From Fragmentation to Integration: Bringing Medical Care and HCBS Together

Jessica Briefer French
Senior Research Scientist
Integration: The Holy Grail?

• An act or instance of combining into an *integral* whole
• The act of combining or adding parts to make a unified whole
Models of Integration

- Home-based primary care
- Enhanced primary care
- Program of All-Inclusive Care for the Elderly
- Medicare-Medicaid Financial Alignment
- Medicaid Accountable Care Organization
- Guided Care
- Care Management Plus
- Hospital at Home
NCQA Guiding Principle:
The Person Must Be At The Center
**Integrated Care**

### Current State

- Siloed, redundant care plans, that are service oriented
- Unclear what population-level outcomes organizations can fairly be held accountable for
- Unclear where accountability lies resulting in multiple layers of “care coordination”

### Where we want to be

- Single, shared care plan that addresses whole person needs
- Individualized outcome measure targets as performance measures
- Clear and fair accountability without adding additional layers
Barriers to Integration

- Structural
  - Financing
  - Legal
  - Technical
- Cultural
  - Training
  - Language
  - Authority
Integration Approaches Observed

• Personal relationships
• Team care
  • PACE
  • RN, SW Care management team
• Care management embedded in PCMH
• Care manager accompanies individual to medical appointments
• Real or virtual case conferences
Interdisciplinary Team Structure

POPULAR IMAGE OF AN INTERDISCIPLINARY TEAM MEETING

PCP  Consumer  Care Coordinator

Specialist  Pharmacy Consultant

Physical Therapist  Daughter  Social Worker

REAL WORLD CARE COORDINATION

Specialist
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- Electronic Transfer
- EMR
- F-to-F (office visit)
- Phone
- F-to-F (co-located)
- Phone
- F-to-F (team mtg)
- PCP
- Phone
- F-to-F (home)
- Care Coordinator
- F-to-F
- Phone
- F-to-F (team mtg)
- Internal Info System
- Phone
- F-to-F (in-home services)
- Phone
- F-to-F (home)
- Phone
- F-to-F
- Phone
- Phone
- F-to-F
- Phone
- F-to-F
- Phone
- State/County
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- CBOs

Images from: TRUVEN Health Analytics
Other Efforts to Overcome Fragmentation

- Joint case management meetings between health plan case manager and outpatient behavioral health staff
- Health plan team meetings with CBOs
- Integrated health portal for sharing information
- Health plan trains and provides resources to its CBOs
• CBO partnership with hospitals to effectively manage transitions
• Health plan collaboration with personal care agencies to better understand assessment processes and find ways to streamline.
What Are Your Best Practices?

How do you integrate HCBS with medical care and behavioral health care?

• Organizational structure
• Financing
• HIT
• Training
• Communication
• Relationships
Measuring Quality

• What is quality in the context of HCBS?
• How does measuring the quality of HCBS affect fragmentation/integration?
NCQA’s Approach

Standards guide design of integrated person-driven care systems

Process measures assess implementation

Outcome measures assess goal attainment and person-driven outcomes

Best practices aid implementation

Evaluating the quality of person-driven care requires a special approach
Case Management-LTSS Accreditation

CM 1: Program Description
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CM 7: Rights and Responsibilities
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LTSS Module for Health Plans

LTSS 1: Core Features

• Develop and implement program description, assessment and person-centered care planning.

LTSS 2: Measure and Improve Performance

• Measure member experience, program effectiveness and participation rates and take action to improve performance.

LTSS 3: Care Transitions

• Establish a process for safe transitions and analyze the effectiveness of the process.
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Accreditation standards

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Assessments, care plans complete and timely, goals documented

Outcome measures assess goal attainment and person-driven outcomes

% of goals met

Accountability for quality as defined by consumers
Goals Vary

- Live at home
- Maintain independence
- Garden
- See my friends
- Stay as healthy as possible
- Get back to knitting and crafts
- Maintain vision
- Minimize pain

- Keep up with grandchildren
- Walk to the store
- Stay out of hospital
- Live many years
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Goal Setting & Outcome Measurement Framework

- % patients with Person-Reported Outcome Measurement at two points in time
  - % patients with person-centered goal documented
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How Do You Measure Quality?

• What does “quality” mean to the consumer?
• Who is accountable for quality, as defined by the consumer?
• How can the quality of shared accountability be measured?
• What do you think about goal-based outcome measurement?
Thank you
From Fragmentation to Integration

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Manager, Special Needs Purchasing, Health Care Administration
Minnesota Department of Human Services
What is the problem to solve?

Funding backdrop

- Over one million, or 1 in 5 Minnesotans rely on Medical Assistance and MinnesotaCare for access to health coverage and care. The long-term sustainability of these programs is of paramount concern.
- State spending for Medical Assistance and MinnesotaCare is approximately $5.0 billion for 2016 (approximately $4.9 billion projected for Medical Assistance and $162 million for MinnesotaCare)
- Medical Assistance is projected to be approximately 21% of the State general fund budget in 2016, with annual cost growth of approximately 6%.
- Approximately 70% of the state Medical Assistance spending is on health care and long term care for the elderly and individuals with disabilities.
Seniors clinical challenges

- On average our dual senior population is older and has 4.6 chronic conditions. Overall, 19% are under age 70, 38% are aged 70 to 79, 28% are aged 80 to 89, and 15% are 90+ years old.
- 82% rate of high blood pressure
- 52% rate of high cholesterol
- 42% rate of depression
- 37% rate of arthritis
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- 22% rate of Alzheimer’s/dementia
- 16% rate of osteoporosis among seniors enrolled in MSHO or MSC+.
Disabled adults clinical challenges

- The average SNBC enrollee has 5 chronic conditions
- 46% rate of substance use disorder
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For a person who falls and suffers a broken hip, there are many transitions to navigate between hospital, rehabilitation facility and home. At each juncture, medication mistakes may be made, instructions not clearly communicated, and other pre-existing chronic conditions may be exacerbated.
Minnesota Landscape: Duals are a Fraction

- Roughly 891,000 Minnesotans receive coverage through Medicare

- In 2014:
  - Full benefit dually eligibles: 118,000 (56,000 seniors 62,000 PWD)
  - Total Medicaid seniors 65+: 59,000 (95% dual)
  - Total Medicaid people with disabilities: 125,000 (50% dual)
  - Partial benefit Medicaid (Medicaid covers only Medicare cost sharing): 10,000
Tools for Change

- Medicaid managed care can be leveraged to make one entity responsible for acute care, behavioral health care and long term care.

- MIPPA can be used to mandate that Medicare Special Needs Plans serving duals must integrate care with Medicaid managed care program and meet state requirements.

- Within managed care, especially integrated managed care, value-based purchasing initiatives can provide further incentives to coordinate across silos of care.
Minnesota Landscape: Medicaid Managed Care

- Medicaid managed care for families, children, adults: 647,019
- MinnesotaCare: 76,702
- 90% Medicaid seniors enrolled in managed care under two options:
  - Minnesota SeniorCare Plus (MSC+): 13,677 enrollees (coordinates Medicare, enrollment mandatory)
  - Minnesota Senior Health Options (MSHO): 35,291 enrollees (integrates Medicare, enrollment voluntary)
- Special Needs BasicCare (SNBC): For people with disabilities, 40% (50,150) enrolled, all behavioral and physical health, home health aide and skilled nurse visit, not MLTSS
Medicaid managed care for seniors

- Medicaid seniors are required to enroll managed care
- Goal is to focus on improved management of chronic conditions, appropriate utilization of services and control of costs.
- Services provided include all Medicaid services including Long Term Services and Supports (LTSS), HCBS waiver services, 180 days nursing facility care, in all settings and levels of care
- MSHO achieves integration of Medicare by contract and allows coordination of benefits across programs. Combines Medicare (including Part D) and Medicaid services
MIPPA Contract Requirements

- D-SNP’s responsibility to provide or arrange for Medicaid benefits
- Categories of dual-eligible beneficiaries
- Medicaid benefits covered under SNP
- Cost-sharing protections covered
- Information on Medicaid provider participation
- Verification of enrollee eligibility
- Service area
- Contract period
MSHO features

- Aligned capitated financing supports innovation and payment reform
- Integrated member materials, one enrollment form, aligned enrollment dates, one card for all services
- State MLTSS assessment tool integrates Health Risk Assessment (HRA) into assessment process
- All members are assigned individual care coordinators. The State sets uniform standards, audit protocols and criteria for care plans, face to face assessment and care coordination
- Flexible care coordination delivery models
- High degree of collaboration among SNPs and State on member materials, PIPs, care coordination, benefit policy, demo decisions, etc. through multiple joint workgroups
SNBC Program

- SNBC is a voluntary statewide managed care program for people 18-64
- Participating health plans; two plans have D-SNPs
- 50,621 total enrollees. Of these 842 are in fully integrated SNBC. An additional 26,118 duals are in the Medicaid-only program.
- Empahasis on preventive, primary and behavioral health care
- Health plans provide care coordination/navigation assistance
- 100 days NF; no HCBS waiver services, home care nursing or PCA
What is value-based purchasing?

- Value-based purchasing is an umbrella term for financing strategies that attempt to reward providers for high quality, good outcomes, and population-based approaches.
- In fee-for-service, the financial incentive is to simply provide more services for more pay.
- Value-based purchasing tries to shift the financial incentive to reward providers who invest in staff training, care coordination, taking extra time with the sickest people, and working to prevent problems before they become more costly.
Types of Value-Based Purchasing

- **Pay-for-performance** – providers get bonus payments or a share of an incentive pool for hitting quality targets.

- **PMPM fee for Care Coordination** – providers are paid a set fee each month to manage care for a group of patients.

- **Total Cost of Care or Accountable Care Organization (ACO)** – provider system is paid fee-for-service all year for caring for a group of patients. Actual expenditures are then compared to what care would have cost for the patients. Provider system shares in gains and may pay for losses.

- **Capitation and subcapitation (Managed care)**
Integrated Care System Partnerships

- Builds from current managed care organization/care system contracting arrangements
- Proposals are subject to state contract requirements for care coordination, quality metrics, financial performance measurement and reporting
- Tied to a range of quality metrics:
  - Clinical work group developed quality measure options; can propose alternatives
  - Measures differ between systems based on population services, setting of care, geographic area, etc
Minnesota Managed Care Analysis

- *Minnesota Managed Care Longitudinal Data Analysis*, prepared by Wayne L Anderson, PhD and Zhanlian Feng, PhD of RTI International and Sharon K. Long, PhD of the Urban Institute

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Findings

- MSHO enrollees tended to be older, female, have more medical conditions, have died during the year, and likely to live in rural areas.
- Very few MSHO enrollees ever switched to MSC+, but 12.8% of MSC+ enrollees selected MSHO during the year.
- MSHO enrollees were:
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PCP

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F-to-F (co-located)
Electronic Transfer
Phone, Fax

F-to-F (team mtg)
Internal Info System

Rx Consultant

Consumer

F-to-F (home)
Phone

F-to-F (team mtg)
Internal Info System
Phone, Fax

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Care Coordinator

Home Care Provider

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