Innovations in Medicaid: Addressing the Care Fragmentation Crisis for Dually Eligible Individuals

NORC Managed Care Organization Learning Hub Webinar Series with Support from MolinaCares Accord

11/1/2021

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NORC MCO Learning Hub

- **What is the NORC MCO Learning Hub?**
  - The NORC MCO Learning Hub is committed to providing information on ways to transform health equity and health care to key Medicaid and MCO leadership, consumer groups, and other key industry groups
- **Innovations in Medicaid Webinar Series**
  - Six-part quarterly webinar series through 2022, highlighting innovations in Medicaid
  - First session focused on meeting the behavioral health needs of Medicaid members post-pandemic; the slides and recording are available on the Hub website: https://www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

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Webinar Logistics

- All attendees will remain in listen-only mode
- Please send any questions for presenters using the chat box at the bottom – we'll have a Q&A session at the end
- The slides can also be accessed on our website: https://www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

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Agenda

- Introduction
- Presentation from Tom Betlach with Facilitated Discussion
- Presentation from Carolyn Ingram with Facilitated Discussion
- Presentation from Jennifer Baron with Facilitated Discussion
- Open Q&A
- Conclude

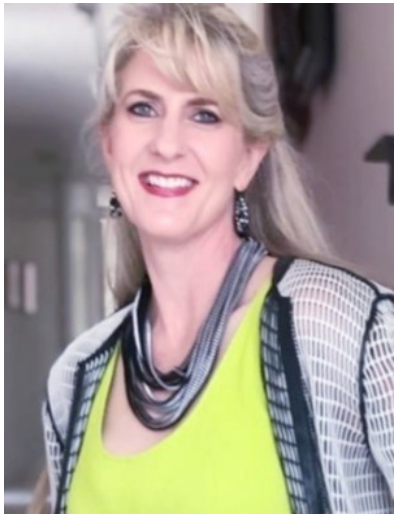
Speakers

Darin Gordon

Moderator
Founding Partner
Speire Healthcare Strategies

Tom Betlach

Speaker
Partner Speire Healthcare Strategies



Carolyn Ingram

Speaker
Executive Vice President of External Affairs
Molina Healthcare

Jennifer Baron

Speaker
Senior Strategist, Policy & Product
Cityblock Health

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State Challenges and Opportunities to Integrate Care for Dually Eligible Individuals

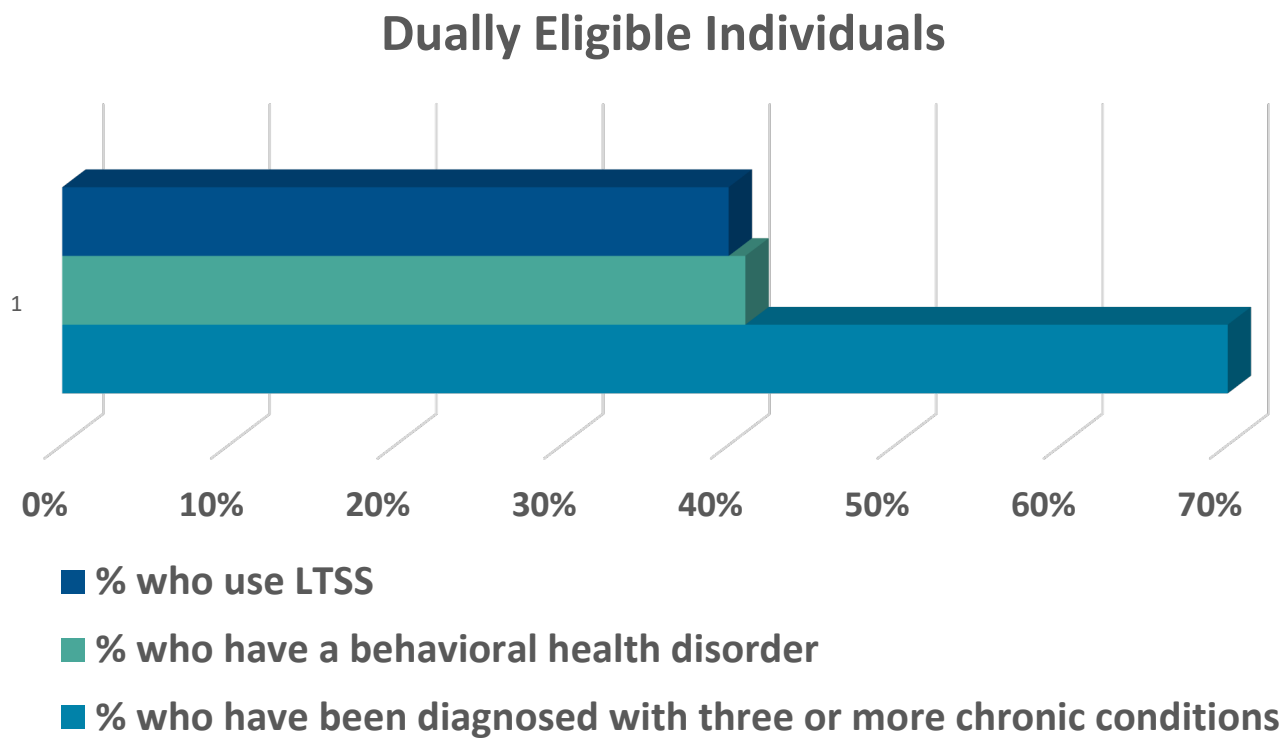
Addressing the Care Fragmentation Crisis for Dually Eligible Individuals

Tom Betlach
Partner
Speire Healthcare Strategies

11/1/2021

High Need Population

Dually eligible individuals are a higher need population than the general Medicare or Medicaid populations



Source: Integrated Care Resource Center. Dually Eligible Individuals: The Basics. March 2021. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Dually_Eligible_Individuals_Fact_Sheet.pdf

Dually Eligible Individuals Face Numerous Challenges, Exacerbated by COVID-19

- **Fragmented Care**
  - ✓ No financial alignment
  - ✓ Uncoordinated care
  - ✓ Limited alignment of incentives across Medicare and Medicaid
- **Integrated Care Models**
  - ✓ Financial alignment
  - ✓ Coordinated care
  - ✓ Align across Medicare and Medicaid through Dual Eligible Special Needs Plans (D-SNPs)

Key Issues during COVID-19 Crisis
Structural
Caregiver Supports
Higher Cost of Care
Operational
In-Home Care
Maintaining Necessary Services
Member and Family Communications
Transitions of Care
Services
Access to personal protective equipment (PPE) and Testing
Behavioral Health Issues
Meals
Social Isolation
Transportation

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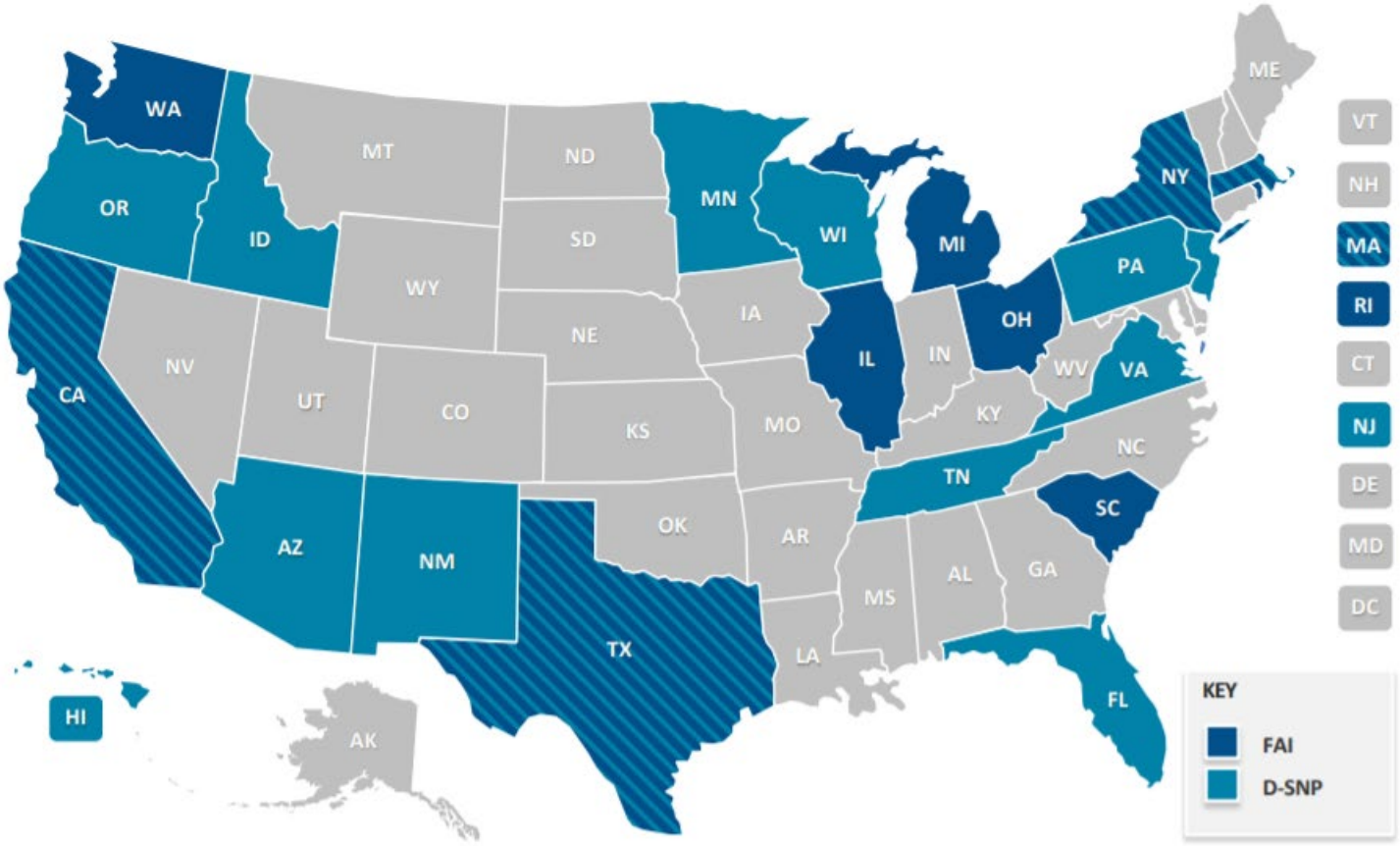
Integrated Care Models



Source: https://www.chcs.org/media/Integrated-Care-Programs-for-Dually-Eligible-Individuals-in-the-Era-of-COVID-19.pdf

Benefits of Duals Alignment

Members

- ✓ Align enrollment
- ✓ Easier and less complicated access to care
- ✓ High satisfaction
- ✓ Likely one care manager with view of all services and ailments

Providers

- ✓ Minimize provider abrasion
- ✓ Streamline claims

States

- ✓ Increased use of primary care and home and community-based services (HCBS)
- ✓ Decreased use of nursing facility and avoidable hospital care
- ✓ States can leverage demonstration authority to generate savings

Health Plans

- ✓ Integrated benefits under same entity
- ✓ Streamline utilization management – integrated review and provision of services
- ✓ Streamline claims adjudication and payment

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Facilitated Discussion

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A Medicaid MCO's Perspective: The Opportunity of Integration

Addressing the Care Fragmentation Crisis for Dually Eligible Individuals

11/1/2021

Carolyn Ingram
Executive Vice President,
Molina Healthcare

MOLINA® HEALTHCARE

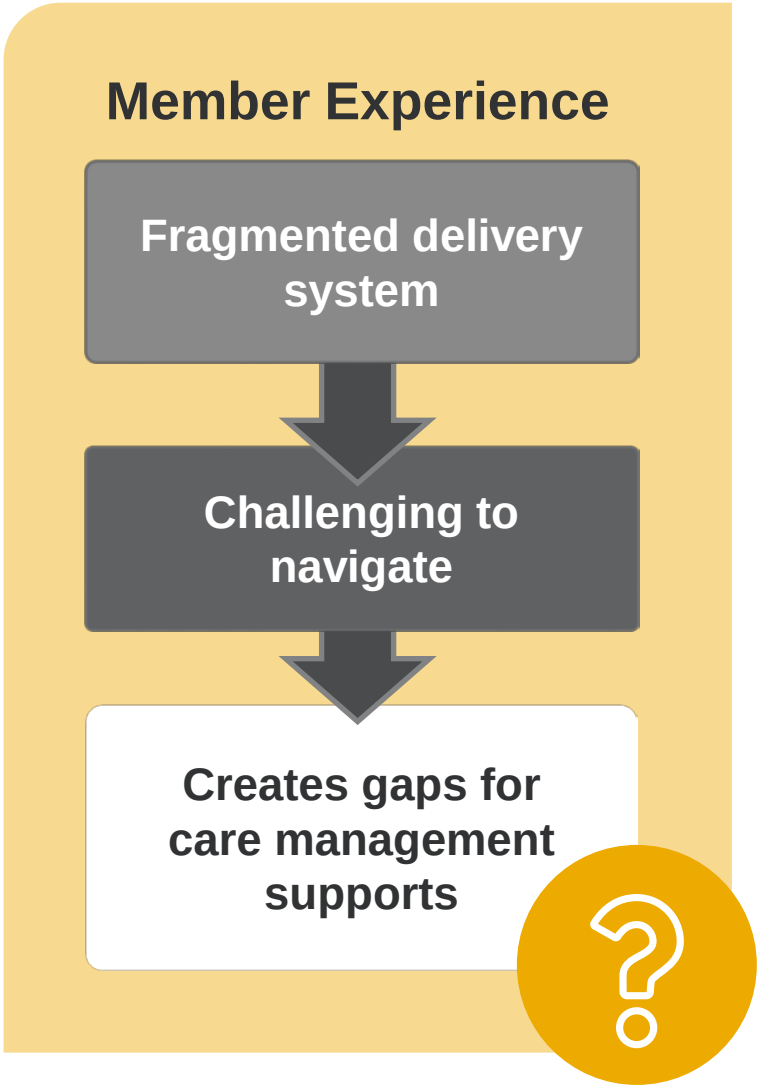
Operating in a Fragmented Delivery System

Hard to address without integration

- Caregiver needs
- Developing comprehensive care plans
- Addressing social determinants of health

None or limited notification for transitions of care

- Hospital discharge
- Skilled nursing facility entry
- Prescription changes



What Integration Delivers

Fully Integrated Plan Experience

- ✓ Direct data exchange with providers
- ✓ Comprehensive care plans
- ✓ Caregiver needs
- ✓ In-home risks
- ✓ SDOH
- ✓ Transitions of care
  - ✓ Discharge from hospital
  - ✓ Skilled nursing facility entry
  - ✓ Nursing home entry
  - ✓ Community based care

Member Experience

- ✓ Holistic
- ✓ Easier to navigate
- ✓ Better care management supports become possible

Outcomes of Transitions of Care Program

SDOH Transitional Meals program

Who: High-risk members who lack access to nutritionally appropriate food

What: Provided medically tailored meals (2 meals/day)

When: For 4 weeks after hospital discharge

Why: Nutrition is a critical SDOH need that impacts post-discharge health outcomes

Impact Over 6 Months

For participants pre- vs post-participation

Hospital 70% ↓

Medical Spend 39% ↓

Improving health equity among members with high food insecurity:

African Americans Hospital 85% ↓

Hispanic / Latino Hospital 85% ↓

"Impact" data come from affiliate health plans, members participating in Transitional Meals Program from January 2019 through September 2020, comparing 180 days pre- and post-intervention

MOLINA HEALTHCARE

Spotlight: Supporting Caregivers in Integrated Programs

The Opportunity: Capitated Financial Alignment Demonstration

- Molina has participated in the FAD since its launch
- Demonstrations provide experience operating fully integrated Medicare/Medicaid programs, creating new opportunities

Molina Caregiver Support Program

- Offered care management and evidence-based intervention programs to members' caregivers
- Gained insights from caregivers related to members' needs, helped ensure access to benefits across programs
- Caregiver support for populations for under 65
- Reduced caregiver stress and impacted downstream outcomes

Key Takeaway: By aligning Medicare and Medicaid for dually eligible enrollees, states empower plans to innovate. Innovations are helping advance our members' well-being.

MOLINA HEALTHCARE

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Cityblock Health

Medicare-Medicaid Integration for Dually Eligible Individuals

November 1, 2021

CITYBLOCK

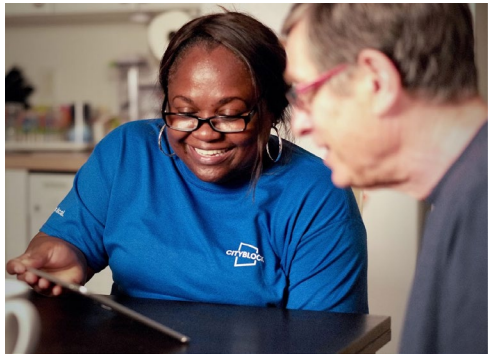
Who we are

As a healthcare provider, Cityblock's mission is to rebuild trust, eliminate inequities, and improve outcomes for marginalized communities.

We've built a scalable care delivery model and technology stack that is a one-stop-shop for individuals with complex needs, seamlessly integrating primary care, behavioral health, and social services, 24/7 / 365, in a flexible, personalized model.

We take on total cost of care risk on high-risk populations in Medicaid, Medicare, and dual-eligible populations.

Cityblock's care model captures value through personalized care teams, multi-modal community care, and technology designed to engage members and improve outcomes



PERSONALIZED CARE TEAMS AND PLANS

Multidisciplinary care teams with MD, NP, RN, BHS, LCSW, and Community Health Partners

Primary care and care management

Individualized care plans, with programs for focus areas like palliative care and End-Stage Renal Disease

Fully integrated behavioral health, with Psych and SUD programs, including Medication-Assisted Treatment

Direct social services delivery, CBO network build and management, and loop closure

MULTI-MODAL COMMUNITY CARE

Strive to always meet members where they are

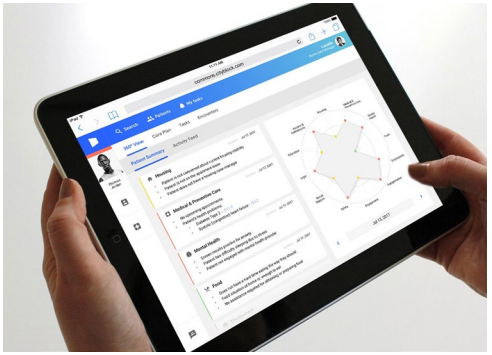
Neighborhood Hubs where our members live

24 / 7 / 365 clinical access with remote triage (voice / text / video)

In-home routine care, and urgent care via Community Rapid Response teams

Care transitions with facility rounding

Boots-on-the-ground outreach staffed with local teams who have deep community expertise



CUSTOM TECHNOLOGY

Built-for-purpose digital care delivery platform serving as backbone of support

Enables scale / provides high-value care innovation to members

Real-time protocolized alerts, including live ADT feeds and workflows

Integrated reporting across all domains

360° member view informed by data feeds and care team input

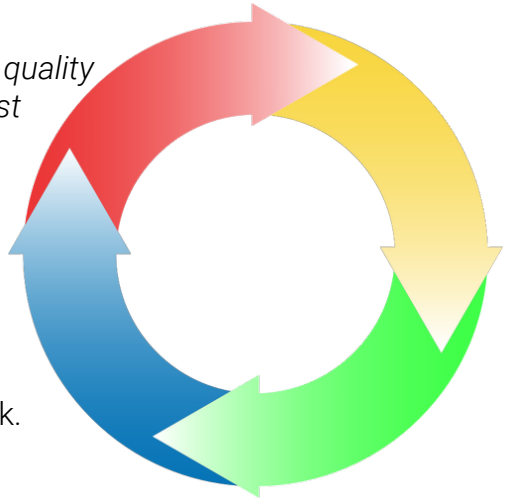
We deliver outcomes through advanced understanding of the heterogeneity of complex lower-income populations

	 Socially isolated & unmanaged	 Polychronic & undermanaged	 Serious mental illness	 Approaching end-of-life
Care model interventions	**Non-clinical engagement** (CHPs) and connection to CBOs and community resources	Interdisciplinary team (MD, RN, CHP) providing **MTM, BH care, and social care**	High-quality primary care integrated with **accessible behavioral health**	Advanced care planning with **aggressive home-based primary care** and palliative care
Desired outcomes	Reduced **social admits** to the hospital	Better **underlying health** and fewer acute events	Reduced inpatient **BH-driven admits**	Reduced unnecessary **end-of-life utilization**
Prevalence in early cohorts	70% reporting social vulnerability	69% with 3+ chronic conditions 33% with 5+ chronic conditions	30% with behavioral health diagnosis	15% identified as eligible for palliative care

Experience- and brand-driven retention captures recurring value over time

We see a powerful opportunity to partner with health plans on integrated models serving dually eligible individuals that deliver superior clinical, quality, and cost outcomes

- Cityblock's model is ideally suited to total cost of care risk sharing arrangements for complex, lower-income populations
- Whole person care
    - Integrated plans are responsible for the full set of Medicare and Medicaid services. This sets the stage for payer-agnostic, whole-person care delivery and coordination that improves health outcomes and member experience
- Improved member health outcomes and experience
    - Trust-based, whole-person care is the foundation for improved outcomes and member experience
- Investing in community health & social services
    - ASPE 2016 Report: *"Beneficiaries with social risk factors had worse outcomes on many quality measures, regardless of the providers they saw, and dual enrollment status was the most powerful predictor of poor outcomes"*
    - Integration sets the stage for connecting members with social services as part of a comprehensive care plan reflecting all Medicare, Medicaid, and any additional services
- Financial alignment
    - Cityblock increases investment in primary, behavioral, and social care to decrease avoidable hospital spend and drive total cost of care savings. When Cityblock partners with integrated plans, savings from high-value care accrue to the plans and to Cityblock. This enables a virtuous circle of reinvestment in whole-person care



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Q&A

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Presentation Slides/Recording and Future Webinars

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- Future webinars in this series will be scheduled soon; subscribe on our website to receive notifications!

Thank you.

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