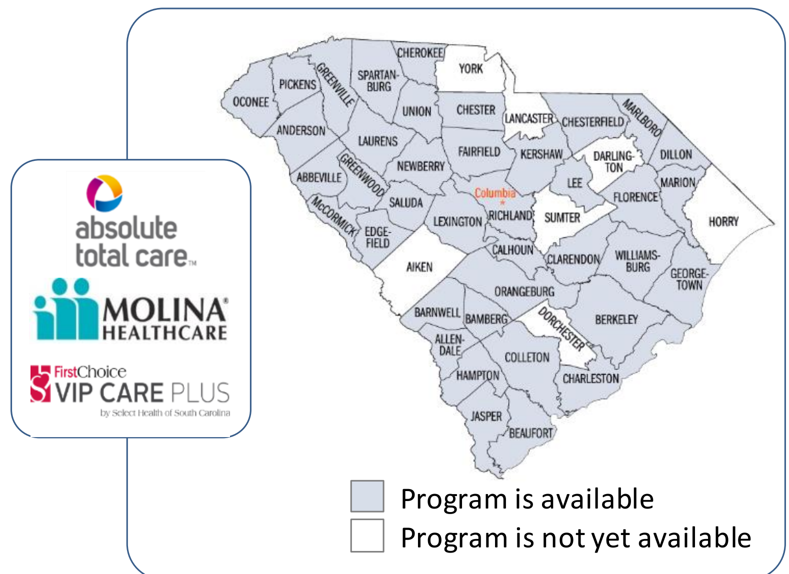
Program Update

Program Overview

Healthy Connections Prime integrates and coordinates care for beneficiaries 65 years old and older with both Medicare and Medicaid. The program's aim is to provide **better care, better value and better health** to its members by combining all the services of Medicare and Medicaid, including Medicare Part D and Medicaid long-term services and supports, under a Healthy Connections Prime Medicare-Medicaid Plan (MMP). South Carolina is one of ten (10) states participating in the national capitated demonstration under the Medicare-Medicaid Financial Alignment Initiative in an effort to address integrated care for people who are dually eligible. Through integrated care and supportive care coordination, the program seeks to reduce avoidable hospitalizations, increase access to home and community-based services and delay the need for Medicaid-sponsored long-term care in nursing facilities.

Access to Care

Launched in February 2015, Healthy Connections Prime is an option for people who are dually eligible, live in the community and reside in one of 39 participating counties in South Carolina. Since the start of the program, the provider network has grown and includes primary care providers and specialists, as well as **2,841 Home and Community Based Service (HCBS) providers and 153 nursing facilities**. Currently three (3) MMPs serve our members:



- Absolute Total Care
- First Choice VIP Care PLUS
- Molina Dual Options

Member Receives Improved Access to Primary Care

"I am excited to continue on a path to good health."

Our member had a toothache and did not have a regular doctor to see for a checkup or preventive care. For 40 years he did not see a doctor or check on his health. However, after joining Healthy Connections Prime, a care coordinator helped him choose a primary care provider, schedule a routine physical and lab work, and find a dentist. Our member was able to get the care he needed to avoid an infection and unnecessary emergency room visit or hospital admission.

Better Care

Member Profile

Although our members are diverse, there are some common traits that are descriptive of the average member. Based upon an independent analysis of health care status and utilization patterns conducted by the South Carolina Revenue and Fiscal Affairs Office, the average Healthy Connections Prime member is an African-American female between ages 65 to 74 with three to four chronic conditions. Care coordination is key for members who must navigate the health care system to address their multiple chronic conditions. To support these members, Healthy Connections Prime provides:

- **A care coordinator** for each member to help them access needed services and assure the integration of these services, including primary, acute, behavioral health and long-term services and supports;
- **A comprehensive in-home health assessment** conducted within 90 days of initial enrollment; and
- **An individualized care plan** that includes both health-related and personal goals as well as the appropriate steps to reach those goals.

Comprehensive Assessment

Each member receives a comprehensive health assessment from their MMP. This standard tool looks at behavioral and emotional health as well as functional capabilities. This assessment also measures the member's preferences, strengths and goals. Caregivers are also evaluated for overall well-being. Assessments are conducted face-to-face in the member's home. The care team uses the information to identify the member's needs and goals and to develop an individualized care plan. In 2016, MMPs conducted over 6,500 assessments.

2016 Assessment and Care Plans Completed within 90-Days of Enrollment[1]

Metric	South Carolina	Demonstration National Average
Comprehensive Assessments	94.5%	89.5%
Care Plan	83.8%	70.6%

Source: MMP Monitoring Report (Q4 2016). Data is based upon completion of assessments and care plans for members who were reached and willing to participate in these activities. Data does not constitute official evaluation results.

Chronic Conditions

Chronic conditions are very common among people who are dually eligible.

- 64% of our members have three or more chronic conditions
- 15% of our members have seven or more conditions

Management of these multiple conditions is critical to helping members live safely at home in the community.

Top Ten Chronic Conditions Among Healthy Connections Prime Members

Condition	Percent
Hypertension	68%
Hyperlipidemia	45%
Diabetes	35%
Rheumatoid Arthritis or Osteoarthritis	25%
Ischemic Heart Disease	25%
Chronic Kidney Disease	22%
Anemia	20%
Heart Failure	16%
Chronic Obstructive Pulmonary Disease	15%
Depression	14%

Better Value

No Costs for Doctor Visits, Hospital Stays and Drugs

Under Healthy Connections Prime, members have no copays or other cost sharing for doctor visits, hospital stays and prescription drugs. This removes a key barrier to healthcare for our members.

The Right Care, at the Right Time, in the Right Setting

Both the state and Centers for Medicare & Medicaid Services (CMS) are interested in reducing unnecessary hospital emergency department usage. A comprehensive and integrated program like Healthy Connections Prime can ensure delivery of the **right care, at the right time and in the right setting,** thus, reducing unnecessary emergency room visits and hospital readmissions.

This can be addressed by ensuring members have access to the appropriate primary care services and other outpatient behavioral health services. After a member is discharged from the hospital, their care coordinator can help make sure they follow up with their primary care physician. This can help to address the underlying issues that led to the initial hospital admission and potentially avoid a readmission.

Care Coordinator Supports Timely Follow Up

After our member's hospital stay, her care coordinator worked closely with the doctor to review her post-discharge care. During the discussion, the care coordinator discovered that she missed a gastroenterology appointment because of the hospital stay. The appointment was quickly rescheduled and during that appointment, some serious issues were identified. The care coordinator's involvement helped our member uncover a serious issue and possibly avoid another hospital admission.

2016 Emergency Room and Hospital Discharge Follow Up		
Metric	**South Carolina**	**Demonstration National Average**
Behavioral Health-Related Emergency Room Visits, Annual Visits / 10,000 Member Months	19.8%	38.6%
Percent of Hospital Discharges with an Ambulatory Care Follow-Up Visit Within 30 Days After Hospital Discharge	77.4%	71.1%

Source: MMP Monitoring Report (Q4 2016). Data includes Quarter 1 2016 - Quarter 3 2016). Data does not constitute official evaluation results.

Better Health

Member Receives Support after Loss of Caregiver

A member's spouse (who was her caregiver) suddenly passed away. Her care coordinator helped the family secure adult day care and home health service, and arranged for legal help to create a Power of Attorney for medical and financial needs, grief counseling, home utility assistance and medical equipment services.

MMP Helps Member Resolve Medication Issues

A member has a diagnosis of diabetes but told his MMP he refuses to take his medication because it makes him nauseous and sluggish. His doctor continued to prescribe the same medication despite the member's complaints about the side effects. Upon learning of the situation, the member's care coordinator located a different doctor at the member's request. The new doctor prescribed a different medication that did not result in the earlier side effects. The member now takes his medication properly.

Flexible Benefits to Allow Members to Stay Home Longer

Members can access waiver benefits through the Community Long Term Care (CLTC) program to help them live safely in their community as long as possible. MMPs may also offer these "waiver-like" services to members who do not meet the state's eligibility requirements. "Waiver-like" services typically are short-term and meant to either help members return safely back to the community after a hospital stay, or provide temporary relief to caregivers. In 2016, nearly 2,000 members used CLTC services. Waiver services and flexible benefits are valuable tools that the MMPs use to successfully support members' choices to continue living in their homes and communities and/or to return to their homes.

Support for Family Caregivers

Caregivers play an integral role in supporting seniors. Yet their efforts are often uncompensated and done at the sacrifice of their own health and well-being. South Carolina MMPs address the needs of caregivers through including caregiver assessments and supports into the overall care plan for members. MMPs also provide help through creative approaches such as fall prevention workshops, care for the caregiver initiatives and the offer of respite services.

Dementia-Capable Training for Care Coordinators

Approximately 11 percent of Healthy Connections Prime members have a diagnosis of Alzheimer's Disease or related dementia. The State requires that MMP care coordinators receive training in dementia to support both members and caregivers. Training is conducted by the University of South Carolina Office for the Study of Aging as well as the Alzheimer's Association South Carolina Chapter. This required training and focus on caregivers has been noted as a promising design feature by AARP Public Policy Institute.

(Source: Reinhard, S. C., Fox-Grage, W., & Feinberg, L. F. (2016, November). Family Caregivers and Managed Long-Term Services and Supports. Retrieved April 19, 2017, from http://www.aarp.org/content/dam/aarp/ppi/2016-08/AARP1080_FSandMLTSS_REPORT_WEB.pdf)