Care Coordination Perspectives: Past and Future

Best Practices Care Coordination Conference
November 17, 2014
Pam.parker@state.mn.us
History of MSHO/MSC+

- A Bright Idea: Medicare and Medicaid should coordinate!
- Platforms? Providers vs Managed Care
- Long path to CMS approval of first Medicare Medicaid demonstration in MN
- Focus Group Advice: “One person to help me coordinate my care”
- Evolution of Dual Eligible Special Needs Plans (D-SNPs)
- From Care Coordination to Models of Care
- MSHO as an early national model
- Integrated demonstrations nationwide
- MSHO returns to demonstration status, paves way for D-SNP demonstrations
- Rebalancing the system in MN
- Integrated Medicare Medicaid platform necessary success in triple aim goals:
  - Improve Quality
  - Improve Cost
  - Improve beneficiary experience
Integration Timeline

1985-2007: Social HMO Demo (transitioned to SNPs in 2007)
1987: Evercare begins in MN
1980s: MN Managed Care contracts include Medicare/Medicaid services to duals through Medica/Evercare and Health Partners/Social HMO
1991: First MN proposal to CMS for integrated Medicare and Medicaid program for duals, two more proposals follow
1995: CMS approves first State dual demo in MN
2001: MN adds people with disabilities to demo- MnDHO
1997-2004: Two additional State demos implemented in WI and MA
2004: MMA creates MA-SNPs
2005-2006: CMS requires the 3 State Dual Demos to transition to D-SNP
2008: SNBC is statewide with 7 plans, all have D-SNPs
2010: ACA provides additional authority to CMS to align Medicare/ Medicaid for dual eligibles
2011: CMS awards 15 states planning contracts for new dual demos
2011: SNBC Medicaid expands statewide, but most Medicare D-SNPs drop out
2011: CMS issues new Capitated and FSS Financial Alignment Demo (FAD) opportunities beyond the original 15 states, 36 States respond
2012-13: OR, MN, HI, TN and AZ drop out of FAD
2013-14: CMS approves FAD MOUs for MA, WA, IL, OH, CA, MI, VA, SC, NY, CO, TX and MN SNP Alternative Demo
Evolution of Care Coordination Functions

- Base: EW case management requirements
- “Kitchen sink” care coordination: whatever it takes
- Assessment for all
- MCOs endorsed “personal touch” models
- Many flowers bloomed
- Group exercise on common functions
- Contract language/MSHO Expectations Chart
- Overnight statewide Part D and MLTSS expansion (MSC+, counties)
- Increased attention to chronic conditions
- Development of care plan and care system audit protocols
- SNP MOC (strengthened model)
- Transitions Collaborative
- PIP/QIP Collaboratives
- Person centered planning!
MSHO Expectations

- Integrated delivery of primary, acute, LTC
- Person centered care planning
- Comprehensive assessments and evaluations are provided

Costs and utilization for both Medicaid and Medicare are managed (e.g. reduced hospital, ER, long term NF admits)

Transitions between settings (e.g. home, hospital, NF) are managed to achieve positive clinical and quality of life outcomes.

Satisfaction, self determination and quality of life are maintained or improved.

Care Coordination System
- Health Plan
- Care System
- Clinic
- Care Coordinator

Processes
- Interventions

Access to Home and Community-based Services is increased.

Primary/speciality care is established and maintained to improve clinical outcomes.

- Prevention
- Rehabilitation
- Monitoring
- Follow up are provided.

Long Term Nursing Facility placements are avoided.

- Fiscal incentives support sound clinical practice
- Seamless access and reduced administrative duplication
- Single point of accountability for total costs and outcomes

4/21/03
Disability Models

• MnDHO
  – Loved it but it closed for financial reasons

• SNBC
  – Stakeholder designed
  – Preferred Integration Network (PIN)
  – But no Managed Long Term Supports and Services (MLTSS)

• Medicare Ups and Downs
  – 2008 Statewide integration with Medicare
  – 2011 Expansion of enrollment
  – 2015 Loss of most Medicare Special Needs Plans

• New Horizons
  – Integrated Health Partnerships/ACOs
  – Behavioral Health Homes
Ongoing Challenges

• Triaging: right amount of attention at the right time!
• Documentation and regulations!
  – Medicaid vs Medicare
  – CMS and MDH/DHS, MLTSS
• Care plan audits!
• Effective models: County vs Care Systems vs Community Orgs: What is effective where?
• Medical vs Social Balance (RN-SW roles)
• “Chasing the Doc”: improving physician involvement!
• Increasing patient engagement!
• Implementing DHS MLTSS Changes!
  – Level of Care
  – MN Choices
  – Personal Care-CFSS
To Be Continued:

• Increasing MSHO enrollment: Addressing barriers to enable MSC+ seniors to move to MSHO

• Purchasing and delivery reforms (provider skin in the game, pay for performance, measurement, Integrated Care System Partnerships/ICSPs): Will it make a difference?

• Role of Health Care Homes/Role of Care Systems/ACOs: Impact on who does what?

• More EHR! What should it/will it look like?

• Behavioral and Physical Health Integration: What are the best models?

• Measurement: How do we measure impact and effectiveness of care coordination?
The More it Changes the More it Stays the Same!

• Stick to the Core: Just being there for PEOPLE counts!
• Assessment for EVERYONE has made a difference!
• Assistance in Navigating “the System”!
• Transitions Collaboration!
• Increased Access (rate cell As)!
• Results!
  – MN LTSS ranked #1 in nation by AARP Scorecard (twice)!
  – MSHO continues to be national model for Integrated Medicare Medicaid and D-SNP Demonstrations!
Enrollment by Setting of Care 1996 and 2014

<table>
<thead>
<tr>
<th>Setting of Care</th>
<th>1996</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>14,837</td>
<td>20,045</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>30,104</td>
<td>12,968</td>
</tr>
<tr>
<td>Elderly Waiver</td>
<td>4,726</td>
<td>22,598</td>
</tr>
</tbody>
</table>

Total = 55,611

Total = 49,667
State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiaries, May 2014

NOTES: *CO, CT, IA, MO, and NC proposed managed FFS models. NY, OK, and WA proposed both capitated and managed FFS models; both demonstrations are approved in WA; NY withdrew its managed FFS proposal. All other states proposed capitated models.

- **MOU signed with CMS to implement financial alignment demonstration (11 states)**
- **MOU signed with CMS to implement administrative alignment demonstration (1 state)**
- **Proposal pending with CMS (6 states plus NY's DD proposal)**
- **Proposal submitted, will not pursue financial alignment but may pursue administrative alignment (1 state)**
- **Proposal withdrawn (7 states)**
- **Not participating in demonstration (24 states and DC)**
Thank YOU for all you do every day!

YOU make a difference in the lives of Minnesota Seniors!