Anthem BlueCross BlueShield

Medicaid

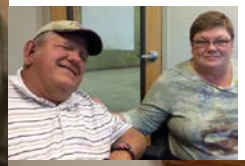
Home and Community-Based Services (HCBS) Modernization

Anthem Blue Cross and Blue Shield

Notice of Public Hearing
July 17 - 18, 2017
Indiana Government Center, South Building
Conference Center Room C
Indianapolis, IN

Introductions

- **Kristen Metzger**
  President, Indiana Medicaid
- **Aimee Brake**
  Sr. Director Product Development, LTSS and ID/DD



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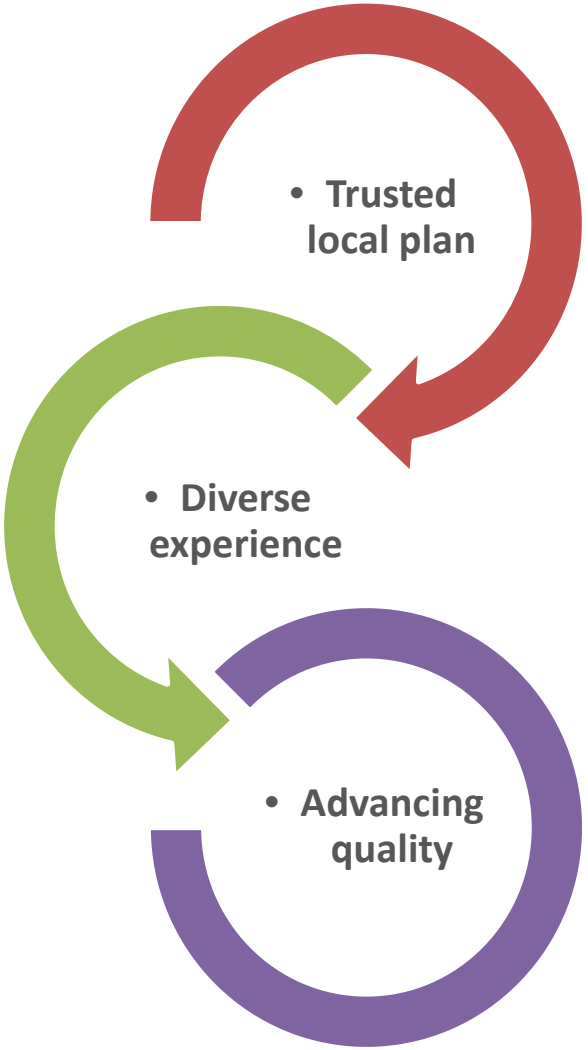
Anthem's Commitment to Indiana



- 73 years of experience serving IN
- More than 4,600 Indiana employees augmented with specialized and operational enterprise resources
- 4.6M Hoosiers carry an Anthem BCBS Card

- We serve Hoosiers in Medicaid, Medicare, Federal Gov't Solutions, and Commercial (Large Group, Small Group self insured and Fully Insured)
- We offer solutions to cover the whole family and connect Hoosiers to the health care and social services that best support their needs

- NCQA Accredited for HMO/POS and PPO
- Anthem collaborates with providers across the state with arrangements that pay for quality and value

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Anthem's Government Business Division

Anthem BlueCross BlueShield | Amerigroup RealSolutions in healthcare | CareMore It's what we do.™ | UniCare

Over 26 years partnering with states to serve Medicaid populations

- **295,000** members covered under managed LTSS in **9 states**
- **730,000** members who are ABD in **17 states**
- **56,000** members in foster care and adoption assistance in **10 states**
- **367,000** CHIP members in **15 states**
- **60%** of our national service area is in rural counties
- **5** new market implementations in **4 years** with **374,000** members
- Partner with **14 states** for over 10 years
- Hold **54** state-sponsored contracts

156,000 babies delivered in 2016

3.9 million members covered under age 19

More than **1 million** members enrolled in Disease Management program

954 members transitioned from NF to community in 2016

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An Experienced Leader in Integrated Care and Services

Anthem and our affiliate Medicaid health plans coordinate all mental health and substance use disorder (MH/SUD) services in-house as an integrated function for more than 943,000 members across the country.

Our deep experience with integrated care provides a strong foundation for continued innovation and informed advocacy to support a holistic person-centered approach to health, well-being, resiliency and recovery.

Results that Matter

Indiana Enhanced Care Coordination (ECC) Services Pilot

Anthem Indiana partnered with six Community Mental Health Centers for an ECC pilot targeted at members with physical and behavioral health conditions. The six month pilot resulted in a **26% reduction in the members' ER expenditures and increased medication adherence**, with a 109% average increase in pharmacy claims per member.

Telehealth Solutions

Our web-based behavioral telehealth solution gives members in geographically remote areas access to qualified behavioral health providers and services. Surveys show that **overall member satisfaction** with the program **is 87%,** with **50% of those responding** reporting that they **would not have access to a behavioral health provider** without this technology.

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Meeting Members Where They Are

Locate and Engage

- On-the-ground community health workers who “locate, engage, educate, and refer” hard-to-reach and homeless members

Substance Use Disorder (SUD) and Behavioral Health Coach

- Onsite case management and field-based visits for discharge/ transition planning, case management and FUH/SUD support

Medical Respite

- Leveraging innovative partnerships to expand access to medical respite and other critical wraparound services for members experiencing homelessness after hospital discharge

Anthem has deployed kiosks in Walmart stores in multiple markets to provide out members with instant access to Health Needs Screening and real time incentives

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Stakeholder Engagement Drives Informed Solutions

From our local advisory committees to our work with the National Advisory Board on Improving Health Care Services for Older Adults and People with Disabilities (NAB), our approach is always guided by the members and families we serve, as well as by the larger community of members/ consumers, advocates, providers, and our state agency partners.

Transparent and ongoing stakeholder communication is critical throughout development, implementation and post go-live

- Proactive information sharing identifies best practices and lessons learned throughout in the process
- Opportunities for stakeholders to provide feedback so that plans can respond and take action

Members

- Our member advisory committees are tailored to the populations we serve and include people of all ages, people with disabilities and children/youth in foster care and member families

Providers

- Our approach to supporting providers is built on collaboration, and we work to ensure providers are engaged in program design, processes and evaluation

State Partners

- We meet frequently with our state partners to promote transparency, ensure program goals are met, and share best practices across health plans

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Specialized and Expanded Provider Networks

Network adequacy provides the foundation for access to care and services

- MCEs have the capability to expand network access and increase provider participation in the program
- State should seek IHAs with extensive LTSS network development and management experience as LTSS providers are very different from traditional Medicaid service delivery networks
- MCEs can promote capacity-building with providers to support transition to the HCBS regulation implementation

Network access standards are an important safeguard

- Access measures should be appropriate to provider types (e.g. LTSS providers not typically measured by distance)
- Access measures should account for the availability of providers within the service area and reflect patterns of practice

Program policies can encourage provider participation

- Any willing providers provisions under which providers agree to accept FFS or comparable contracting rates and policies
- Administrative simplification of processes where possible (e.g. require MCEs to work collaboratively on a uniform LTSS provider credentialing process)
- Prohibition on exclusive provider contracting arrangements

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LTSS Requires a New Approach to Quality

- Quality Measurement in LTSS is still evolving
  - CMS has engaged the National Quality Forum to identify best practices
  - Anthem has established an internal workgroup that reviews progress in the field of LTSS quality measurement
  - Anthem is utilizing National Core Indicators LTSS measures in TN

- We have successfully partnered with states to measure quality in newer, non-medical topic areas, including:
  - Person-centered planning with member/family participation (TN)
  - Integrated Competitive Employment (KS)
  - Nursing facility admission rates (hospitals and the community) (TX)

- Continue to leverage EQRO for program assessment and review and build on strong MCO quality infrastructure in place today through Medicaid managed care

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LTSS Requires a New Approach to Quality

Leverage opportunity to select 5-10 priorities for measurement at the topic level (e.g. member participation in person-centered planning, reduction of ED utilization, medication management, integrated competitive employment, increase selection of self-direction)

- Request health plan input and proposals for appropriate and effective measures to identify potential best practices and leverage experience of health plans
- MCEs should work with the State during implementation to define a standardized measurement approach for all plans statewide
- Timeline must allow for at least a full year of data collection (to align with data collection cycles) to establish baselines prior to performance measurement

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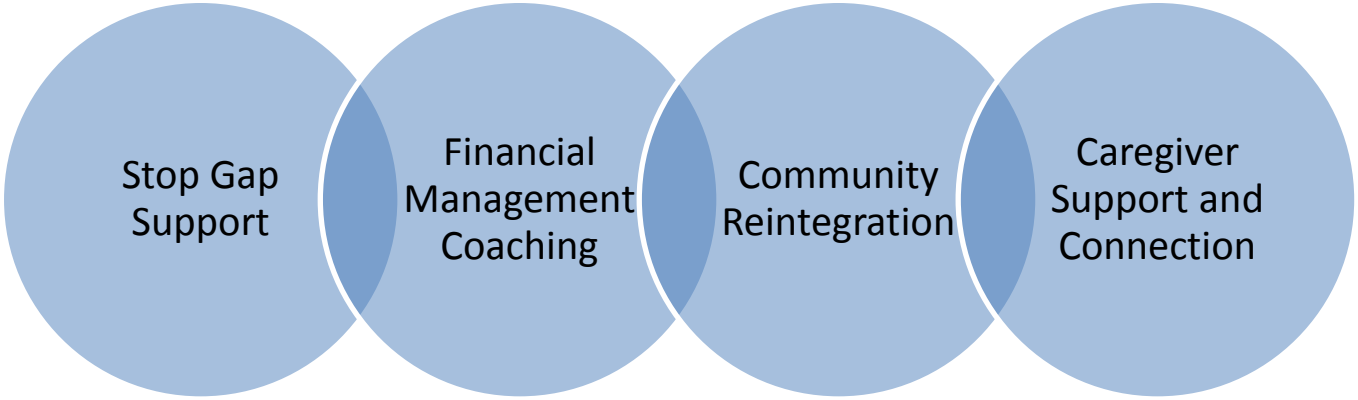
An Ally for Self-Direction and Inclusion

Community isn't just about location – it's about integration, inclusion, full participation, choice and opportunity – and it's not possible without the right supports.

Our programs are structured to be flexible and innovative to ensure quality services are accessible and individualized to meet the needs and preferences of members and allow for greater self-determination and achievement of personal goals.



In 2016, we supported the transition of nearly 1,000 members from custodial nursing facility living to community living.

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Supporting Caregivers

An estimated 44 million Americans (age 18 and older) provide unpaid assistance at a value of **$470 billion** to support older adults and adults with disabilities who live in their homes and communities. Unpaid caregivers and companions **often experience poor health, emotional and physical health care**.

Anthem's approach to care and service planning includes ensuring that caregivers have the support they need to take care of themselves, so they can support their loved one.

Caregiver assessment to identify & link caregivers to meaningful goods, services, supports & training

Enhanced Benefits and Services	Well-being and Social Supports	Knowledge, Training, and Skills
➢ Enhanced respite care ➢ Enhanced personal care ➢ Technology with scheduling reminders and data analytics ➢ Enhanced assistive devices and home modifications ➢ Navigation & access to resources tailored to personal preferences and support needs	➢ Community-based organization partnerships offering supports, information, & resources ➢ Advocacy organization memberships & conference support ➢ Secure technology platforms to support real-time communication & information sharing	➢ Technology supporting real-time care team and learning ➢ Training for caregivers in topics such as self-care, advocacy, financial management and self direction ➢ Dynamic searchable database of localized community resources

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High Touch, High Tech Innovations

High Touch

Our **Bridge Plus** program promotes aftercare for members following hospitalization for a mental health condition.

- A Licensed Mental Health Professional from a participating local Community Service Board (CSB) visits members being discharged from a psychiatric hospital on the day of discharge prior to leaving the hospital.
- After a needs assessment, the clinician connects them with follow-up services at the CSB or provider office.
- The community agency monitors members for 30 days after discharge to verify that they are engaged in treatment and identify and address any emerging needs.

Initial data indicates that more than 90% of Bridge Plus participants keep their appointments after discharge

High Tech

Predictive Modeling

- Likelihood of Nursing Admission (LINA) modeling supports identification of members who may be at risk for an NF admission. By monitoring pertinent data, such as member demographics, ED visits, and fall-related services, our care coordinators conduct early outreach to members who may need additional support.

Supports for Self-Direction

- Anthem offers the a tool to help members connect with personal care assistants with skills that match their individual needs, preferences, and values.

Enhanced Communication

- Anthem also offers technology that increases communication capabilities for the member and supports behavior tracking, information sharing, and direct messaging among the care team to identify issues

Institute for Medicaid Innovations Recognized LTSS Best Practices

Indiana CICOA Care Transitions Program

- Anthem partnered with the Central Indiana Coalition on Aging (CICOA) and Area Agency on Aging (AAA) 8 to target high-risk members for home visits by a care coordinator to identify and assist with unmet needs.
- The pilot program provided in-home care coordination to members discharged from the acute inpatient setting with a high risk of inpatient readmissions or emergency department visits based on predictive modeling data.
- Utilizing one electronic medical record (EMR), Anthem and CICOA were able to seamlessly coordinate care.

From January through June 2015, members who were referred by Anthem and experienced a face-to-face care coordination visit had a readmission rate ***31.2 percent lower*** than those referred who did not have a home visit (i.e., refused, were unable to be reached).

Long Term Care (LTC) Transitions Program

Our Florida affiliate implemented a multipronged program that helps individuals achieve their personal goals, using their strengths, and taking into account their autonomy, wishes, goals, and independence. Supported by our clinical case management solution, the program works as a team with the member, family, caregivers, and primary-care provider to reach agreement and identify needs.

In 2015, 77 members were identified, through service coordinators, as having expressed a person-centered goal to move from a nursing facility setting to HCBS. The health plan successfully transitioned all identified 77 members to HCBS with a ***97 percent success rate.***

The Value of a Fully Integrated Approach to MLTSS

Continued Rebalancing	Quality	Sustainability
• Increase access to quality home and community-based services (HCBS) • Avoid unnecessary institutionalization • Support individual choice	• Shift to person-centered, integrated care and services • Expand access to services • Improve health outcomes • Demonstrate success through data	• Leverage savings gained through rebalancing to expand access to HCBS and reduce overall LTSS costs • Slow growth of program costs • Establish budget predictability

Savings and Sustainability

- TN launched its MLTSS program, CHOICES, in 2010
- In 2014, TN ranked 6th in the percentage of its Medicaid population with disabilities but had the 4th lowest Medicaid spend per enrollee nationwide
- A 2015 Pew report showed TN had the second lowest change in Medicaid spending as a share of own-source revenue between 2003 and 2013 (a change of 0.3 percentage points v. the national average change of 4.7 percentage points)

Tennessee and Kansas MLTSS Program Results

Kansas

- Launched KanCare in 2013
- Integrates MLTSS with physical health and with mental health and substance use
- Prior to implementing KanCare, costs rose at an annual rate of 7.4% over the decade of the 2000s triggering rate reductions and creating waiting lists

Data Comparisons between Pre-KanCare and Year Three of KanCare

- Inpatient expenditure reduced by 26%
- Facility utilization reduced by 37%
- Primary Care Physician utilization increased by 14%

Reinvestment of KanCare savings cleared the waiting list for the state's Physical Disability Waiver in 2016

Tennessee

TennCare launched MLTSS for older adults and adults with physical disabilities in 2010 with the CHOICES program, and added the I/DD population in 2016. Some key outcomes achieved to date:

- More than 2,500 individuals have transitioned from NFs to HCBS as of June 30, 2014—an average of 646 individuals per year, compared to 129 people in the baseline year immediately preceding CHOICES implementation
- More than 10% of CHOICES members receiving HCBS are actively participating in Consumer Direction for some or all of their HCBS

HCBS waiting list eliminated in CHOICES

Best Practices

Program Structure

Integration is key

Fully integrate benefit packages, inclusive of behavioral health, LTSS, and non-emergency medical transportation to allow for seamless care management

Simplifies the member's and provider's experience, and reduces fragmentation, potential duplication of services, and program costs

Phased-in Implementation

Build support

Engage stakeholders early and often and stage implementation starting with less complex, more urban populations

Stakeholder engagement is the cornerstone of successful MLTSS programs; staging implementations allows for continual engagement and improvement and builds on successes

Plan Selection

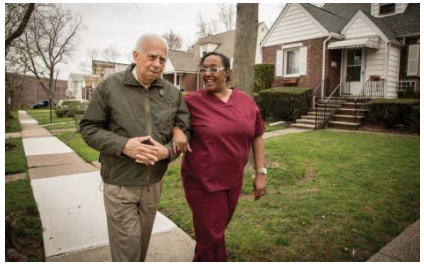
Focus on experience

Experience should be specific to unique program aspects—i.e. transitioning populations with minimal disruption, building on existing program infrastructure, provider collaboration

Plans with more diverse experience will meet the needs of the current program, as well as provide the needed flexibility to meet evolving program needs and objectives

Anthem – Solutions Built from Experience

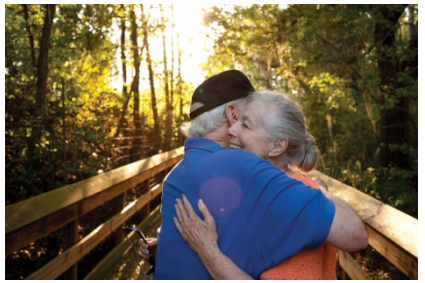
Specialized Networks



Co-location of BH/PH at Service Sites

Provider Education and Incentives

Technology that Connects



CMHC/RHC Partnerships

Holistic Care Model

Innovative Member Engagement

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