Fireside Chat: Beneficiary Attribution

December 3, 2020

Medicaid Team:

Kelly Crosbie, Director Quality and Population Health NC Medicaid
Shannon Dowler, Chief Medical Officer Jay Ludlam, Associate Medicaid Director NC Medicaid
Jay Ludlam, Deputy Secretary

Tribal Team:

Casey Cooper, Chief Executive Officer for Cherokee Indian Hospital Authority (CIHA)
Richard Bunio, Executive Clinical Director for Cherokee Indian Hospital Authority (CIHA)
Tara Larson, Vice President Cansler Collaboration Resources, Inc – Consultant with CIHA

Poll 1

Any American Indian/Native American in North Carolina can qualify to sign up for the Tribal Option?

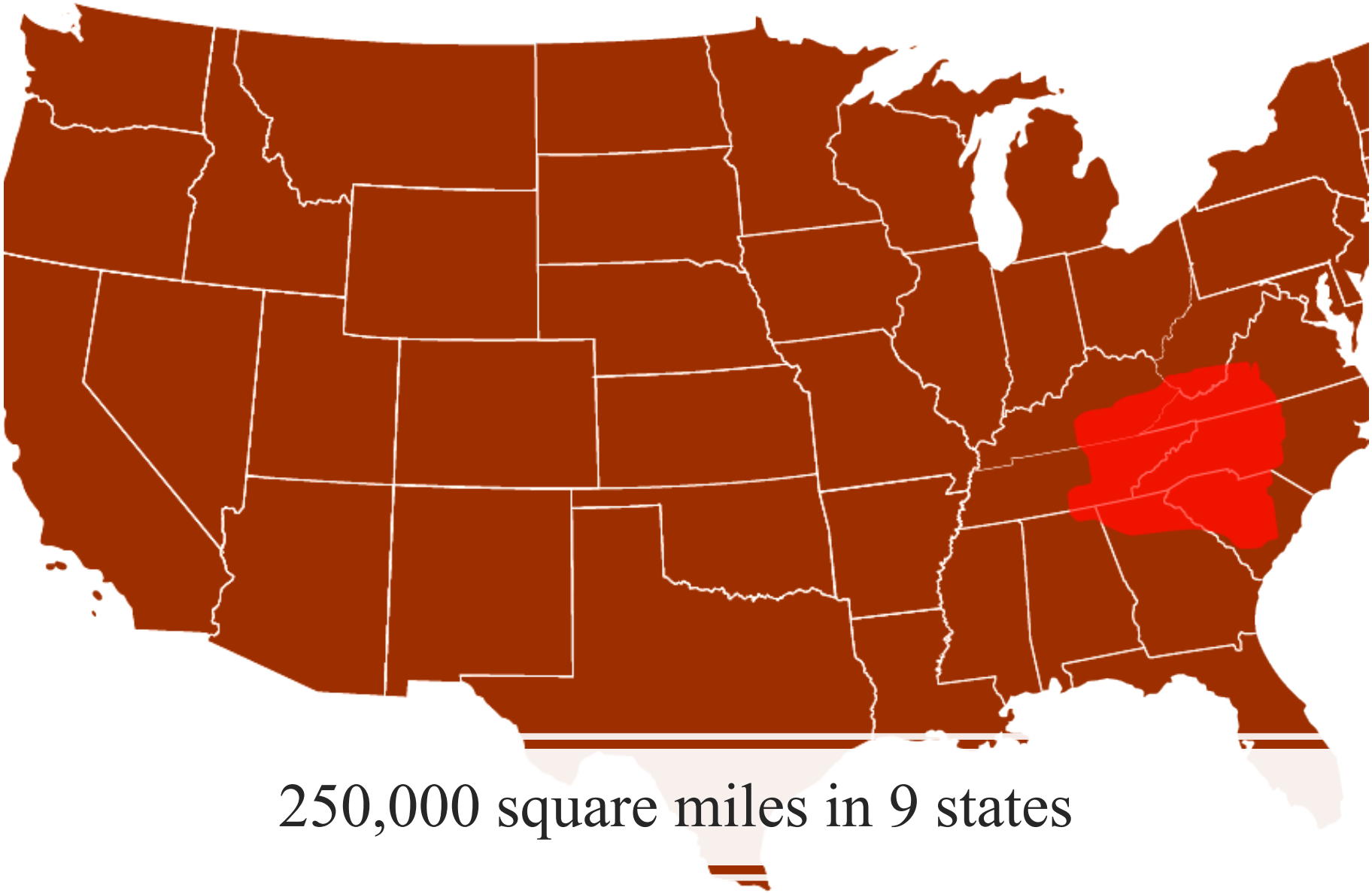
a. True

b. False

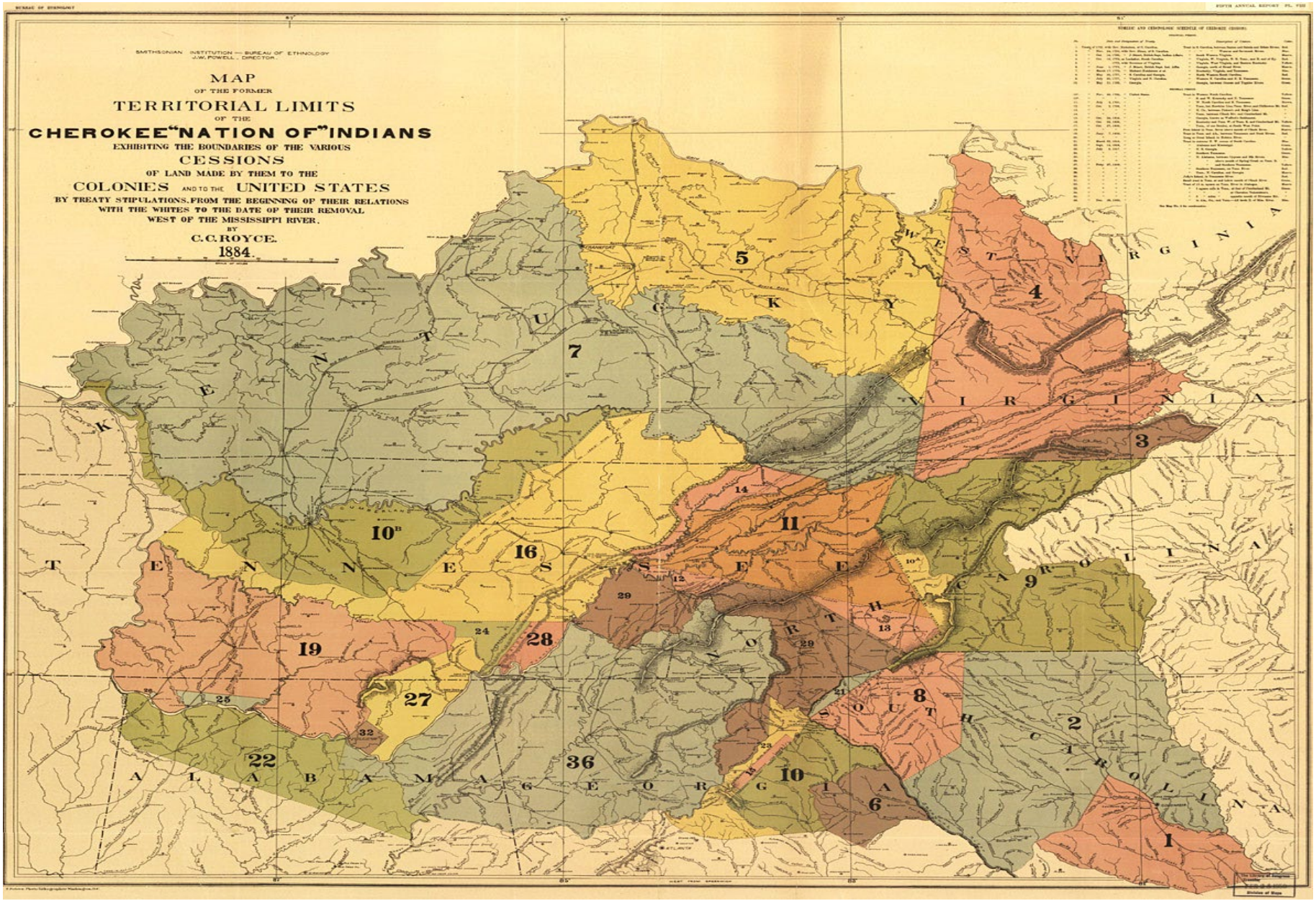
Tribal Option

Eastern Band of the Cherokee Indians

- Descendants of the Cherokee Nation and the Oconaluftee Cherokee of 1817 and 1819
- Duly incorporated in 1889 under a corporate charter
- Located on 56,000 acres in 5 of the western most counties known as the Qualla Boundary
- Enrollment today is approximately 16,0000 and is at this time the only federally recognized tribe in NC
- Approximately 12,000 AI/ANs are considered active users of the Tribal Health System referred to as the Cherokee Indian Hospital Authority
- Diabetes, Depression and Substance Use Disorders are the top three priorities for the Tribe
  - At least 3,000 members have been diagnosed with Diabetes
  - Approximately 4,000 have been diagnosed with Depression and or SUD



250,000 square miles in 9 states


SMITHSONIAN INSTITUTION — BUREAU OF ETHNOLOGY
J.W. POWELL, DIRECTOR
MAP
OF THE FORMER
TERRITORIAL LIMITS
OF THE
CHEROKEE "NATION OF" INDIANS
EXHIBITING THE BOUNDARIES OF THE VARIOUS
CESSIONS
OF LAND MADE BY THEM TO THE
COLONIES AND TO THE UNITED STATES
BY TREATY STIPULATIONS. FROM THE BEGINNING OF THEIR RELATIONS
WITH THE WHITES TO THE DATE OF THEIR REMOVAL
WEST OF THE MISSISSIPPI RIVER.
BY
C.C. ROYCE.
1884.
TENNESSEE
KENTUCKY
VIRGINIA
WEST VIRGINIA
NORTH CAROLINA
SOUTH CAROLINA
GEORGIA
ALABAMA
1
2
3
4
5
6
7
8
9
10
10a
10b
11
12
13
14
16
19
22
24
25
27
28
29
32
36

Indian Health Care: Legislative History

- AI/ANs Have Unique political relationship with US founded in treaties predated the origin of the US.
- AI/ANs were forced into treaties resulting in the loss of millions of acres of land.
- In more than **22 of the treaties with the US from 1778 to 1871**, the government obligated to provide health services as recompense for the forced surrender of land
- In the late 1880s AI/ANs lost even more land during the allotment error and by the early 1900s communicable disease and starvation were the leading causes of death among AI/ANs according to the **Meriam Report in 1928**
- **The Snyder Act of 1921** is the founding authorization for provision of health services to Indians.
- Indian reorganization Act of the 1934 allowed Tribes that had formally been terminated to reorganize and regain their sovereign status because the Removal and Allotment policies had decimated the social and economic structures of Tribes leaving them in horrific conditions
- The **Transfer Act of the 1950s** formally transferred the responsibility from the Department of the Interior to the Public Health Service in the Department of Health Education and Welfare

- **1965 SSA is amended to create Medicare and Medicaid**
- Indian Self-determination Education and Assistance Act of 1973 which was later amended in the 1980s allowed tribes to take control of the federal programs that were being provided to them by the US in carrying out its trust responsibility
- The Indian Healthcare Improvement act of 1974 provided more authority for funding Services and Facilities and authorized the Indian Health Services to collect third party payments as a means to supplement the underfunded system
- Congress enacted Section 1911 of the social Security Act authorizing Indian Health Services to collect payments from the Medicaid program to the supplement funding to IHS

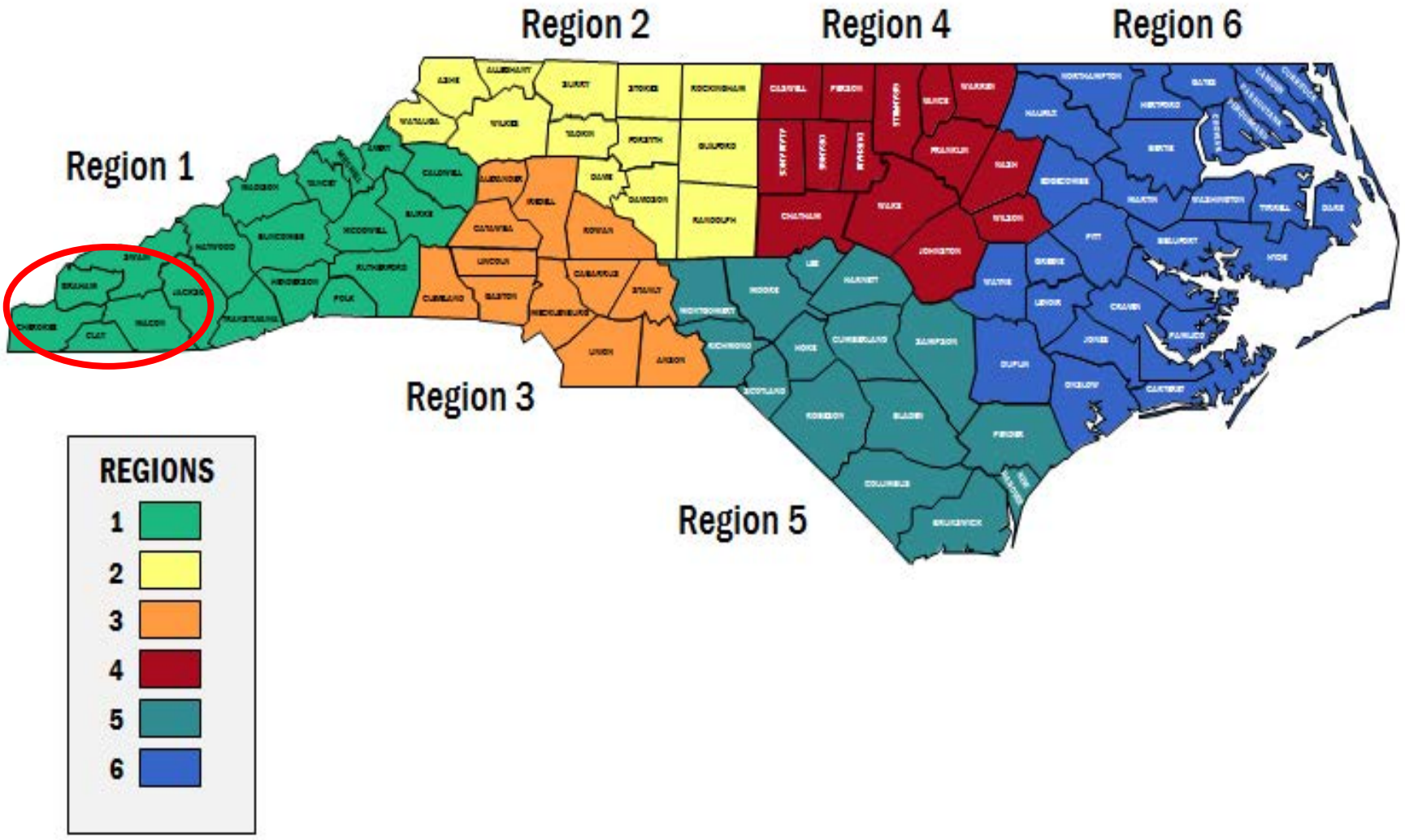
- **1976 Congress amended 1905 (b) of the Social Security Act to allow for 100% FMAP to states**
- 1997 Congress authorized IHS and Tribal services to collect payments from CHIP
- **In the American Recovery Act of 2009 Congress authorized more Indian specific provisions to protect the ability to collect Medicaid Revenue recognizing how vitally important it is to supporting the grossly underfunded Indian Health System**
- Indian Health Service Funding is still significantly underfunded and is estimated to be funded at approximately 50% of the level of need.

American Indian/Alaska Native Health Disparities

American Indians are more likely to die from certain diseases than general population

Alcoholism	514% Higher
Tuberculosis	500% Higher
Diabetes	177% Higher
Mosaic Variegated Aneuploidy (MVA) Syndrome	229% Higher
Accidents	140% Higher
Suicide	92% Greater
Pneumonia, influenza	52% Higher

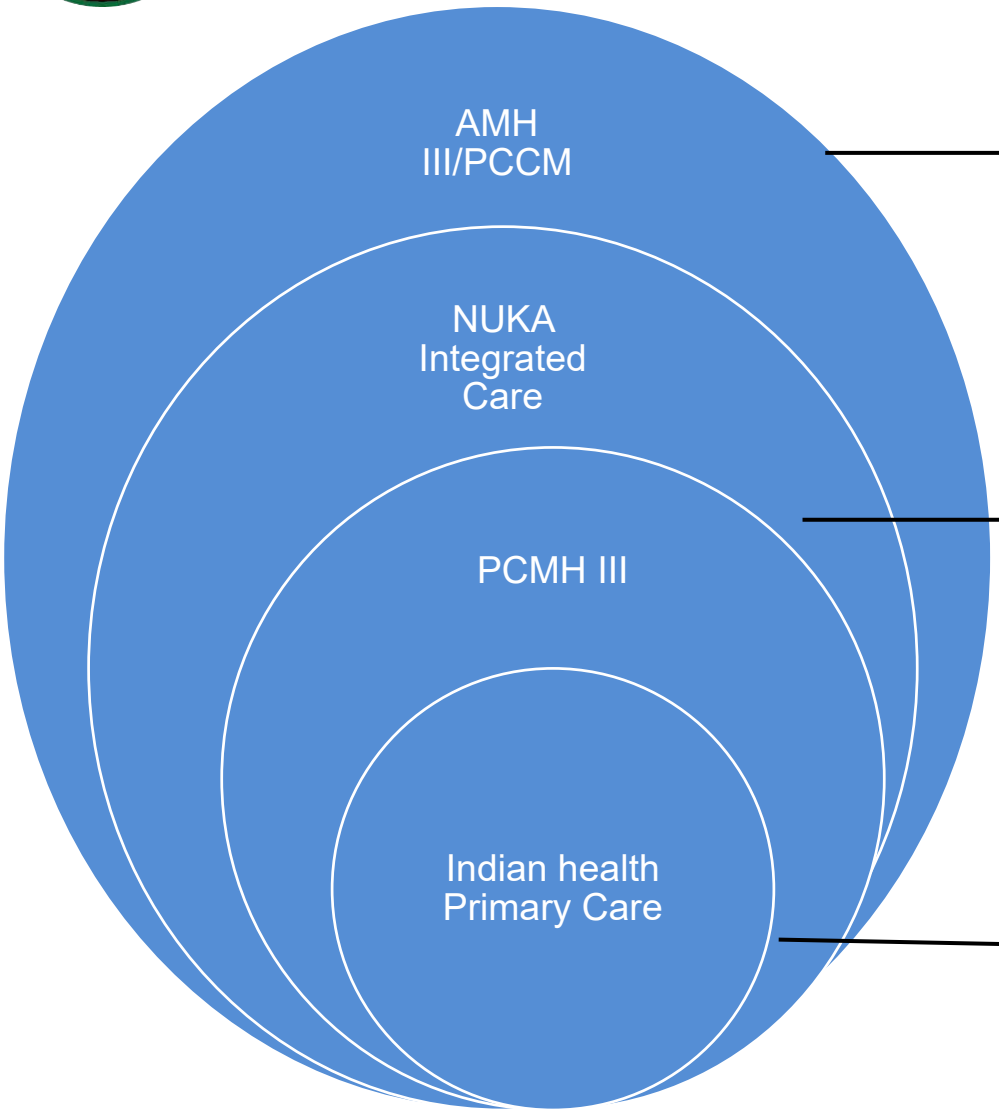
PHP regions


Region 1
Region 2
Region 3
Region 4
Region 5
Region 6
REGIONS
1
2
3
4
5
6

EBCI TRIBAL OPTION

Du yu ga dv

- **U wa shv u da nv te lv**
- **Ni hi sta ste li**
- **To hi**
- **Di gwa tse li i yu s di**

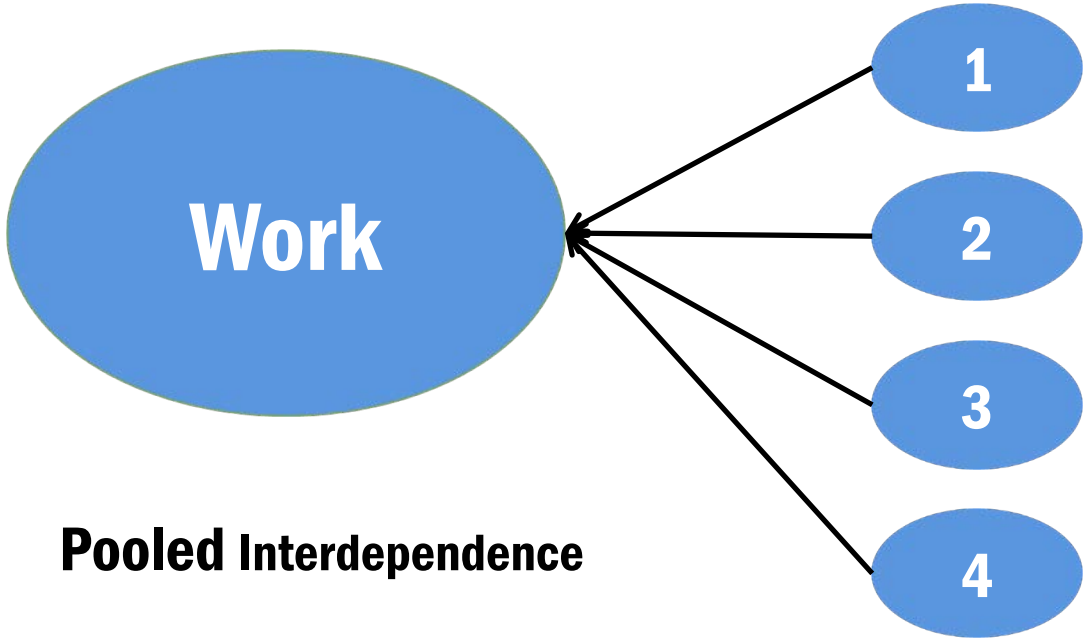


- Risk Stratification
- Active Care Management
- Transitional Care Management
- Utilization of Claims Data for Risk Strat
- Bi-directional exchange of data with NCDHB
- Meet Security Standards for data exchange
- Referrals for Specialty Care
- Utilization Review and Management (future state)
- Member services
- Provider Network Management
- Quality Monitoring

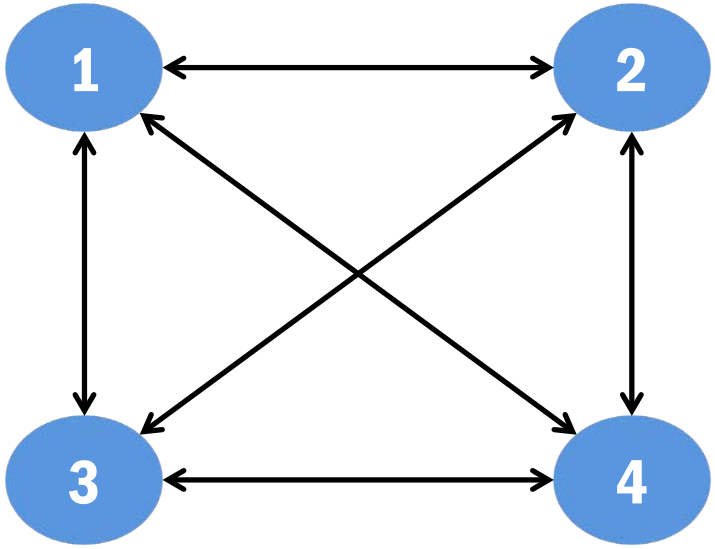
- Integrated Team Based Care (embedded shared resources)
- Reciprocal Interdependent system
- Parallel processing
- Trauma Informed
- Key workforce competencies include (empathy, compassion, and influential relationships)

- Traditional Primary Care embedded with ER, Inpatient, Clinical Support Services, Pharmacy, Behavioral Health, and Dental
- **Purchased and Referred Care** (referral and acquisition of specialty care from regional partners)
- RPMS (fully integrated electronic health record.

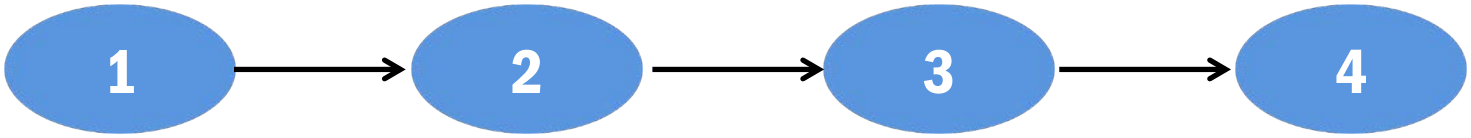
What is a Team



Pooled Interdependence

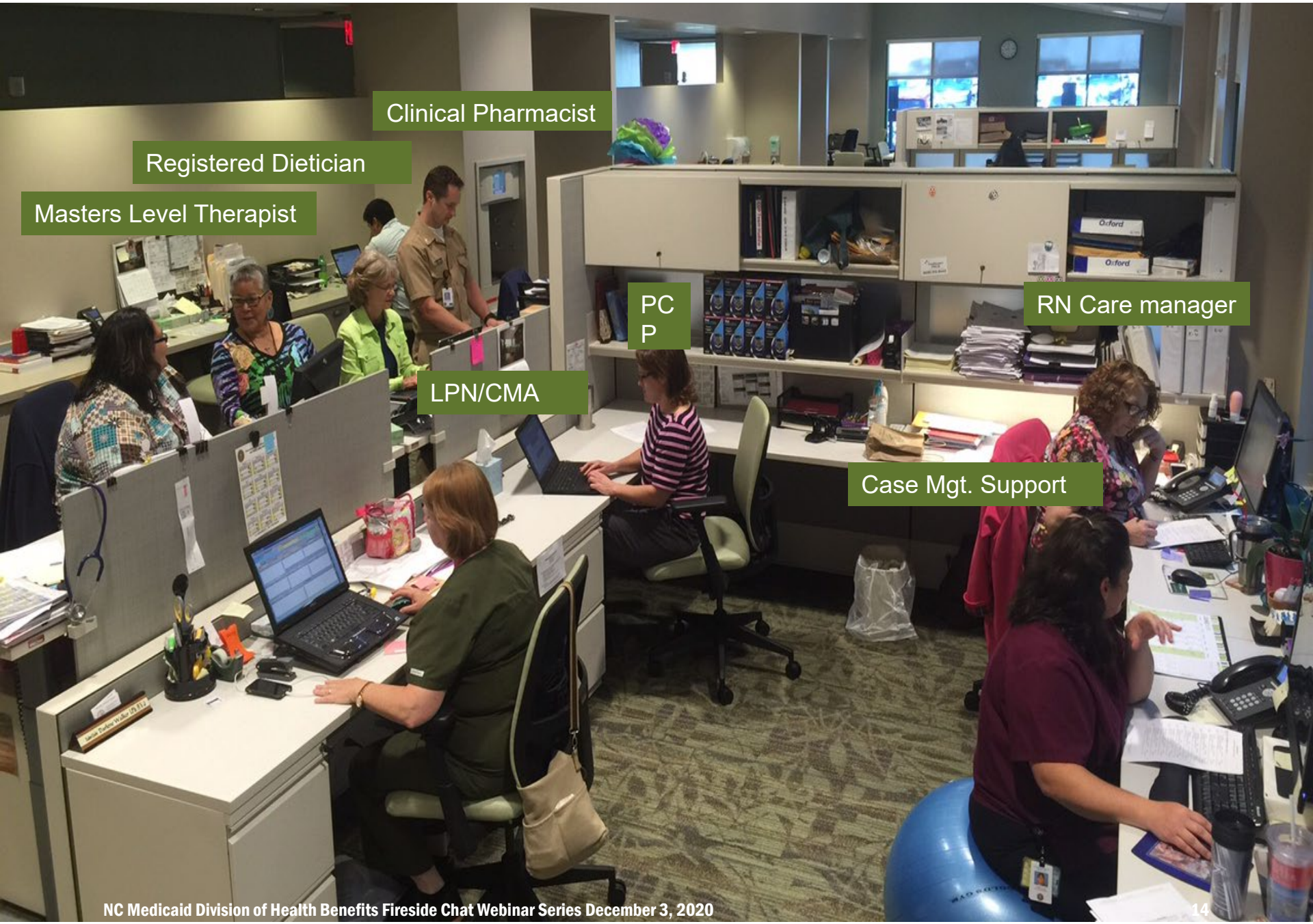


Reciprocal Interdependence

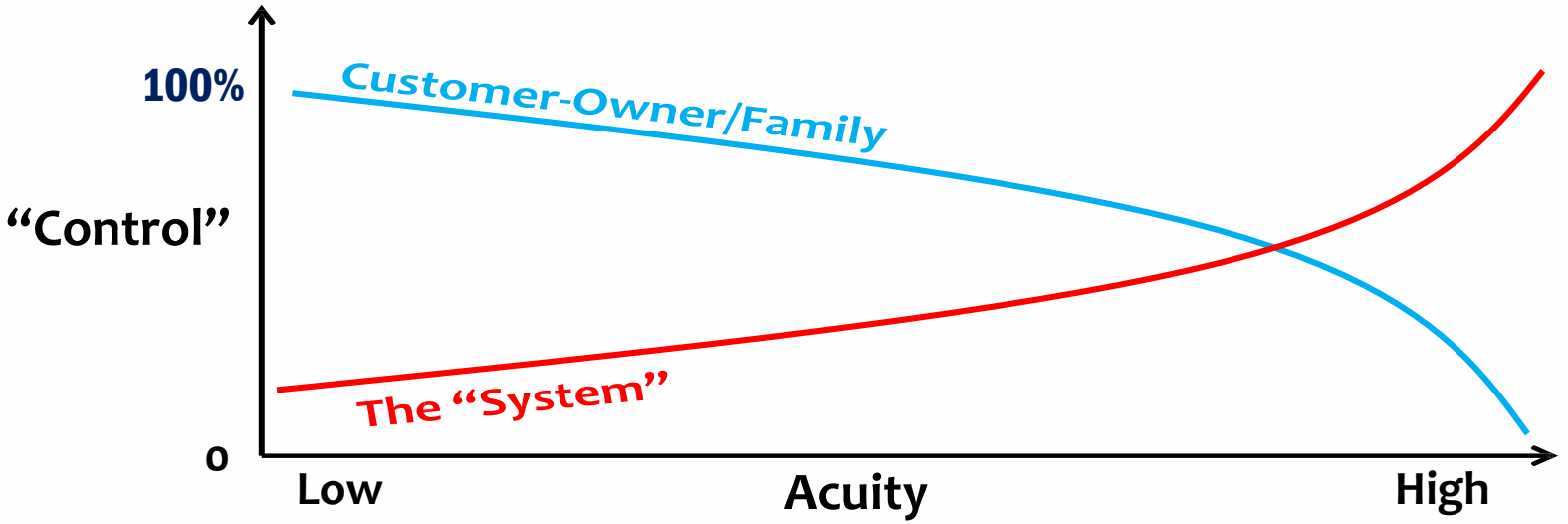


Sequential Interdependence

Cohen & Bailey 1997


Clinical Pharmacist
Registered Dietician
Masters Level Therapist
PC
P
RN Care manager
LPN/CMA
Case Mgt. Support

Control: Who really makes the decisions?



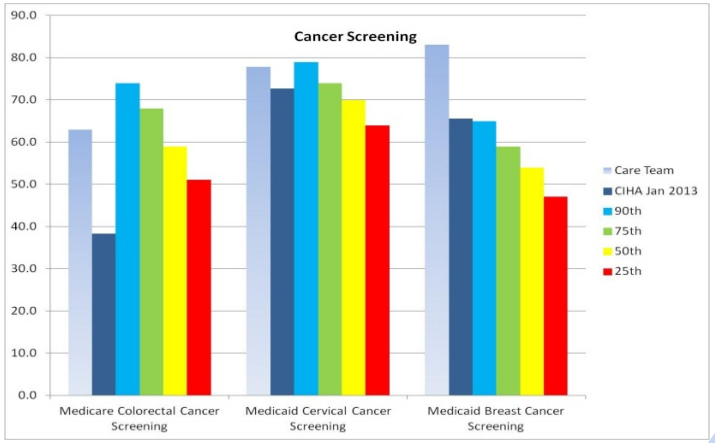
1. Control – who makes the final decision influencing outcome?
2. Influences – family, friends, co-workers, religion, values, money
3. Real opportunity to influence health costs/outcomes – influence on the
4. choices made – behavioral change

   Current model – tests, diagnosis, treatment (meds or procedures)

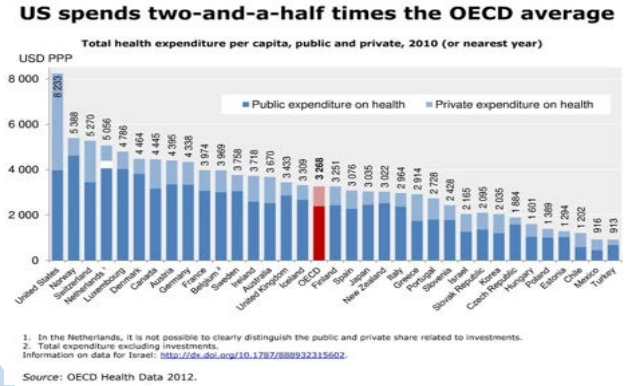
Malcolm Baldrige National Quality Award
2011 Award Recipient

Copyright © 2011 Southcentral Foundation. All Rights Reserved.

Population Health



Cost per Capita



Excellent outcomes

Healthy choices and behaviors

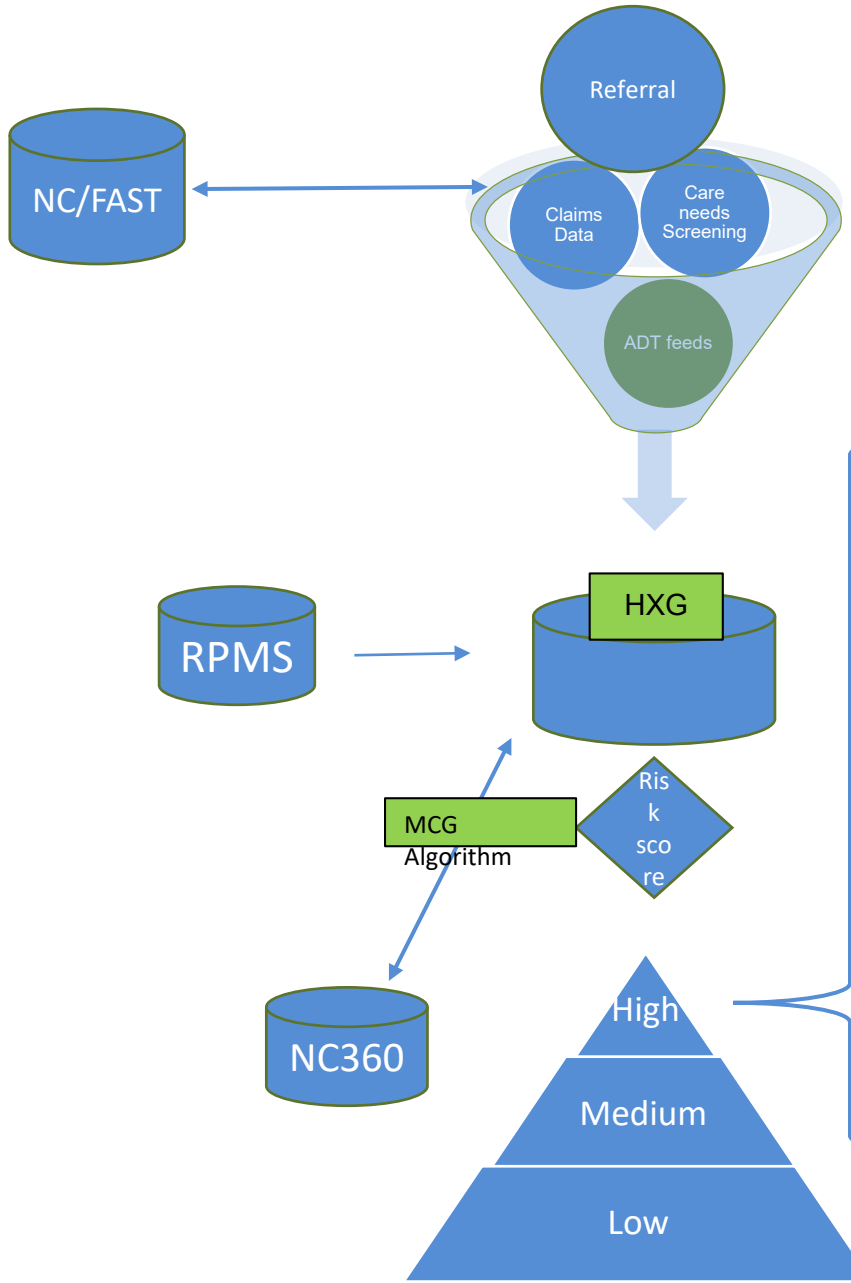
Patient and Family Engagement

Experience of Care

Relationship based Care

Trust

(compassion, core competencies, continuity, consistency, and consultation)



Care Needs Screening

- Chronic or Acute Conditions
- Chronic Pain (> 3 months passed normal tissue healing)
- Behavioral Health/SA needs
- LTSS (members at risk of or requiring LTSS)
- Medications
- Other Immediate Factors or Conditions (e.g., pregnancy)
- SDOH priority domains (housing, food, transportation, Interpersonal Safety)
- Person Centered

Comprehensive Assessment

- Ongoing Special Conditions
- Health Care needs (evidence based disease management, dental, MH/SA,)
- Functional needs (physical, intellectual or development disabilities)
  - LTSS needs shall be stratified as High Risk
- Accessibility
- Strengths and Supports
- Goals
- SDOH (Housing, food, transportation, interpersonal safety)

Care Plan

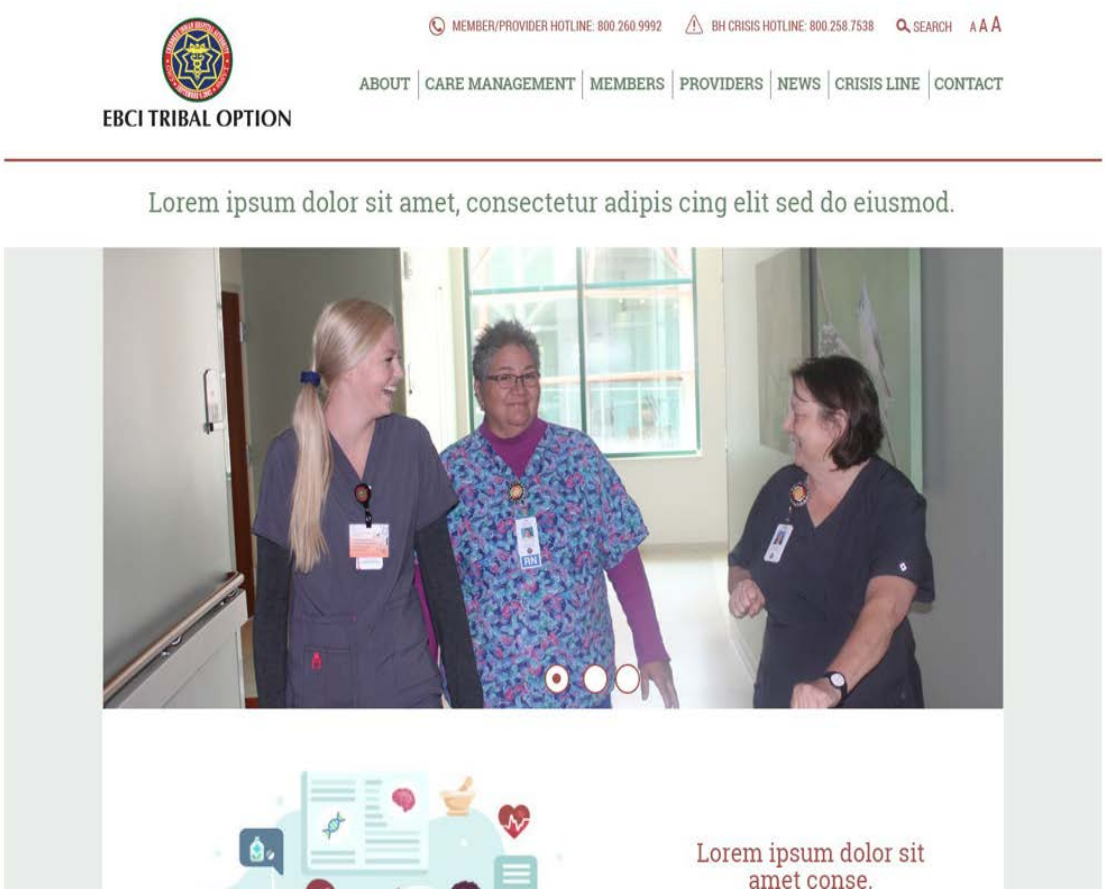
- Includes: Care Needs Screening, Claims Analysis, Risk Scoring, Relevant Medical Information
- Key Elements: Goals, Medical Needs including BH/SA/IDD, Dental Needs, Medication management, and Social Services needs
- Measureable Goals
- Intended Outcomes
- Communication to PCP within 30 days of development
- Updated at least annually or when changes occur
- Documented, Centrally stored, portability for interdisciplinary review and input

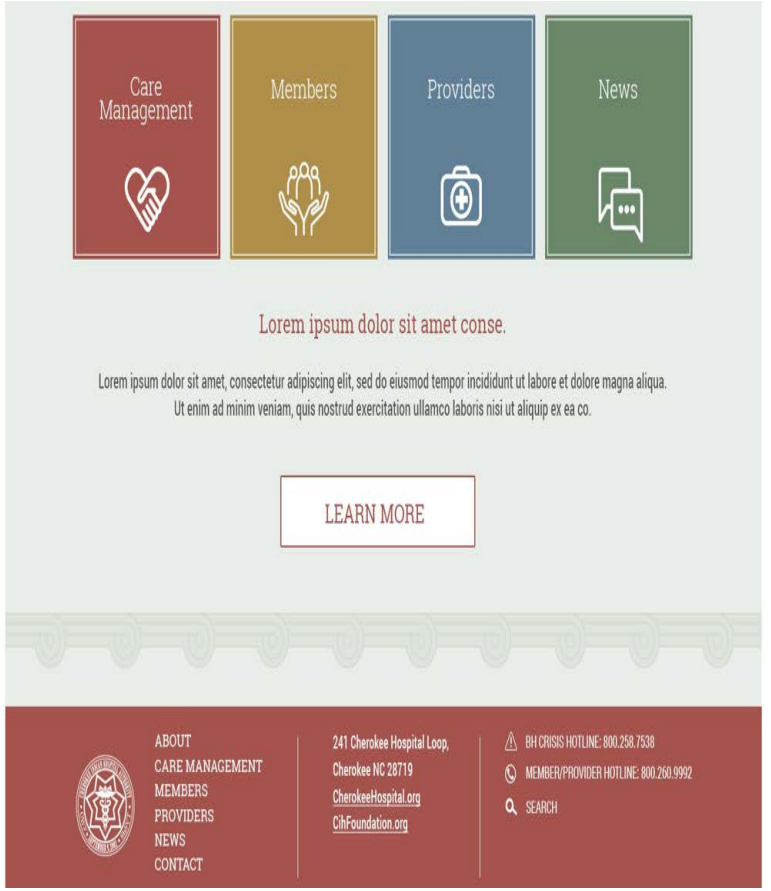
Care Management

- Coordination of Care across the continuum
- Medication Management including; reconciliation, understanding, and compliance
- Progress
- Referral Follow-up
- Peer Support
- Training related to Self-Management
- Transitional Care Management
- In-person assistance with health-related social service needs
- NC360

EBCI TRIBAL OPTION

Website Construction – www.ebcitribaloption.com





Poll 2

Members who live in the Westernmost 5 counties may be enrolled to the EBCI Tribal Option if:

a. They are members of the EBCI

b. They are members of another federally recognized tribe

c. They are eligible for Indian Health Services (IHS)

d. All of the above

Who is eligible to enroll?

- Beneficiaries must be eligible to receive Indian Health Services at EBCI facilities (as described at 25 U.S.C. Sec. 1603 (12) and 42 C.F.R. Sec. 136.12), which includes the following populations:

- Federally-recognized tribal members, including enrolled members of the EBCI, as defined in Cherokee Tribal Code, Sec. 49.2, as well as members of other federally-recognized Native American Tribes and Alaskan Natives.
- Direct lineal descendants
- Any individual who has not attained 19 years of age and is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian (25 U.S.C. sec. 1680)
- Non-Indian women pregnant with an eligible Indian's child for the duration of her pregnancy, and through postpartum. (42 C.F.R sec. 136.12)

Why are we doing it?

- Improved Population Health
- Improved patient and family engagement
- Preservation of Influential Relationships (Care management should happen in the medical home)
- Remain Provider of Choice for the EBCI
- Enhance Care Quality
- Protect Tribal Sovereignty and principles of Self-determination
- Acquire the resources necessary to build Care Management Infrastructure
- Obtain Reimbursement for Care Management services currently being provided
- Control cost per capita

Poll 3

Du Yu ga dv means:

a. Continue in this direction
b. Any way is a good way
c. The Right Way
d. Everyone has their own way


Teen Miss Cherokee 2015

Questions

North Carolina's Vision for Medicaid Transformation

"To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health."

Moving to NC Medicaid Managed Care

1.6 - 1.8 million Medicaid beneficiaries will enroll in Standard Plans.

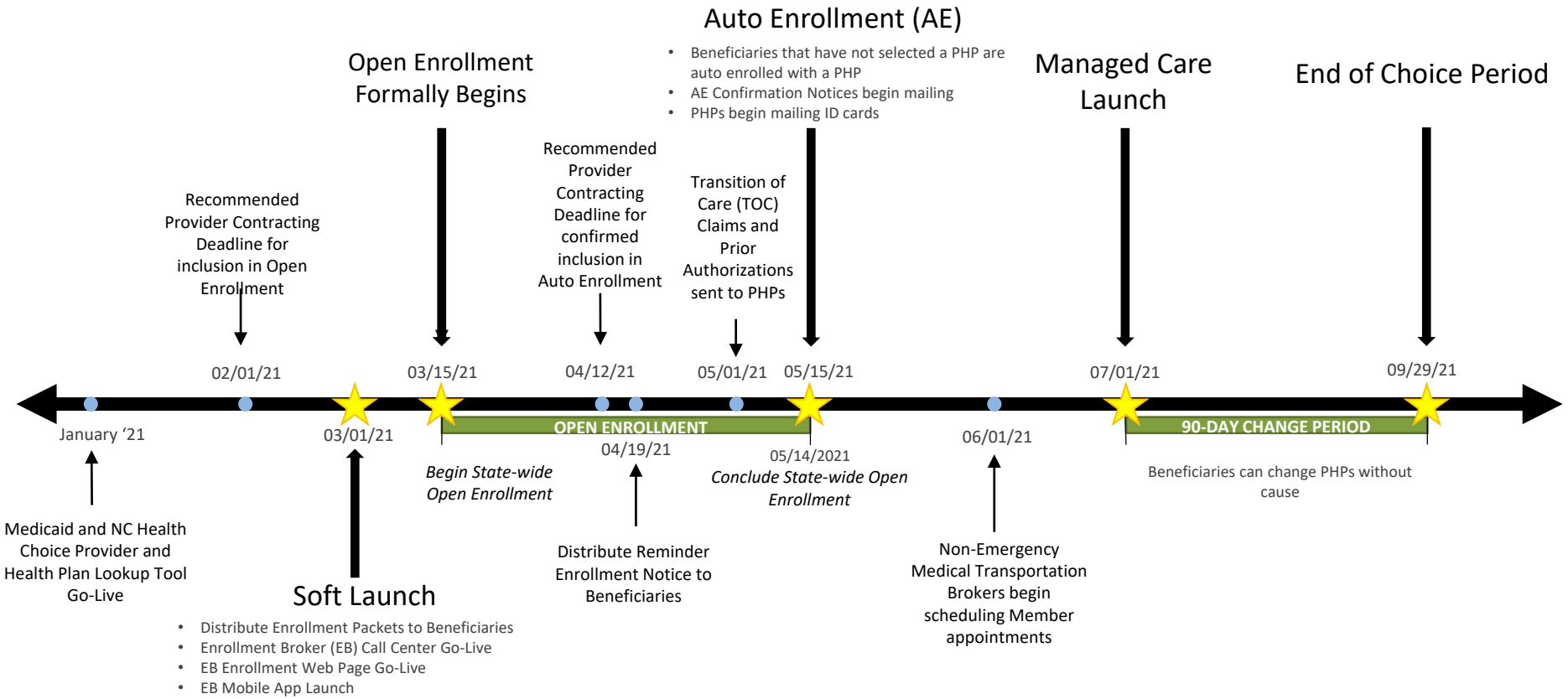
Beneficiaries will be able to choose from 5 Prepaid Health Plans (PHPs)

AmeriHealth Caritas, Healthy Blue, United HealthCare, WellCare, Carolina Complete Health (Regions 3, 4, 5)

All health plans, all regions will go live on July 1, 2021.

Some beneficiaries will stay in fee-for-service because it provides services that meet specific needs, or they have limited benefits. This will be called NC Medicaid Direct.

Managed Care Standard Plan Timeline



Poll 4

How confident are you that your patients will select their current PCP during open enrollment?

a. Super duper confident

b. Most will

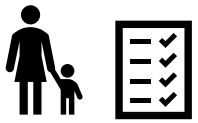
c. Probably half

d. Some might

e. Pretty sure they will all go through auto assignment

How do Beneficiaries get assigned to a plan and a PCP in NC Medicaid Managed Care?

Member Enrollment Diagram



Selection

Beneficiary contacts the Enrollment Broker (calls, web, smart phone application) and finds their Primary Care Provider (PCP) who contracted with Pre-paid Health Plan (PHP) or is in the Tribal Option (TO).

Transmit + Record

State transmits beneficiary records to PHPs or TO for those who chose and for those who are auto-enrolled. Records include historical PCP and new PCP selections.

Communicate

Health plan sends Welcome Packets and Medicaid ID cards to beneficiaries.

NO Selection

Beneficiary does NOT make an active selection of a health plan and/or Primary Care Provider (PCP) through the Enrollment Broker.

Auto-Enrollment

State uses six-step enrollment algorithm to assign Managed Care eligible beneficiaries to a PHP or TO.

PCP/AMH Assignment

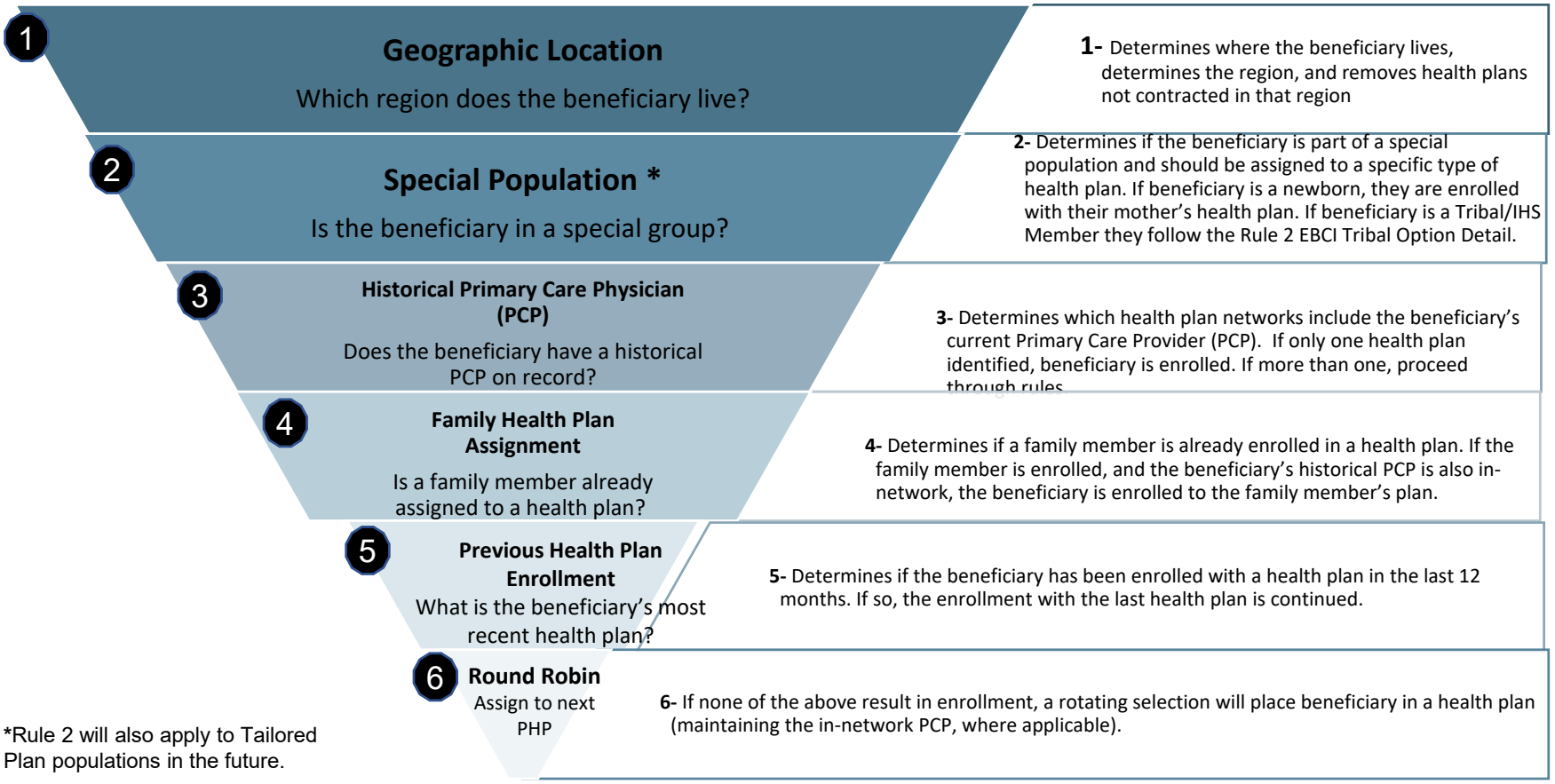
Health plans will run the algorithm to assign a beneficiary to a PCP when beneficiaries:

- Did not select a PCP at eligibility application or through Enrollment Broker at the time of health plan selection.

Health Plan Auto-Enrollment

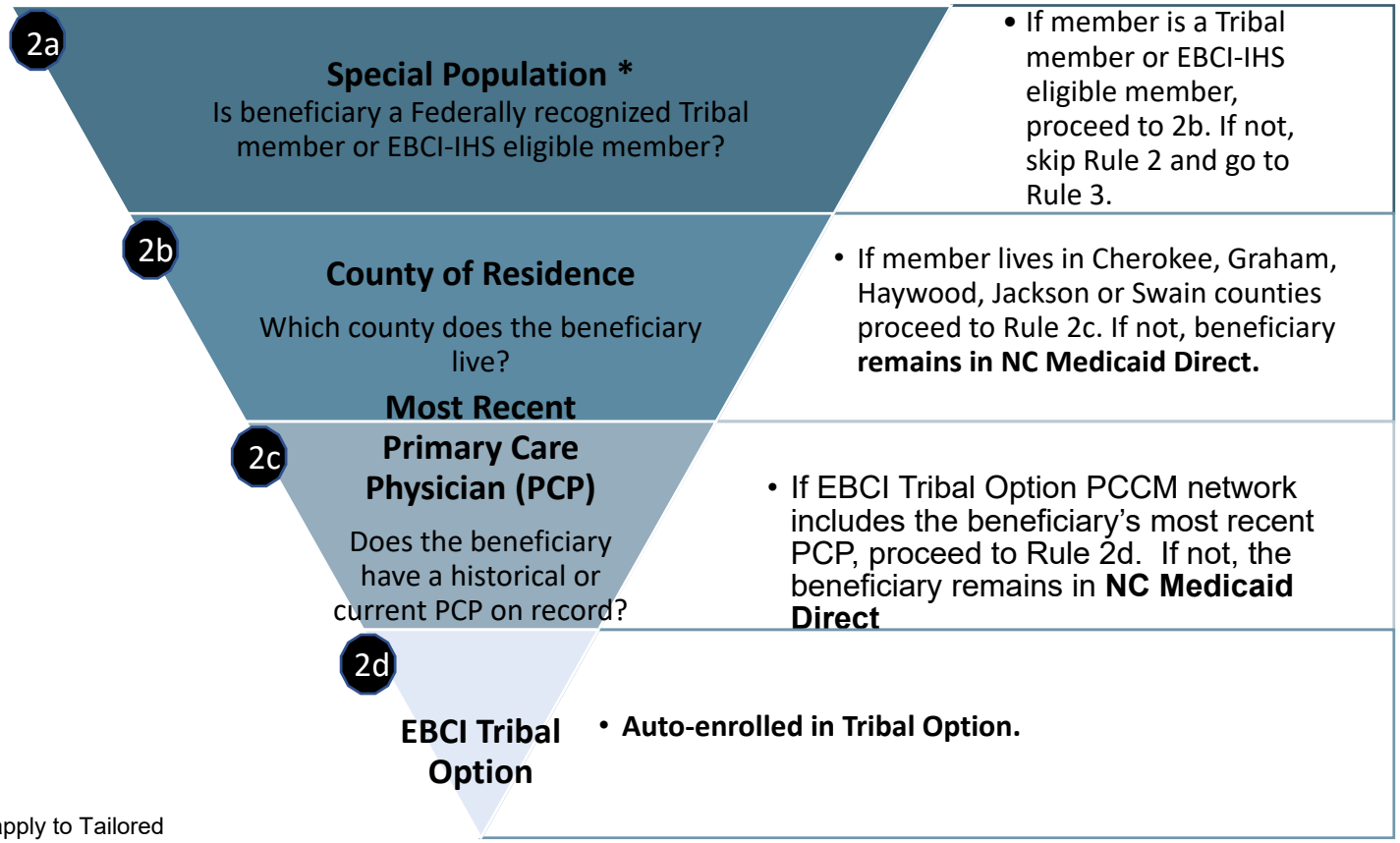
Health Plan Auto-Enrollment: Algorithm

If a member does not choose a PHP or the EBCI Tribal Option , they are auto-enrolled according to the funnel below.



*Rule 2 will also apply to Tailored Plan populations in the future.

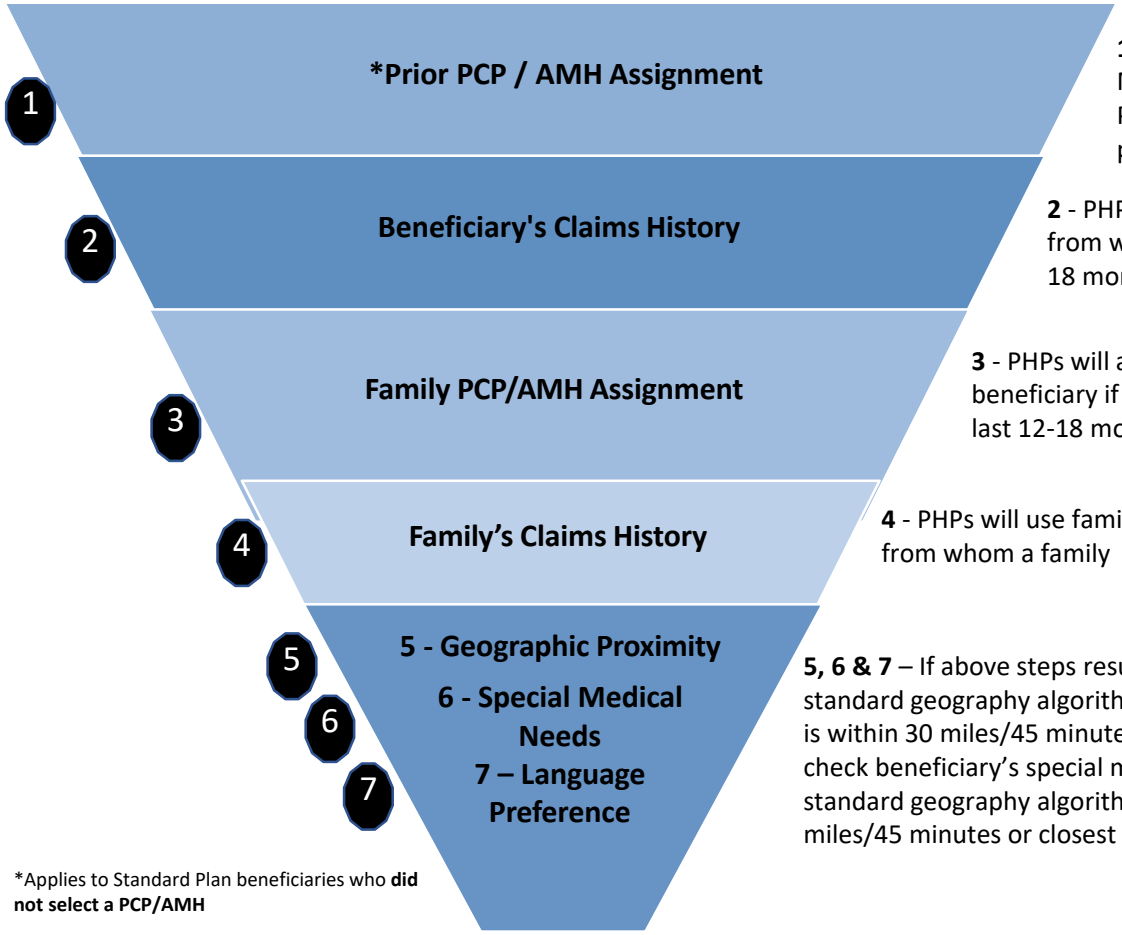
Health Plan Auto-Enrollment: Rule 2 EBCI Tribal Option Detail



*Rule 2 will also apply to Tailored Plan populations in the future.

PCP/AMH Auto-Assignment

PCP / AMH Auto Assignment Algorithm



*Applies to Standard Plan beneficiaries who **did not select a PCP/AMH**

1 - If the beneficiary has a prior assigned PCP/AMH (in Medicaid Direct) and beneficiary has been seen by the Prior PCP/AMH in last 12-18 months then the PHP will assign their prior PCP/AMH to the beneficiary.

2 - PHPs will use beneficiary's claims history to match to a PCP/AMH from whom the beneficiary has previously received care in the last 12-18 months.

3 - PHPs will assign beneficiary to a PCP/AMH assigned to another family beneficiary if the family beneficiary has been seen by the PCP/AMH in the last 12-18 months.

4 - PHPs will use family claims history to match beneficiary to a PCPs/AMH from whom a family beneficiary has received care in the last 12-18 months.

5, 6 & 7 – If above steps result in multiple PCPs/AMHs then health plans will use their standard geography algorithm to narrow the results to an in-network PCP/AMH that is within 30 miles/45 minutes or closest to beneficiary's home. Otherwise PHP will check beneficiary's special medical needs and/or language preference and apply their standard geography algorithm to find an in-network PCP/AMH that is within 30 miles/45 minutes or closest to beneficiary's home.

Poll 5

My practices' biggest concerns with auto assignment and auto enrollment are: (pick 3)

A. They will select a plan we are not contracted with

B. They will come to my office but I am no longer their PCP

C. The plans will make me take new patients I can't accommodate

D. Beneficiaries won't know where to go

E. Beneficiaries won't know how to change their plan/PCP

F. Beneficiaries open enrollment choices won't be honored

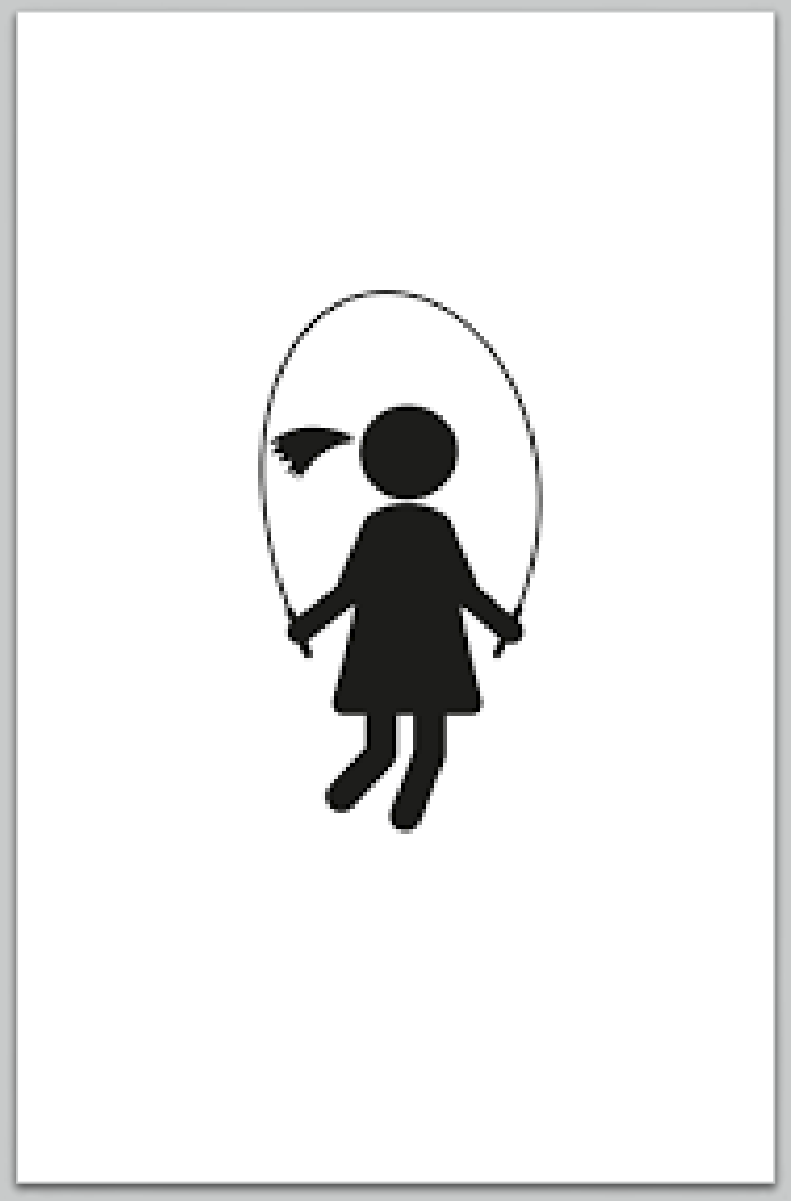
G. I'll lose my existing patient panel

H. I'm afraid the assignment won't work at all

I. Disruption in continuity of care

J. Me?! I have no worries!

Example Scenarios



Jane is a 9 year old who is generally healthy. She last saw her PCP 5 months ago for strep throat.
Her family missed the memo about Open Enrollment.

How will she get assigned to a plan?
How will she get assigned to a PCP?

What if she has received specialized services for IDD?

John is a 23 year old who qualifies for Medicaid after a bad accident and while he sees a trauma surgeon regularly, he does not have a primary care provider.

Both of his children have Medicaid and see a pediatrician.

How will he get assigned to a plan?
How will he get assigned to a PCP?

What if he had Emergency Medicaid only?

Juana delivers a perfect baby girl on July 1st. She has Pregnancy Medicaid(MPW) and got her prenatal care at a community health center. She delivered with the local residency program.

Her older son has a doctor at the same community health center she went to.

How will her daughter get assigned to a plan?
How will she get assigned to a PCP?
How will mom know where to take her for her bilirubin check on day 3 of life?

What if her son saw a doctor in another practice than mom?

What if her mom had “regular” Medicaid and not MPW?

Deona is a 48 year old patient with Medicaid. Her primary care provider of many years only contracted with one health plan.
She did not select a provider or plan during open enrollment.
How will she get assigned to a plan?
How will she get assigned to a PCP?

What if she signed up for a plan during open enrollment that her PCP does not accept?

What if her PCP did not sign up with any plans?

What if she hasn't been to a doctor in two years?

What is Deona has schizophrenia?

Poll 6

Okay, I get it. But…

A. I'd still like to have additional education opportunities with examples
B. I'd still like to have an interactive educational opportunity where we can bring examples
C. I want to know who to call if it goes sideways
D. I still don't understand what my practice can do to influence this process, so care is not disrupted
E. I'm solid on this content.

Poll 7

After this overview of auto assignment and plan attribution I feel:

A. Like making a double Martini…is that bad?

B. Curious to learn more.

C. Tired. So very tired.

D. Optimistic about the future!

E. More confused than ever.

QUESTIONS?