



# Magellan Complete Care Long Term Services and Supports (LTSS) Model of Care

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**Magellan**  
COMPLETE CARE®

# Agenda



- Magellan recognizes that the spend in complex populations nationally is growing, unsustainable and poorly managed. It is recognized that:
  - Polychronic patients are 5% of the population and they result in 45% of the spend
  - Episodic patients are 20% of the population and they result in 35% of the spend
  - Healthy patients are 75% of the population and they result in 20% of the spend
- At the completion of this presentation, participants will have received an overview on the following:
  - Magellan Health overview
  - Magellan in Montana
  - Virginia LTSS population served
  - Program description and objectives in Virginia
  - Overview of model of care in Virginia
  - Operations in Virginia
  - Our suggestions for Montana
  - Program measurements



Offices in 26 states & D.C.



10,700 Total Employees

## Magellan HEALTHCARE<sup>SM</sup>

Focused on Complex  
Populations, Delivering  
Differentiated Services

- ✓ State Medicaid programs and integrated management for special populations, including individuals with serious mental illness and those needing long-term services and supports

- ✓ Behavioral health management and employee assistance programs
- ✓ Specialty healthcare management, including musculoskeletal, cardiac and advanced imaging

**38M** commercial lives

**1.5M** government lives

**1k+** employer contracts

## Magellan Rx MANAGEMENT<sup>SM</sup>

Full-Service PBM  
Focused on High-Growth  
Specialty Spend

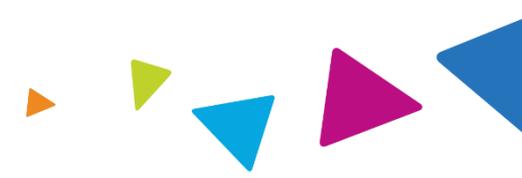
- ✓ Full-service Pharmacy Benefit Manager (PBM) that expands beyond traditional core services
- ✓ More than 40 years of Medicaid and more than 30 years of self-funded employer experience

- ✓ Value-driven solutions: targeted clinical and powerful engagement strategies, advanced analytics, leading-edge specialty pharmacy programs
- ✓ Medicare Part D Prescription Drug Program

**13.7M** medical pharmacy lives

**2M** commercial PBM lives

**27** states & Washington DC in State Medicaid PBA business



## Mental Health and SUD ASO

- Magellan currently holds Medicaid contracts with Montana's Children's Mental Health Bureau (CMHB), and Addictive and Mental Disorders Division (AMDD)
- Services Include:
  - Utilization Management
  - PRTF, MH, SUD
  - Care coordination CMHB
  - Retrospective reviews



## Employee Assistance Program

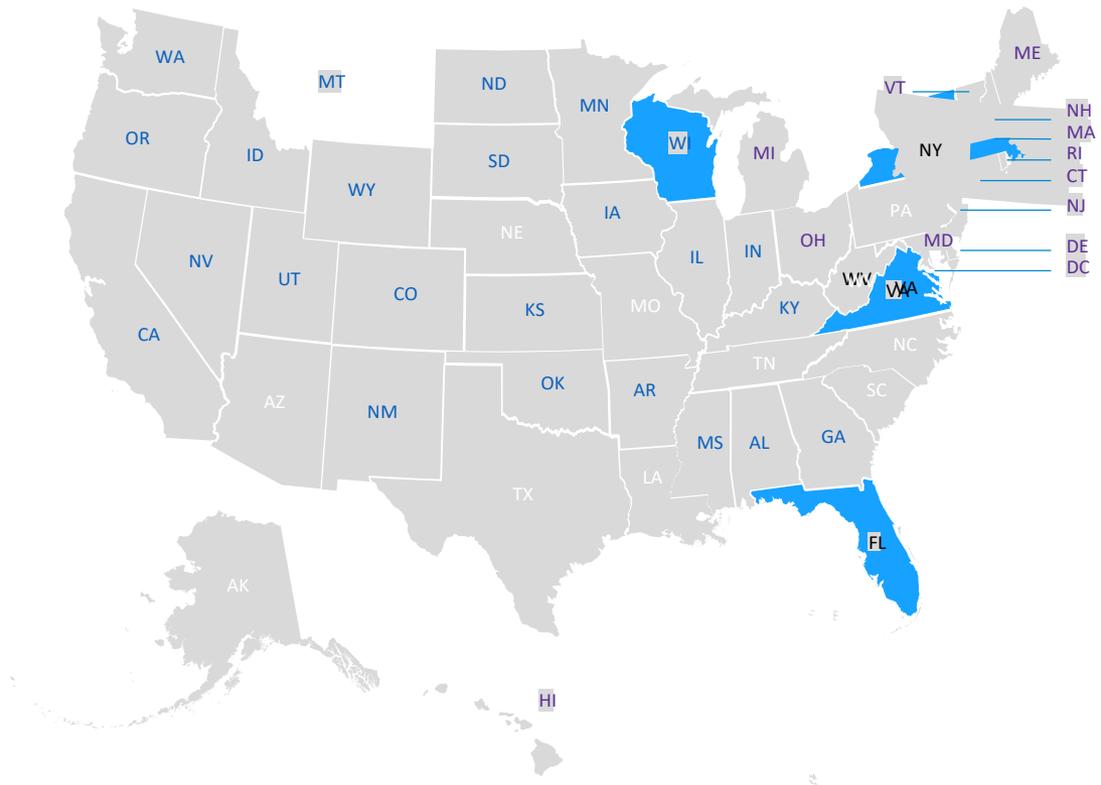
- Montana employers use Magellan's EAP to improve their organizational health and resiliency
- Condition specific services for anxiety, depression, insomnia, substance use disorder and more
- Innovative online solutions:
  - Cobalt computerized cognitive behavioral therapy (available 24/7 via mobile devices)
  - Talkspace messaging therapy
  - Clickotine mobile smoking cessation therapy
  - Management in the workplace



## Pharmacy Services

- Magellan holds a Medicaid Preferred Drug List (PDL) contract with the state of Montana
- Services include:
  - Clinical consulting
  - Manage PDL document
  - Pharmacy & therapeutics committee support
  - Reporting and analytics
  - Supplemental rebate
  - Management, negotiation and contracting

# Magellan Complete Care LTSS and specialty programs

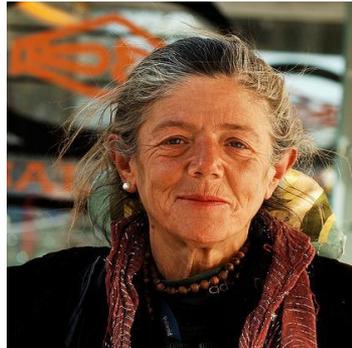


- New York and Massachusetts**-managed long-term care (MLTC) and dual Medicare/Medicaid-eligible populations
- Florida**-managed SDMI population
- Wisconsin**-IRIS self-direction program for long term services and supports
- Virginia**-managed long-term care

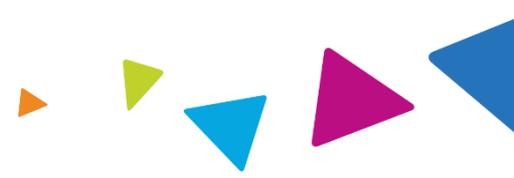
# VA MLTSS membership population



- Over 22,000 members
- Individuals who are 65 and older
- Adults and children with disabilities
- Individuals living in Nursing Facilities (NFs)
- HCBS waiver populations
- Other waiver programs serving the Developmental Disabled (I/DD) populations
- Aged, blind and disabled populations including SDMI
- Emerging high risk populations



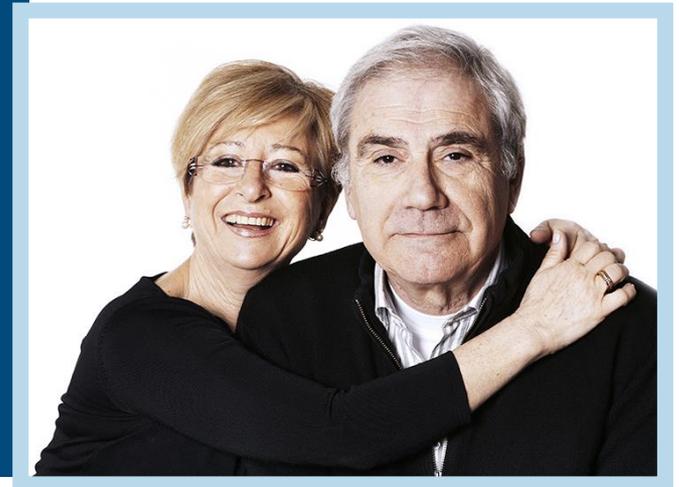
# MLTSS program description



Magellan Complete Care MLTSS is a Medicaid integrated health plan designed for the total care of individuals.

It integrates long-term services and supports, including nursing facility services and Home and Community-Based Service (HCBS) alternatives to nursing facility care, behavioral health services, and acute and primary care services.

Our clinical and operational LTSS model of care promotes person centered care coordination aimed at meeting the individual needs of our members.



# MLTSS program objectives



- Develop a person-centered system of care that addresses the range of individual needs by:
  - Achieving high quality care, budget predictability and cost savings
  - Increase access to HCBS
  - Safely decreasing institutional utilization
  - Build on member choice and enhance quality of life



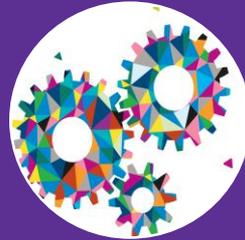
# Key elements of our approach



*Identification of enrollee health status and enrollee LTSS needs, including: health, housing, employment status, health risks and gaps in care of each individual.*



**Health Risk Assessment  
(HRA)**



**Predictive Modeling**



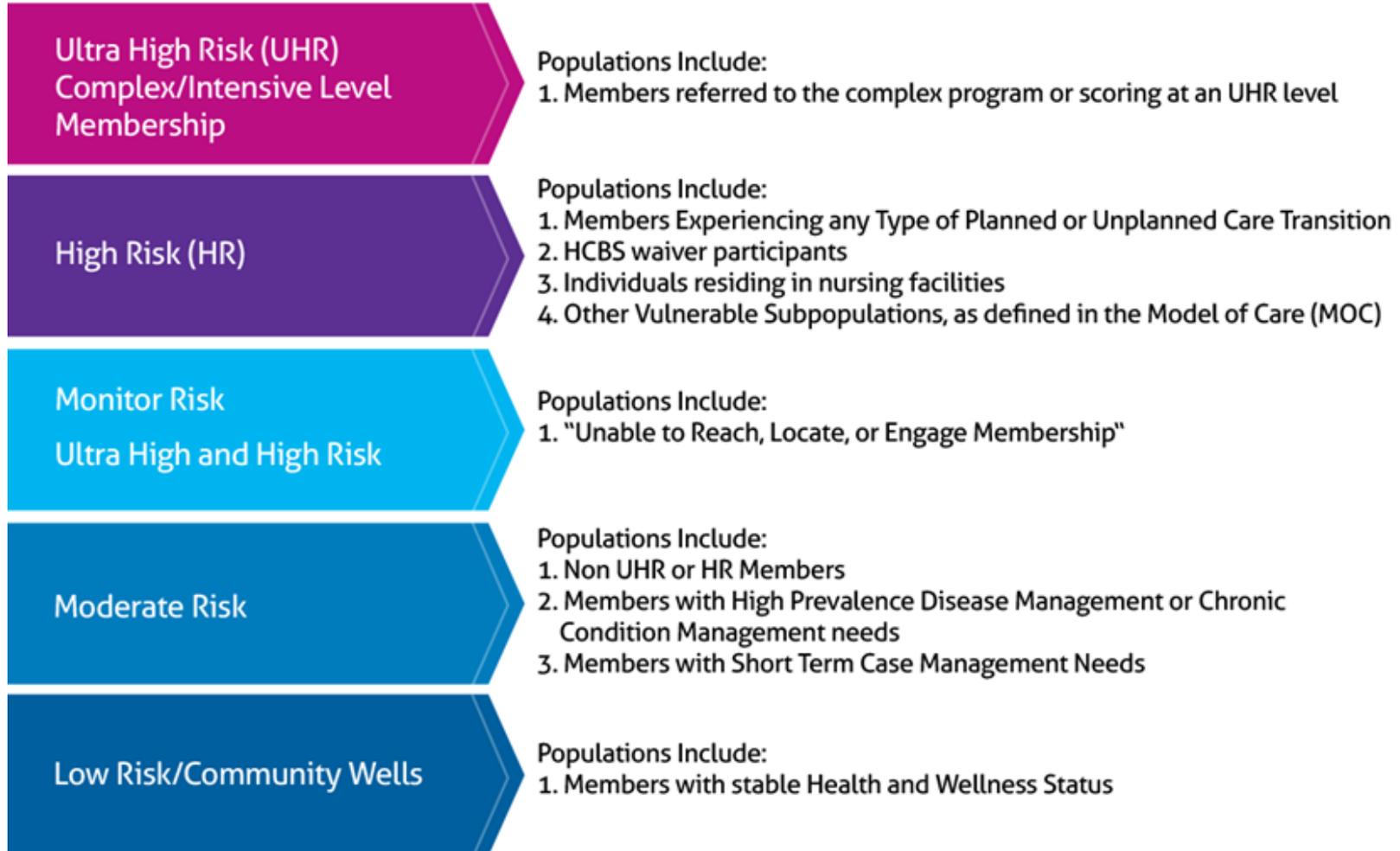
**Stratification**



# Health risk stratification



## Care Coordination Program





## Global HRA

Health status, clinical history, ADLs, IADLs, behavioral status, cognitive functioning, social determinants of health, social functioning, health beliefs and behaviors, cultural and linguistic needs, visual and hearing needs, physical environment for risk, paid and unpaid caregiver needs, available benefits within the organization, community resources + other areas.

## Population Branching HRA

Condition  
specific  
Branching  
HRA

Tech  
assist  
waiver

HCBS  
waivers

NF  
waiver

Pediatric  
HRA

Mental  
Physical  
LTSS

# Individualized Care Plan



- The critical components of an LTSS person-centered plan:
  - A care plan serves as an individualized plan regarding the types of services a member will receive and when they will be provided
  - A service plan is a document of the type of duration and frequency of services needed to support the individuals plan of care

# Key positions for coordination of care



- **Care Coordinator: Licensed nurse or licensed social work professional**

Responsible for the overall coordination of the member's acute and chronic behavioral and physical health care, LTSS, and related service needs to support the member's overall health and wellness. Each member is assigned to a CC who has support staff and subject matter expert assistance.

- **Health Guide: A non-licensed staff member**

Assists the Care Coordination Teams with a variety of member engagement activities, such as assisting with medical and non medical needs, referrals, setting up ICT conferences, etc.

- **Transition Coordinator: Licensed nurse or licensed social work professional**

Assists the member and the care team during transitions in care from one setting to another for at least 30 days to address immediate care coordination needs, communicate to receiving physician, update plan of care and collaborate with CC on service plan needs and authorizations for services.

- **LTSS Member Associate: Non licensed**

Responds to member calls, assists CC and team with logistics of care, follow up on services



# Key positions for coordination of care



- **Wellness Specialist: Licensed or non-licensed (certified)**

Assists members on how to improve their daily choices, prevent illness and access local resources. Provides disease specific information and assist with setting goals for self management of care and conditions. Sends evidence based information at appropriate level of understanding.

- **Recovery Navigator: Certified (peer support) specialist**

Assist members by applying whole health resiliency and recovery principles and tools such as wellness recovery action plans (WRAP®). They model and assist members in making lifestyle improvements and the self-management of chronic conditions and make additional outreach to members as needed.

- **Housing support specialist: Social work/related field**

Provides a variety of office and field activities to manage and monitor a rapid re-housing/transition-in-place program for families, performs direct client services, and compiles related documentation.



# Interdisciplinary care team



The ICT is comprised of the member and individuals engaged in the member's circle of support

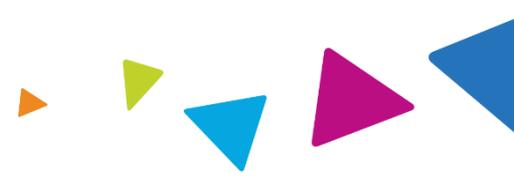
# Case loads are a challenge



Required Care Coordinator Ratio	Tech Assist waiver	Nursing Facility Members	HCBS waivers-vulnerable subpopulations	Emerging High Risk (*Individuals other than High Risk Subpopulations)
	1:70	1:175	1:100	1:350

Care Coordination staff are augmented by support staff: Health guide, transition coordinator, wellness specialist, Community outreach specialist, recovery navigator, provider support specialist, etc.

# A case study from Virginia



- Caseload of 1CC: 100 members
- Care Coordinator-overall accountability for case load
- Assignments based on experience/expertise and member profiles (medical vs. SDMI)
- Potential support staff-support more than one Care Coordinator
  - Transition coordinators (Assumes care at the time of transition-outreach within 24 hours, follow up at 7, 14 and 30 days)
  - Health guide (could see member at home, go to MD visits, find member in shelter, etc.)
  - LTSS specialist follows up on service needs and submits authorization paperwork
  - Recovery navigator (outreach to member to find peer support in area and/or carries a case load)
  - Housing specialist
- Tasks are assigned and tracked through the CC system and can be pulled and prioritized by the due date.

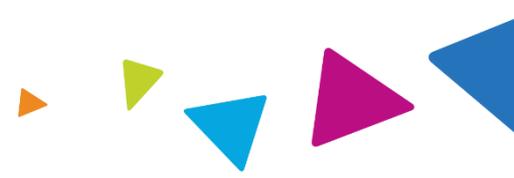


# Our suggested solution for Montana



- Standardize assessment tool to focus on identification of needs, strengths, medical status, mental health, long term supports, social determinants of health, and identify specific conditions with a need for treatment
- Determine cost drivers for individuals based upon claims data and utilization of services
- Stratify population to prioritize outreach and interventions
- Determine standard outcome measurements such as:
  - Utilization data-acute vs. outpatient
  - ER utilization
  - Readmission data
  - Clinical outcome data
- Develop a staffing strategy that distributes care coordinator case load across a wider population, and augments with specialists (such as a recovery navigator/peer support, housing specialist, wellness specialist, etc.)

# Outcome measurements

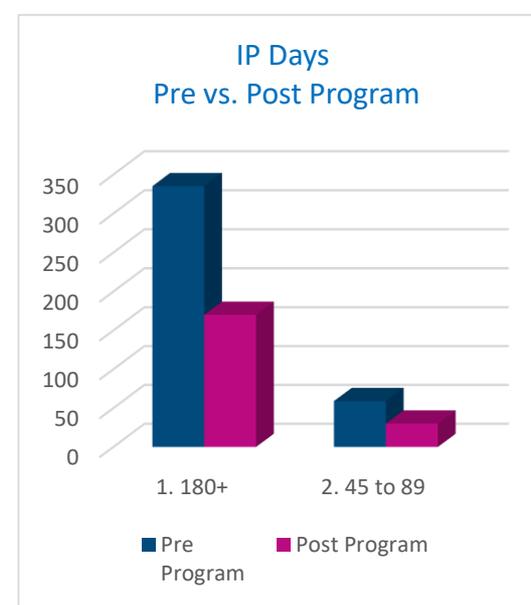
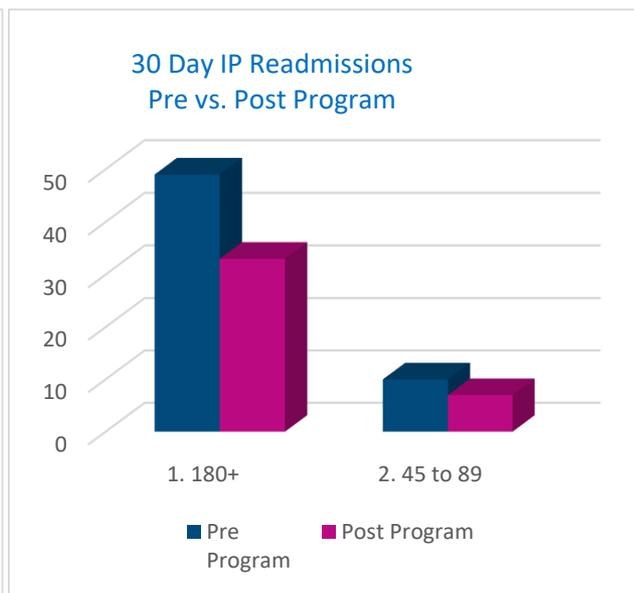
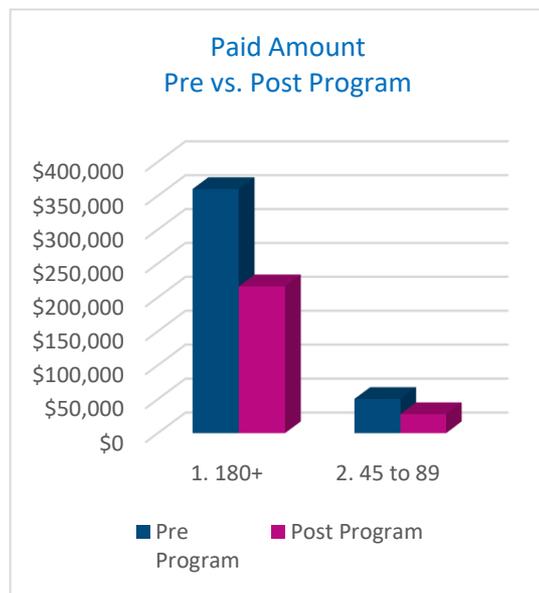


- HEDIS measures
- NCQA LTSS measures
- Cost PMPM-total and by population
- LTSS specific measures per contract requirements
- Provider profiles may include: Patient Satisfaction Rate, Readmissions/1000, ER visits/1000, No Fall Rate
- Recovery metrics
- Utilization management data

# A peer navigator success story



- Outcomes for cohort of members with a \*Minimum of Two Inpatient Admissions in 30 days upon enrollment in Magellan Complete Care's Peer navigator program

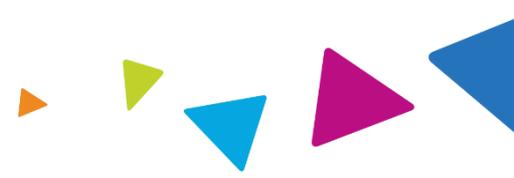


- After 89 days in the peer support program, 44% reduction in paid amount, 30% decrease in inpatient readmissions, and 49% decrease in inpatient days.
- After 180 days in the peer support program, 40% reduction in paid amount, 33% decrease in inpatient readmissions, and 49% decrease in inpatient days.

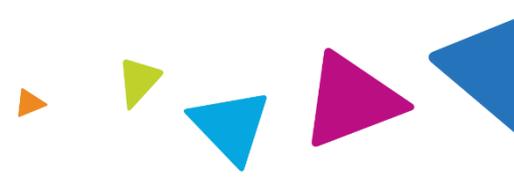
Leading humanity  
to healthy,  
vibrant lives



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