



# AETNA BETTER HEALTH®

Doing the right thing for the  
right reason



# Aetna Better Health<sup>®</sup>

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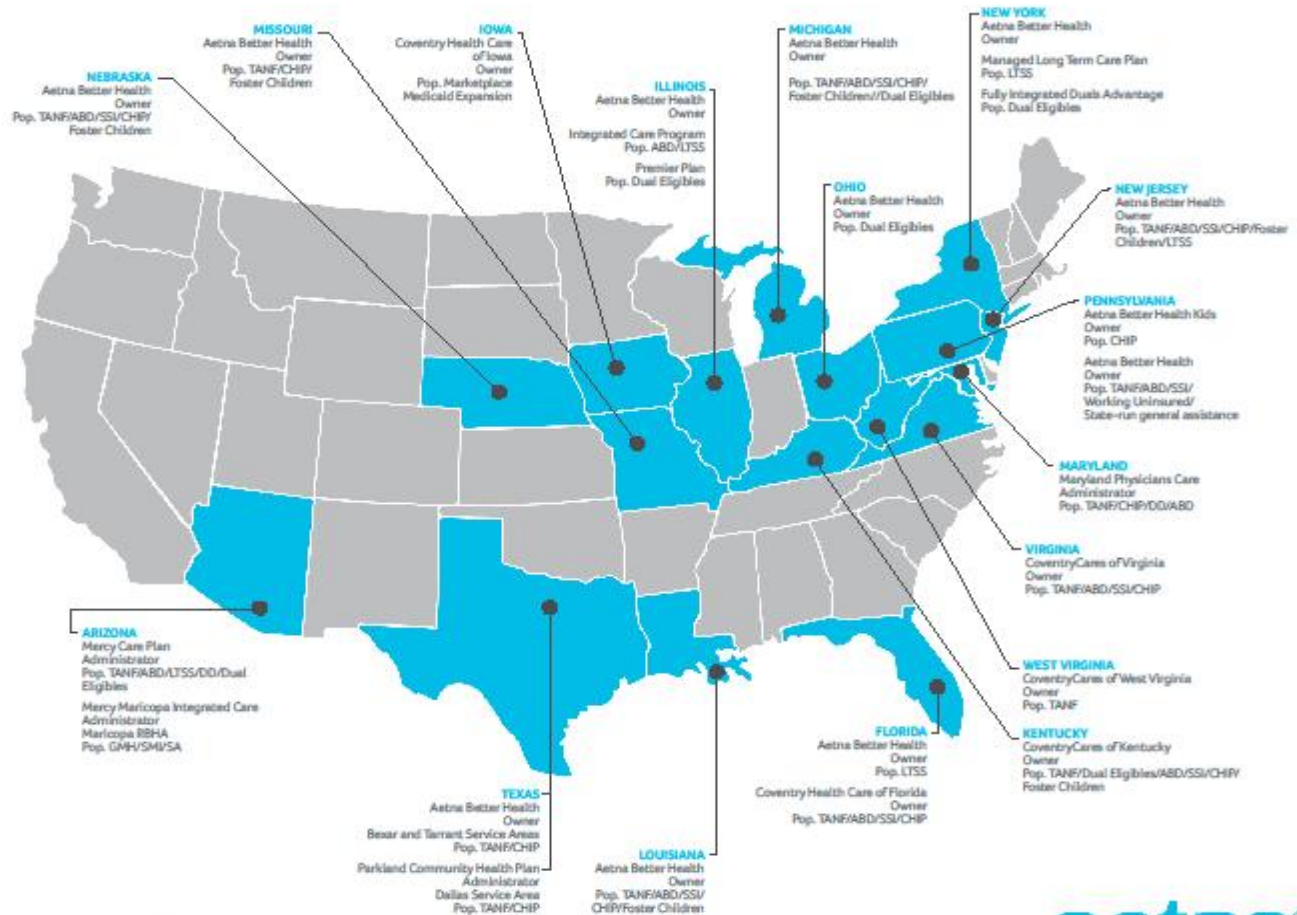
**Understanding Care Coordination**

December 16, 2015

# About Aetna Better Health

- Medicaid business unit owned by Aetna
- Twenty-nine (29) years of experience as a Medicaid Managed Care leader nationally
- Serving Families and Children, Seniors and Persons with Disabilities, Long Term Care, and Medicare/Medicaid Enrollees
- Manage services for just over 3 million Beneficiaries in seventeen (17) states

# AETNA MEDICAID PROGRAMS



The names listed above do not, in all instances, reflect the licensed legal entity or full name of the health plan or line of business in each state.



# Aetna Better Health of Illinois— Care Coordination Guiding Principles

- Focus on each individual member (member directed)
- Work with members and providers to address medical, behavioral, social, and long-term care needs
- Partner with the member and/or caregiver to maximize the member's self management ability
- Enhance quality of care outcomes
- Support member's choice of community living

# Illinois Integrated Care Program (ICP)

# What is the Illinois Integrated Care Program (ICP)?

- A Medicaid program designed to link primary, specialty, institutional and community services focused on improving quality through coordination, quality measures and creation of health homes

# Care Coordination At-a-Glance

Integrated Care Program (ICP)	
<b>Where is the program?</b>	<p><u>Greater Chicago region:</u> Cook, Dupage, Kane, Kankakee, Lake and Will</p> <p><u>Rockford region:</u> Winnebago, Boone and McHenry</p> <p><u>Central Illinois region:</u> Champaign, Christian, DeWitt, Ford, Knox, Logan, McLean, Macon, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell and Vermillion</p> <p><u>Quad Cities region:</u> Mercer and Rock Island</p> <p><u>Metro East region:</u> Madison, Clinton and St Clair</p>
<b>Who is eligible?</b>	<p>Individuals who:</p> <ul style="list-style-type: none"> <li>•Are currently eligible to receive Medicaid (Seniors and Persons with Disabilities)</li> <li>•Reside in one of the counties participating in the ICP</li> <li>•Are 19 years of age and older</li> </ul>
<b>Who is <u>not</u> eligible?</b>	<p>Individuals who:</p> <ul style="list-style-type: none"> <li>•Are under 19 years of age</li> <li>•Receive Medicare</li> <li>•Are an American Indian/Alaskan Native (you may choose to voluntarily enroll)</li> <li>•Are enrolled in the Spenddown program</li> <li>•Receive temporary medical benefits</li> <li>•Are in the Illinois Breast and Cervical Cancer program</li> <li>•Have comprehensive Third Party insurance</li> </ul>



# Integrated Care Service Packages

**Responsibilities of health plan will include all covered services currently funded by Medicaid through the State Plan or waivers.**

- Acute Medical Services: including medical, pharmacy, dental, vision and behavioral health
- Long Term Services and Supports: including nursing facility services and services provided through the Home and Community Based Services waivers, except those waivers serving individuals with developmental disabilities.
- **Service Package III:** Home and Community Base Services Waiver services for individuals with developmental disabilities

# Medicare-Medicaid Alignment Initiative (MMAI)

# What is the Illinois Medicare Medicaid Alignment Initiative (MMAI)?

- Joint initiative of Federal and State governments
- Managed care organizations contracted to coordinate all Medicare and Medicaid services for dual-eligible individuals within demonstration area

# Care Coordination At-a-Glance

Medicare-Medicaid Alignment Initiative (MMAI)	
Where is the program?	<p><u>Greater Chicago region:</u> Cook, Dupage, Kane, Kankakee, Lake and Will</p> <p><u>Central Illinois region:</u> Champaign, Chrsitian, DeWitt, Ford, Knox, Logan, McLean, Macon, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell, Vermilion</p>
Who is eligible?	<p>Individuals who:</p> <ul style="list-style-type: none"> <li>•Are currently eligible to receive both Medicare and Medicaid</li> <li>•Reside in one of the two Illinois demonstration areas for MMAI</li> <li>•Are at least 21 years of age</li> </ul>
Who is <u>not</u> eligible?	<p>Individuals who:</p> <ul style="list-style-type: none"> <li>•Are under 21 years of age</li> <li>•Have a Developmental Disability and who receive DD services in an institutional setting or through a HCBS waiver</li> <li>•Are in spenddown</li> <li>•Are in the Illinois Breast and Cervical Cancer program and other partial benefit programs</li> <li>•Have comprehensive Third Party Insurance</li> </ul>

# What is the primary goal of the MMAI?

## Triple Aim is....



# Family Health Plan (FHP)

# What is the Family Health Plan (FHP)?

- A Medicaid program designed to link primary, specialty, institutional and community services focused on improving quality through coordination, pay for performance and creation of health homes

# Care Coordination At-a-Glance

Family Health Plan (FHP)	
Where is the program?	<p><u>Greater Chicago region:</u> Cook, Dupage, Kane, Kankakee, Lake and Will</p> <p><u>Rockford region:</u> Winnebago, Boone and McHenry</p> <p><u>Central Illinois region:</u> Champaign, Christian, DeWitt, Ford, Knox, Logan, McLean, Macon, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell and Vermillion</p> <p><u>Quad Cities region:</u> Mercer Henry and Rock Island</p> <p><u>Metro East region:</u> Madison, Clinton and St Clair</p>
Who is eligible?	<p>Individuals who:</p> <ul style="list-style-type: none"> <li>•Are eligible for Medicaid (pregnant women or family with one or more dependent children, receive TANF)</li> <li>•Are eligible for Medicaid as defined by the Affordable Care Act guidelines(ACA)</li> <li>•Reside in one of the counties participating in the FHP</li> </ul>
Who is <u>not</u> eligible?	<p>Individuals who:</p> <ul style="list-style-type: none"> <li>•Qualify for Medicare</li> <li>•Are in spenddown</li> <li>•Have comprehensive Third Party Insurance</li> </ul>



# Care Coordination

- Offers members a Single Point of Contact Care Coordinator to assist in navigating the health care system
- Coordinate interdisciplinary care teams not limited to caregivers, medical homes, specialty care, behavioral health care, and local community resources and supports.
- Offer disease management and education for chronic conditions
- Assist with arranging transportation to appointments, finding and securing appropriate housing, and arranging for necessary durable medical equipment to enhance independence
- Promote member empowerment and autonomy

# Member Outreach

- Welcome call within first 30 days of eligibility to conduct Health Risk Questionnaire to explore care needs
- Once enrolled into case management program, regular contact with member every 30 or 90 days based on risk
- Outreach to members while hospitalized to assist in discharge planning, coordinated with hospital staff to reduce risk of readmission
- Follow up within 24 hours when members referred from providers, community agencies, or friends/family
- Home visits conducted to high risk members at least once per quarter
- Engagement with providers to enhance care and create collaborative solutions in response to budget adjustments

# Care Planning

- Right services at the right time to the right people from the right resources
- Member directed care plan
- Care plan shared with member of Interdisciplinary Care Team to promote success in achieving goals
- Care plan is holistic, not specific to medical and/or behavioral health, but also includes addressing of psychosocial needs
- Care plan addresses both long term and short term goals

# Long Term Services and Supports (LTSS)

## Services –

- Nursing Facility Services
- Supported Living Facilities
- Home and Community Based Services provided through the Home and Community Based Services waivers
- **Does Not Include** those waivers serving individuals with developmental disabilities.

## Service Planning-

- Home/facility visits on a regular basis to ensure member receiving appropriate level of care
- Follow up after hospital admission to ensure appropriate discharge care in place
- Offer respite care to families as needed

# Long Term Services and Supports (LTSS)

Agency	Waiver	Services
The Illinois Department on Aging (IDOA) & CCU	Elderly Waiver a.k.a Aging Waiver Community Care Program	<ul style="list-style-type: none"> <li>• Adult Day Service</li> <li>• Homemaker</li> <li>• Emergency Home Response</li> </ul>
The Division of Rehabilitation Services within DHS (DHS-DRS)	Persons with Disabilities Waiver a.k.a. Disability Waiver	<ul style="list-style-type: none"> <li>• Adult Day Service</li> <li>• Environmental Accessibility Adaptations</li> <li>• Home Delivered Meals</li> <li>• Home Health Aide</li> <li>• Homemaker</li> <li>• Nursing, Intermittent</li> <li>• Personal Care (Personal Assistant)</li> <li>• Personal Emergency Response System</li> <li>• Physical, Occupational, and Speech Therapy</li> <li>• Respite</li> <li>• Skilled Nursing</li> <li>• Specialized Medical Equipment and Supplies</li> </ul>

# Long Term Services and Supports (LTSS)

Agency	Waiver	Services
The Division of Rehabilitation Services within DHS (DHS-DRS)	Persons with Brain Injury a.k.a Brain Injury Waiver TBI Waiver	<ul style="list-style-type: none"><li>• Adult Day Service</li><li>• Behavioral Services</li><li>• Day Habilitation</li><li>• Environmental Accessibility Adaptations</li><li>• Home Delivered Meals</li><li>• Home Health Aide</li><li>• Homemaker</li><li>• Nursing, Intermittent</li><li>• Personal Care (Personal Assistant)</li><li>• Personal Emergency Response System</li><li>• Physical, Occupational, and Speech Therapy</li><li>• Prevocational Services</li><li>• Respite</li><li>• Skilled Nursing</li><li>• Specialized Medical Equipment and Supplies</li><li>• Supported Employment</li></ul>

# Long Term Services and Supports (LTSS)

Agency	Waiver	Services
The Division of Rehabilitation Services within DHS (DHS-DRS)	People with HIV or AIDS a.k.a AIDS Waiver	<ul style="list-style-type: none"> <li>• Adult Day Service</li> <li>• Environmental Accessibility Adaptations</li> <li>• Home Delivered Meals.</li> <li>• Home Health Aide</li> <li>• Homemaker</li> <li>• Nursing, Intermittent</li> <li>• Personal Care (Personal Assistant)</li> <li>• Personal Emergency Response System</li> <li>• Physical, Occupational, and Speech Therapy</li> <li>• Respite</li> <li>• Skilled Nursing</li> <li>• Specialized Medical Equipment and Supplies</li> </ul>
The Illinois Department of Healthcare and Family Services (HFS)	Supportive Living Facilities a.k.a SIL Waiver	<ul style="list-style-type: none"> <li>• Also known as Assisted Living Service</li> </ul>

# Provider Services

- The Provider Services department is made up of Network Consultants (Internal Representatives) and Network Account Managers (Field Based)
- Our purpose is to assist participating providers in issue resolution when provider is unable to resolve via normal channels
- Provide outreach and education to providers to ensure they are aware of any changes related to Medicaid covered services.

Contact number is 866-212-2851, option 2.

## Who to Contact:

Network Account Managers are assigned based on provider type:

Supportive Living Facilities Team Lead – William Henderson

[HendersonW2@AETNA.com](mailto:HendersonW2@AETNA.com)

Skilled Nursing and Intermediate Care Facilities Team Lead – Magali Dure

[DureM@aetna.com](mailto:DureM@aetna.com)



# HEDIS and Behavioral Health Measures

Measure	Interventions
Antidepressant Medication Management (AMM) (2 rates)	<ul style="list-style-type: none"> <li>• Patient education</li> <li>• Pharmacy reminders</li> </ul>
Follow-Up Care for Children Prescribed ADHD Medication (ADD) (2 rates)	<ul style="list-style-type: none"> <li>• Educate and Engage caregiver /guardian regarding treatment options</li> <li>• Partnerships with BH provider</li> </ul>
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	<ul style="list-style-type: none"> <li>• Educate team and care givers regarding risk for physical health co-morbidities</li> <li>• Partnerships with BH providers</li> </ul>
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	<ul style="list-style-type: none"> <li>• Review appropriate detoxification codes</li> <li>• Engage treatment team and social supports to promote recovery</li> </ul>
Follow-up after hospitalization for Mental Illness (FUH)	<ul style="list-style-type: none"> <li>• Member and caregiver education</li> <li>• Develop partnerships with inpatient facilities. Early discharge planning</li> </ul>

# Recovery Focused- Peer Advocacy

- Dedicated Peer Advocate Roles unique to Aetna Better Health of Illinois
- Enhanced cultural competency among staff, providers and external stakeholders
- Role functions on a multi-tiered approach
  - Internal –to strengthen the level of understanding and education for staff
  - Member support to impact their recovery

# The Member's Voice in the Health Plan: Member Advisory Council (MAC)

- Participants include members, family members, advocates and providers
- Empower our members to take an active role in their health plan
- Agenda: Council members draft agenda items; discuss and provide feedback on issues ranging from member material to access to care

# Contact Information

## Aetna Better Health of Illinois

[www.aetnabetterhealth.com/illinois](http://www.aetnabetterhealth.com/illinois)

**1-866-212-2851** Integrated Care Program

**Family Health Plan**

**1-866-200-2139** Medicare-Medicaid Alignment Initiative

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