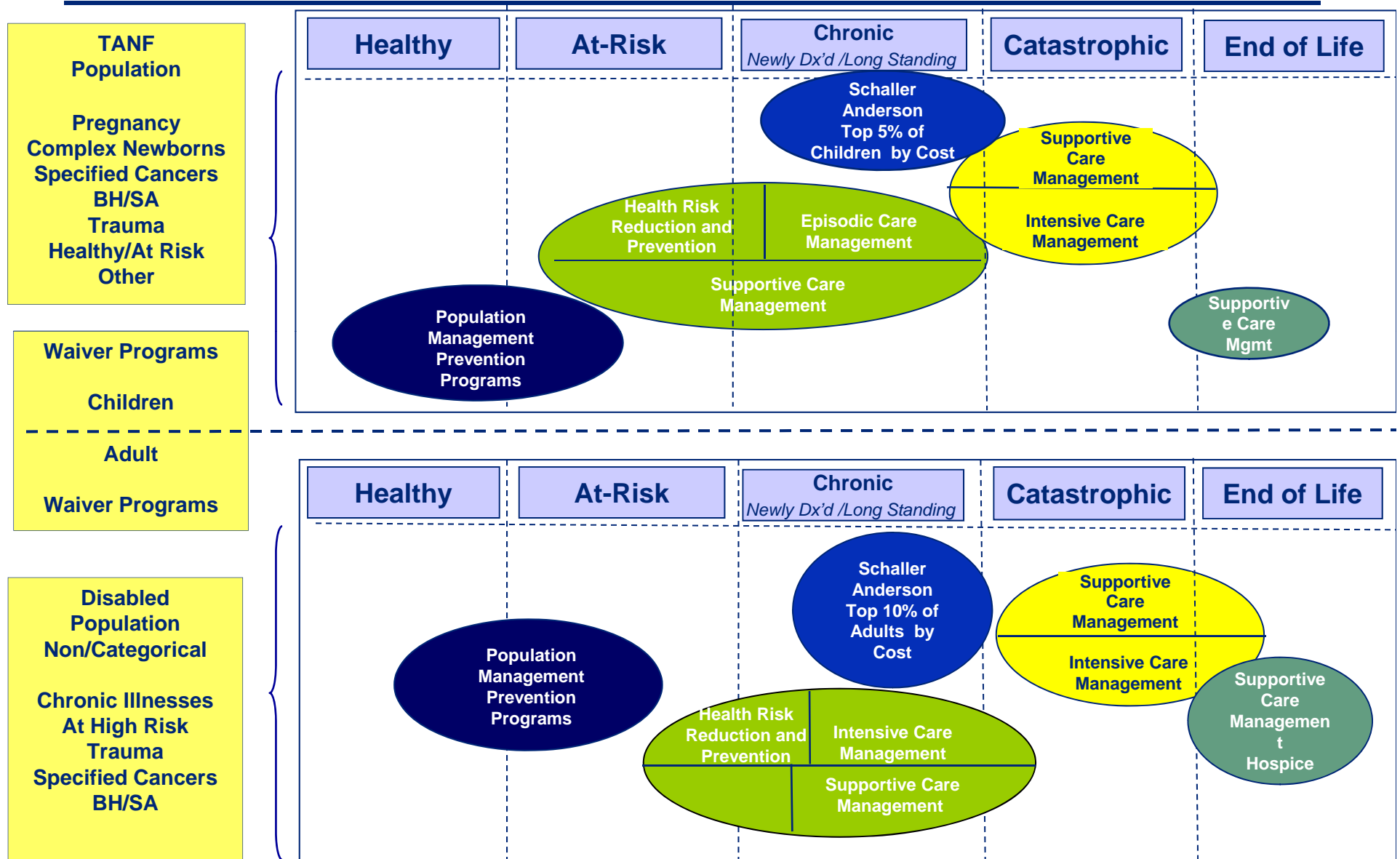
- MaineCare serves three basic populations
 - Temporary Assistance or Needy Families (TANF) and State Children’s Health Insurance Program (SCHIP) – principally mothers and children
 - » Interventions targeted to opportunities with greatest savings potential
 - » High cost, utilization, and needs
 - High-risk pregnancy
 - Complex newborns through first year of life
 - High emergency department (ED) users
 - Behavioral health and substance abuse
 - Aged, Blind, and Disabled and Dual Eligible – principally adults
 - » Interventions targeted to opportunities with greatest savings potential
 - » High costs, utilization, and needs
 - Chronic illnesses
 - Chronic behavioral health issues (depression/anxiety)
 - End-of-life care
 - Waiver and Other Special Programs
 - » HIV/AIDS
 - » Katie Beckett
 - » Non-Categoricals (adults, no children, <100% FPL)
 - » Mental Retardation
 - » Alpha 1-Adult Disabled

Who Will Be Managed by Care Management

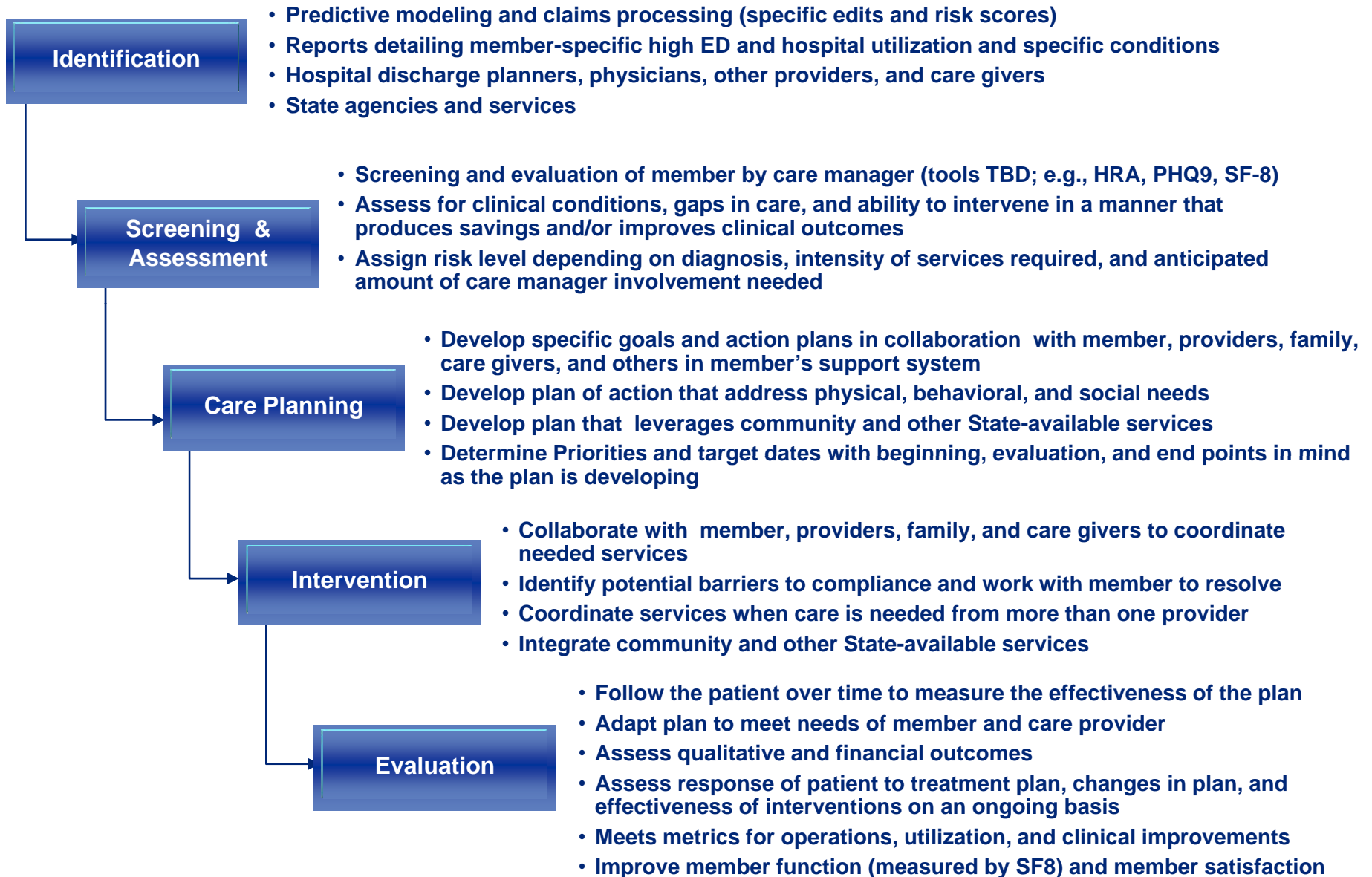
Selection of “who” is not only driven by the numbers, but also must take into account where the care manager can intervene and make a meaningful impact

- Utilization often points to access issues or other failures that are amenable to intervention
 - Multiple ED visits – two or more emergency department visits in six months
 - Multiple hospital visits – two or more hospitalizations in one year
 - Polypharmacy – six or more prescriptions
 - » Leverage Goold to assist in managing these individuals
 - » Evaluate for fraud and abuse in certain categories of drugs
 - Multiple physician visits – eight or more in 12 months
 - Multiple physicians – four or more physicians in non-related practices providing ambulatory care
- Historical costs, viewed in isolation, are not the best indicator of who to manage
 - If using costs, determine the appropriate threshold based on MaineCare data
 - Use in conjunction with other criteria
- “Gaps in care” have become an industry standard for short-term, episodic care management
 - Medication compliance (e.g., MaineCare now intervening with HIV/AIDS members who have gaps in care)
 - Missed appointments or no follow-up post-hospital discharge
- Individuals with chronic illnesses, major trauma, or disabilities who live alone and have no support system often need assistance in obtaining and coordinating care and services

Care Management has to Address the Continuum of Care Needs



Care Management Must Have Sustainable Processes



Integration and Technology

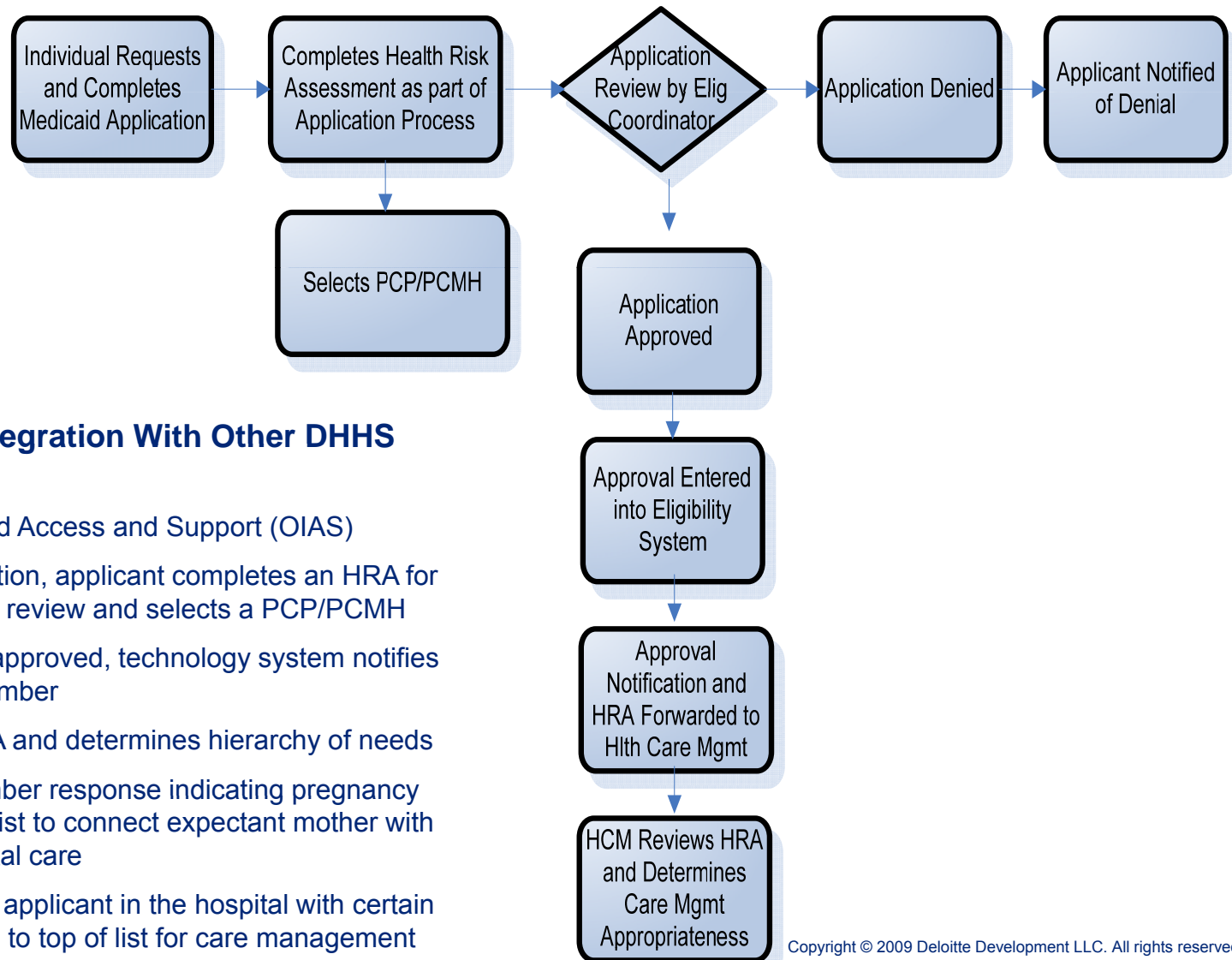
Integration is Critical to Medicaid Care Management

Care management should reinforce a culture of collaboration, coordination, cooperation, and communication

- Integration should include both technical and functional combining independent sub-systems including
 - Analytics and a predictive modeling component to evaluate providers, patients and Medicaid plan
 - Transactional components to automate authorizations, referrals and communications with providers and patients
 - Utilization management, disease management, case management and other components to manage populations across the continuum of care
- Integration with claims adjudication is necessary to consolidate the member record which helps in risk assessment, utilization management and case & disease management
- Care conferences for complex cases should be conducted with partners

Integration with Eligibility – (Example)

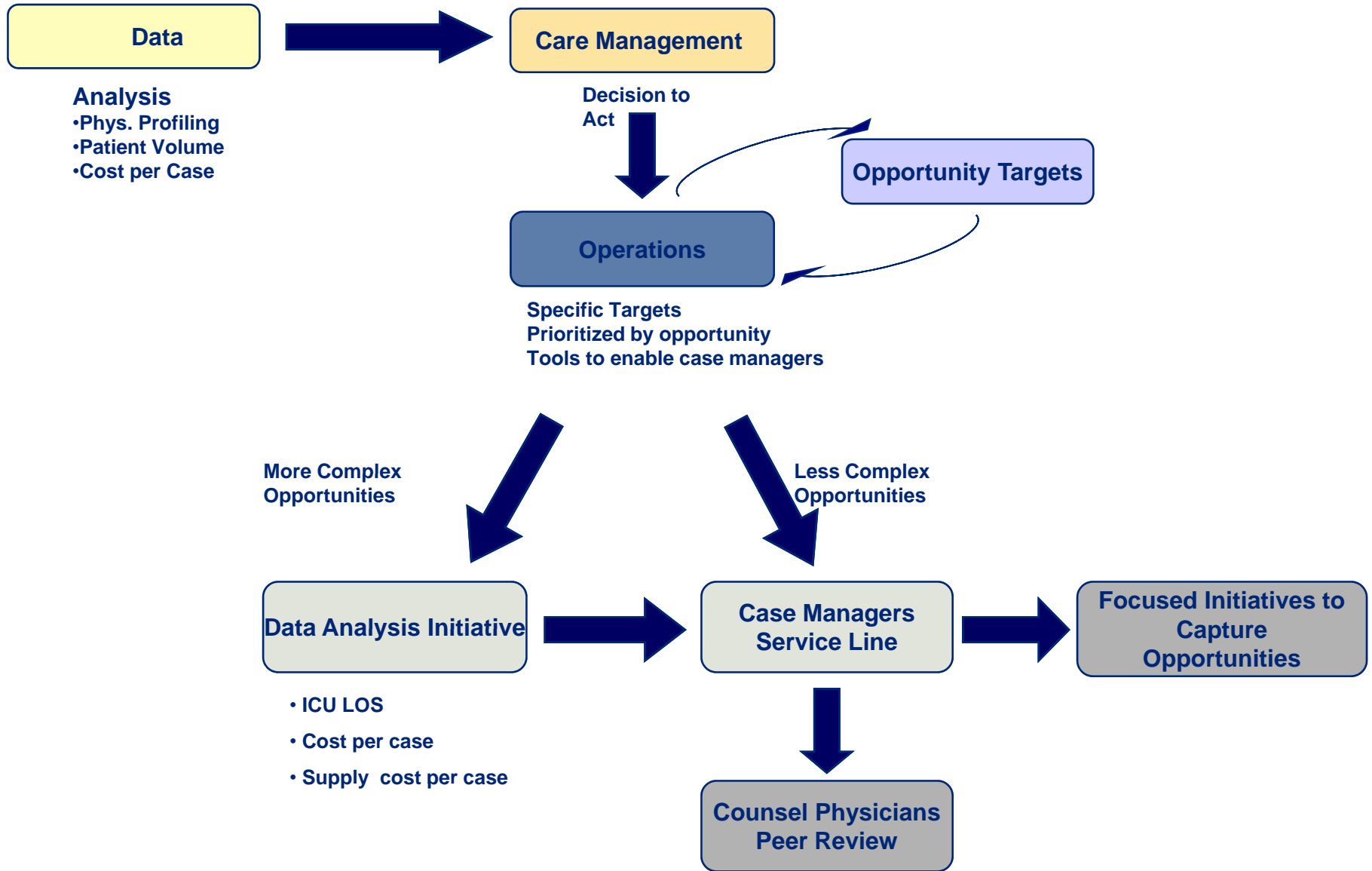
It is critical that members who could benefit from care management support are identified as early as possible with a technology-driven solution



Example of Integration With Other DHHS Agency

- Office of Integrated Access and Support (OIAS)
- At point of application, applicant completes an HRA for care management review and selects a PCP/PCMH
- Once application approved, technology system notifies HCM of active member
- HCM reviews HRA and determines hierarchy of needs
 - Example: Member response indicating pregnancy flags to top of list to connect expectant mother with PCP for prenatal care
 - Example: New applicant in the hospital with certain diagnosis flags to top of list for care management

Data Flow Model



Appendix A

MaineCare has opportunities across the “continuum of needs” to positively impact costs and health outcomes for members with select conditions

Continuum of Care Conditions

Health & Wellness	Chronic Conditions		Catastrophic Sudden Onset Less/Unpredictable	Long Term Care (Behavioral & Medical)	End of Life Hospice
	At-Risk/Newly Diagnosed	Long Standing			
<p>Examples:</p> <ul style="list-style-type: none"> • Age appropriate preventive services <ul style="list-style-type: none"> – Immunizations – Preventive exams and procedures; e.g., mammogram, colonoscopy, etc. • Safety • Health fairs • Weight management • Smoking cessation • Stress management • Exercise • Sleep deprivation • Women’s health • Healthy aging • Healthy heart 	<p>Examples:</p> <ul style="list-style-type: none"> • Diabetes • Chronic obstructive pulmonary disease (COPD) • Asthma • Coronary Artery Disease (CAD) • Cardiovascular Disease (CVD) • Congestive Heart Failure (CHF) • Hypertension • Chronic conditions w/co-morbid depression • HIV/AIDS • Cancer 	<p>Examples:</p> <ul style="list-style-type: none"> • Diabetes • COPD • Asthma • CAD • CVD • CHF • Chronic kidney disease (CKD) • Low back pain • Chronic pain • Chronic conditions w/co-morbid depression • Transplants • HIV/AIDS • Major depression • Metastatic cancer • Obesity • Rare diseases 	<p>Examples:</p> <ul style="list-style-type: none"> • Traumatic brain injury (TBI) • Major trauma <ul style="list-style-type: none"> – Hemiplegia/paresis – Quadriplegia/paresis • Complex neonates with likelihood of readmission • High-risk pregnancy <ul style="list-style-type: none"> – Teenage – Multiple gestation • Sepsis • Bariatric procedures • Gastrointestinal (GI) hemorrhage • Respiratory failure due to environmental conditions • Metastatic cancer 	<p>Examples:</p> <ul style="list-style-type: none"> • TBI • Ventilator dependent • Cognitive impairment • Mobility impairment • Vision impaired (Blind) 	<p>Examples:</p> <ul style="list-style-type: none"> • Cancer • Respiratory failure • Renal failure • Stroke • Sepsis • Other infections • Neurodegenerative Disease • HIV/AIDS • Birth trauma/ defects

*HCM to analyze data to determine conditions it will manage