

Key Components for Successful LTSS Integration: Case Studies of Ten Exemplar Programs

HealthPartners

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Long-term services and supports (LTSS) integration is the integration of medical, behavioral health and LTSS benefits in a single capitated program. This case study is part of a larger research project that hypothesizes that LTSS integration has the potential to improve outcomes and lower overall costs of care for people with substantial functional limitations and complex care needs. This body of research is intended to inform business decisions by health plans and other risk-bearing organizations considering LTSS integration, and to contribute to policy discussions on financing LTSS.

Ten programs that are experienced and successful in integrating medical care and LTSS were selected for this study. The programs vary in structure, population served, and geography in order to reflect the diversity of successful approaches to LTSS integration. Each case report provides an in-depth description of program characteristics and operations, as well as a discussion of key integration strategies and outcomes.

Background Information

HealthPartners is a not-for-profit integrated healthcare organization founded in 1957 that both delivers care and operates several insurance plans. The HealthPartners delivery system cares for about one million patients annually, and includes hospitals, medical and dental clinics, home health, hospice, and long-term care facilities in Minnesota and Western Wisconsin. As an insurer, HealthPartners covers more than 1.5 million members through commercial, Medicare, and Medicaid products.

HealthPartners participates in two Minnesota Medicaid programs that integrate LTSS: the Minnesota Senior Health Options (MSHO) program and the Minnesota Senior Care Plus (MSC+) program. MSHO is a voluntary managed care program for dual eligible individuals age 65 and older. MSHO integrates Medicare and Medicaid financing to cover all care—including medical, behavioral, and LTSS benefits. MSHO plans are structured as Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs). MSC+ is a Medicaid managed care program. In Minnesota, enrollment in a managed care program is mandatory for individuals age 65 and older eligible for Medicaid. Individuals are enrolled into the MSC+ program with the option to opt into the MSHO for individuals who additionally have Medicare A and B coverage. MSC+ integrates all Medicaid benefits, but most participants (85 percent) are dual eligible and have primary medical coverage from fee-for-service Medicare or an unrelated Medicare Advantage plan. Statewide, there are 35,796 individuals enrolled in MSHO and 13,895 in MSC+.

HealthPartners has a long history with the state’s Medicaid managed care programs, and has participated in MSHO and MSC+ since the programs were established. The organization has 3,098

Medicaid Managed Care in Minnesota		
Program Name	Minnesota Senior Health Options (MSHO)	Minnesota Senior Care Plus (MSC+)
Year Established	1997	2005
Covered Populations	Dual eligible individuals age 65 and older	Medicaid beneficiaries age 65 and older
Population Carve-Outs	None	None
Enrollment Approach	Voluntary	Mandatory, including for dual eligible beneficiaries who opt-out of MSHO
Statewide Enrollment	35,796 ¹	13,895
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	None	None
Dual Eligible Population	100%	85%

members in the MSHO product and 1,747 members in MSC+. HealthPartners enrolls MSHO and MSC+ members in a 12 county region surrounding the Minneapolis-St. Paul metro area. Six other health plans also participate in the programs. The state only contracts with Minnesota-based non-profit organizations for Medicaid managed care. HealthPartners is one of the smaller contractors in these programs, with about 10 percent of the enrolled population.

Care Management Approach

All care management functions for HealthPartners’ insurance products are managed by the Disease and Case Management department. The department includes units on complex case management, inpatient case management, disease management, and care coordination. The care coordination unit is dedicated to providing longitudinal care management for MSHO and MSC+ members. Care managers in the care coordination

unit collaborate with staff in other units in caring for their members—for example, to connect the member with disease-specific education or to manage a hospitalization. Care managers also work closely with HealthPartners’ clinical support staff, which includes a medical director, pharmacists, behavioral health specialists, and palliative care providers.

HealthPartners considers all MSHO and MSC+ members to be high risk, and assigns a care manager to follow each member for as long as they are enrolled in the plan. Care managers are a mix of social workers and registered nurses, and each carries case load of about 80 members. Care managers do not specialize, but instead have a mixed panel of members at varying levels of need and complexity. Care managers are assigned to members based on region, cultural competency (e.g., language skills), and caseload capacity. HealthPartners tries to assign all members in a particular nursing home or assisted living facility to a single care manager in order to strengthen relationships between the care manager and facility staff.

¹ All enrollment figures in this section are accurate as of June 2016, and available on the Minnesota Department of Human Services’ “Managed care enrollment figures” webpage. Source: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_141529

As soon as a new member enrolls in MSHO or MSC+, HealthPartners assigns a care manager, who calls the member to introduce the program and schedule an in-home assessment. Prior to the home visit, the care manager does background research on the individual, reviewing medical records, claims and encounters history, pharmacy claims, and their current providers. During the home visit, the care manager completes a comprehensive assessment that addresses functional, psychosocial, mental health, cognitive, and clinical dimensions; does a home safety/falls assessment; and determines, based on results of the assessment, if personal care assistance or other long term services and supports are needed. The assessment is used in part to determine the member's eligibility for Elderly Waiver (EW) services—Minnesota's Medicaid HCBS waiver program for seniors. The state has developed set waiver budgets within which HCBS services must fit based on the level of need determined by the comprehensive assessment. Specifically, the EW budget is determined based on the number of activities of daily living (ADLs) for which the member requires support, intensity of behaviors and daily clinical needs with which the member requires a specific threshold of assistance, whether or not they have a behavioral need or a complex skilled nursing need, and other factors. Members receive a new in-home assessment at least annually, or if there is a significant change in their condition that might impact their assessed amount of need and service plan.

After the assessment is completed a waiver services budget will be determined for those members deemed eligible, and the care manager, member, and the member's caregiver(s) work together to create a care plan. The care manager helps the member identify goals that are most important to them along with clinical goals to support self-management of their chronic health conditions. The care manager implements the care plan by arranging the services and making necessary referrals. Within the waiver budget, the care manager and the member have substantial flexibility in the services provided based on the member's needs. The care manager assists the member in making informed decisions about the different options available and determining the services that best support them safely at home. Ultimately, the member's preferences and clinical needs drive the service plan. The care manager then shares the care plan with the member's providers to get their input, and the finalized document is sent to the member for their signature and the PCP to keep in their patient file. The care manager determines appropriate follow-up time frames to review the care plan with the member and/or their responsible party. HealthPartners has a dedicated administrative support team that assists the care manager with setting up services and ordering supplies according to each individual member's plan of care in order to ensure that all services are started as agreed upon in the care plan.

Care managers have discretion in deciding how often to follow up with members. The state requires that all members receive at least an annual assessment and six-month follow-up call. Beyond that baseline, the frequency of care manager interaction with members depends on their level of need and engagement. Care managers call some members twice annually, while others with greater need for support may be called every other day. Over time, care managers develop close, trusting relationships with the member and their family. Because of this relationship, if a problem arises with the member's health, service plan, or providers, they will often call the care manager directly for support.

HealthPartners holds interdisciplinary team meetings to discuss MSHO and MSC+ members every other week. Participants include the medical director, pharmacists, behavioral health specialists, home care nurses, palliative care experts, and care managers for the members being reviewed. The team reviews challenging cases and engages in collaborative problem-solving to determine how best to address the member's needs. After the meeting, the care manager is responsible for implementing any resulting care plan changes and integrating those changes with the member's interdisciplinary care team. The medical director may reach out to the member's PCP to offer input on the member's treatment.

Care managers follow their members any time they experience a transition to a higher care setting such as a hospital or transitional care unit. Care managers share and explain the transitional care plan with the member and ensure the member knows to contact them for support or assistance when they return home. Care managers complete a post-discharge follow-up call to identify and address any challenges that put the member at risk of readmission or relapse in their health condition. Care managers ensure that the member has a post-discharge follow-up appointment with their PCP, and help the member to schedule this appointment if necessary. Care managers also review medication changes and ensure the member receives any new prescriptions, review with the member signs and symptoms of their condition worsening, and provide education. Care managers ensure members know how to reach HealthPartners 24/7 nurse line.²

This high-intensity approach to care management is HealthPartners' primary strategy for managing emergency room and hospital utilization among their MSHO and MSC+ members. Care managers work to anticipate and avoid these high-cost events by identifying at-risk members and building care plans that put preventive measures in place. Care managers focus on high-risk medical conditions and ensure care plans are in place to avert potential hospitalizations. These conditions include congestive heart failure, diabetes, coronary artery disease, chronic obstructive pulmonary disease, and serious and persistent mental health conditions. HealthPartners also assesses whether members have dementia and ensures that care plans for patients with dementia account for the greater risk of non-adherence and have appropriate goals of care. Additionally, the plan screens all members for depression and assesses medication adherence.

A specific strategy HealthPartners has used to effectively manage high-risk members is home-based care. The HealthPartners delivery system includes a home care team of NPs and physicians who focus on post-acute transitional care, institutionalized populations, and members who are homebound and frail. Although this intervention serves only a small number of MSHO and MSC+ members, it can generate substantial results by enabling HealthPartners to get a comprehensive suite of supportive resources in place very quickly.

HealthPartners also emphasizes robust palliative care services as a critical strategy for improving member outcomes. Care managers assist members in completing advance directives and may refer to

² As a FIDE-SNP, the HealthPartners MSHO program follows a Model of Care that has been approved by CMS. The care coordination model described in this section is part of that Model of Care. MSHO also participates in the CMS Chronic Care Improvement Project.

palliative care for in-home visit to complete an advance directive. Care managers frequently request palliative care consults for hospitalized members, and proactively identify individuals who would be good candidates for hospice. Hospice is an especially powerful tool because it includes on-call clinicians ready to respond to the member's home at all times. HealthPartners also covers palliative home visits by interdisciplinary professionals for non-hospice patients as a value-added benefit in chronic disease self-management.

Relationships with Providers

HealthPartners has a high degree of alignment between payer and provider in that the organization serves in both capacities for much of their enrolled population: 30 percent of HealthPartners delivery system patients have HealthPartners insurance, and 40 percent of members enrolled in a HealthPartners plan use the HealthPartners delivery system. For MSHO and MSC+ members, alignment is even greater. 80 percent of these members see a PCP in the HealthPartners delivery system. HealthPartners sees narrow networks of aligned providers as a key strategy in achieving better outcomes for high-need individuals. When HealthPartners is aligned as both the payer and provider, their care managers and PCPs can more easily operate as a team, with collaboration facilitated through access to a shared electronic health record.

In HealthPartners' role as a payer, its background as a provider organization gives it a unique ability to collaborate with other medical providers. HealthPartners understands from experience the challenges providers face and the most promising opportunities to improve patient care. Providers see HealthPartners as a credible partner in patient care because of that experience. Another benefit of being both payer and provider is that HealthPartners is also able to leverage their delivery system as a site for testing care management and clinical innovations. If a pilot project is successful within their own delivery system, HealthPartners rolls it out to network providers.

HealthPartners's approach to partnering with providers is built on the understanding that some aspects of care management are best provided in a centralized manner, while others are more effective if provided at the point-of-care. HealthPartners' care management functions complement the care management efforts of PCPs. HealthPartners focuses on Medicaid coordination and care management interventions that benefit from economies of scale. For interventions that are best provided at the point-of-care, HealthPartners collaborates closely with and supports PCP care management efforts. One example is the "shared visit," in which HealthPartners provides additional resources to wrap around an MSHO or MSC+ member's PCP office visit. Shared visits are provided for members who need more time with the doctor, especially when social issues have been a barrier to addressing clinical issues. HealthPartners pays for a nurse to meet with the member before and after the doctor visit, ensuring that the patient understands their care plan and receives any necessary clinical coordination and education. After the visit, the member's care manager will follow up to ensure that social and LTSS needs are met. HealthPartners describes this as a "both, and" approach to care management, in which the plan and providers work together to ensure that the member receives the most holistic care possible.

Collaborating with LTSS providers on the care of members can be more difficult due to the heterogeneity and small size of the community-based organizations (CBOs) providing services. Many HCBS providers, for example, are entirely paper-based, and do not have the capacity to participate in quality measurement or performance management initiatives. Minnesota has worked to decrease the administrative burden of working with CBOs by implementing a state system to certify providers eligible to participate in the MSHO and MSC+ programs.³ The state checks credentials and creates contracts for providers in this program, streamlining the process for both providers and plans. Plans still have the ability to operate their own, more restrictive network, which HealthPartners does for personal care aides and home care services.

For both LTSS and medical care, collaboration with providers on member care can be difficult due to the dispersion of the enrolled population. Any individual PCP or HCBS provider may have just two or three MSHO or MSC+ members. It is hard for providers to dedicate additional time and attention to managing such a small share of their panel.

Financial Integration

HealthPartners is a mission-driven organization, and while they have a commitment to being good stewards of public funds, they are not substantially motivated by profit. Nevertheless, financial structure affects program design and influences some of the strategies that HealthPartners can deploy in caring for members.

Financial Alignment

HealthPartners' 3,098 members enrolled in the MSHO product are all fully financially aligned—that is, they receive all Medicare and Medicaid coverage through HealthPartners. HealthPartners also has full financial alignment for 268 non-dual eligible Medicaid beneficiaries in the MSC+ product (15 percent of MSC+ members). The other 1,479 members (85 percent) have their Medicaid coverage with HealthPartners, but are enrolled in either fee-for-service Medicare or an unrelated Medicare Advantage plan.

Financial alignment has been a critical factor in HealthPartners' success with the MSHO population—the plan acts as a one-stop shop for all of a member's care and the care manager can help with anything the member needs. The lack of alignment for dual-eligible members in the MSC+ product presents substantial barriers to HealthPartners' care model and limits the plan's ability to provide the optimal model of care that has been successful in MSHO. Care managers face additional barriers when providing care coordination for non-aligned members. Although care managers do their best to coordinate with Medicare, they are hampered because they do not have responsibility for management of those benefits. HealthPartners does not receive Medicare claims for non-aligned

³ To learn more about the Minnesota Health Care Provider program, see the Minnesota Department of Human Services website:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_181656

members, and thus lacks the data that informs their care model. Care managers cannot be as effective without a comprehensive view of what is happening with members.

The capitation structure puts HealthPartners at full risk for all of the medical and behavioral care that members receive. Rates are set prospectively each year by the Medicaid state actuary and through the Medicare Advantage bid process. This arrangement means that HealthPartners is financially incentivized to invest in care management and other tools that decrease high-cost medical utilization like ER visits and hospital admissions. HealthPartners treats the capitations they receive from CMS and the state as a single pot of money, and manage their financials holistically at the population level. Accordingly, the plan invests in their care model as a tool for managing overall medical costs.

In designing the state's Medicaid managed care programs, Minnesota policymakers limited the influence of profit-seeking behaviors while keeping the benefits of competition among plans. Only not-for-profit health plans are allowed to contract with the state to administer the Medicaid programs, with the state factoring a minimal profit margin (typically around 0.75 percent) into the rate. MSC+ rates are set annually based on aggregate cost and encounter data from participating plans. State policy requires that rates be actuarially sound—the state cannot reduce rates to meet state budget goals.

The LTSS rate structure for the MSHO and MSC+ programs are set to pay plans appropriately for members' care and not unduly incentivize one setting of care over another. There are different rates for members living in institutions, those living in the community with waiver services, and those living in the community without services. There are multiple rates for members receiving waiver services to account for the intensity of services they need to remain independent—rates are adjusted based on the level of functional need, behavioral complexity, and the need for skilled nursing. The rates are designed to be self-sustaining with no cross-subsidization across categories. This rate structure ensures that financial incentives are not a factor in determining the setting of a member's care—instead plans are expected to support the member in the least-restrictive setting and are reimbursed for the cost of doing so. At the same time, plans are not incentivized to decrease the total cost of LTSS service packages, which is typically an advantage of managed LTSS programs.

Comprehensive Benefits and Flexibility in Use of Funds

The MSHO and MSC+ programs offer a comprehensive set of benefits to meet beneficiary needs and support individuals in the least restrictive setting possible. Within this comprehensive set of services, HealthPartners has the flexibility to deliver the best mix of services to meet member needs. The ability to provide right service, in the right amount, at the right place and time is key enabler of HealthPartners' care model. This is especially important in meeting the diverse needs of the LTSS population. Each individual is able to receive the unique set of services they require.

One critical area of flexibility for HealthPartners is integrated encounter reporting. HealthPartners does not have to allocate individual claims to either Medicare or Medicaid. Instead, they report every MSHO encounter to both the state and CMS. For the Medicare Advantage bid process, HealthPartners conducts an analysis of claims to determine what Medicare and Medicaid spending would have been

and subtract all Medicaid spending from the bid. This back-end allocation requires a substantial administrative effort, but does not pose a barrier to the care model. If HealthPartners were required to allocate every encounter to Medicare or Medicaid separately on the front-end, it would hamper their ability to deliver integrated care.

Quality Metrics and Performance Management

HealthPartners has a comprehensive approach to quality measurement based on the Triple Aim,⁴ and strives to be in the top 10 percent nationally in terms of performance on Medicare Star ratings, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and the Healthcare Effectiveness Data and Information Set (HEDIS). The organization also monitors its performance on Minnesota-specific measures. This quality strategy goes beyond clinical measures and includes metrics relevant to populations receiving LTSS, such as: falls, depression screening, advance directive completion, antipsychotic use in nursing homes, and access to palliative and hospice care. HealthPartners has extensive reporting abilities, and is able to measure and analyze performance at a granular level. This approach to quality has been successful—HealthPartners has a 4.5 Star rating for their MSHO Medicare Advantage plan, an extremely unusual achievement on a product that focuses exclusively on duals. HealthPartners also has strong HEDIS scores and patient satisfaction rates.

HealthPartners measures and reports on quality measures for medical providers, but tries to limit the administrative burden of the process. Many providers already have a large number of items they are required to report, and additional measures could be overwhelming, especially if they are relevant for only a small share of the patient panel. Providers in the HealthPartners delivery system receive detailed reports on their own performance and utilization based on claims data, but are not subject to additional reporting or performance requirements.

HealthPartners is in the early stages of determining how to measure quality among LTSS providers. Any quality strategy will have to take into account the diversity of providers and their limited resources for participation. Lack of adequate measures is an impediment to launching a comprehensive LTSS quality strategy. HealthPartners leadership pointed to person-centeredness and care coordination as important areas where there are no tools for measuring performance.

Affordability as a Quality Metric

As part of their commitment to the Triple Aim, HealthPartners is dedicated to providing affordable care and bending the healthcare cost curve. This emphasis on affordability dates back to its founding as a cooperative clinic that self-funded care for patients who otherwise could not afford treatment. Although as a non-profit organization, HealthPartners does not focus on financial returns, they are conscious of efficiency and sustainability in order to be good stewards of funds.

⁴ The Triple Aim is a framework for healthcare quality that incorporates three dimensions: the patient experience of care, population health, and per capita cost. To learn more, see: <http://www.ihl.org/engage/initiatives/tripleaim/pages/default.aspx>

In order to measure healthcare affordability, HealthPartners developed their own “Total Cost of Care” measurement approach.⁵ This model includes measures of both price and resource use, is risk-adjusted to account for the complexity of the population, and is the first such tool to have been endorsed by the National Quality Forum. The model assesses affordability in a more comprehensive way than tools that evaluate the costs of episodes of care. HealthPartners uses claims data to populate the model, and assigns each individual a risk score based on diagnoses, age, and gender. In assessing their own performance on the total cost of care, HealthPartners aims to be 10 percent lower than the median for Minnesota, the region, and the country.

Key Integration Strategies and Outcomes

HealthPartners’ leaders believe they have been able to effectively improve quality and manage costs through the integrated program. The plan’s 4.5 Star rating, strong HEDIS scores, and high levels of patient satisfaction are evidence of this success. A recent Office of the Assistant Secretary for Planning and Evaluation (ASPE) study showing that MSHO beneficiaries have lower rates of hospital admissions and ER visits demonstrates that the program is decreasing high-cost medical utilization.⁶

HealthPartners’ core strategy for achieving the goals of integration is high-intensity care management for high-need members and a focus on prevention. Care managers develop trusting, long-term relationships with members and their families so they can work as a team on delivering care that supports their independence and quality of life. The care model incorporates home visits and includes an emphasis on palliative care to achieve the best results for this population.

The unique ability to align members of HealthPartners’ health plans as patients of the HealthPartners delivery system is another key component of this approach to integration. The plan is able to collaborate with and support providers in a way that is unusual outside of a provider-based program like PACE, and offers a potential hybrid model for expanding integrated LTSS to a broader, community-based population.

HealthPartners’ leaders point to the supportive policy environment as a key enabler of the MSHO program. The close alignment of state and federal payers has led to an integrated program design, including a comprehensive set of benefits, financial alignment, and the flexibility to meet each individual’s unique needs. HealthPartners believes that maintaining the solid policy platform on which MSHO is built is crucial for continuing the program’s long track record of success as a fully integrated program.

⁵ To learn more about HealthPartner’s Total Cost of Care model, see:

<https://www.healthpartners.com/hp/about/tcoc/index.html>

⁶ W. Anderson, Z. Feng, and S. Long, (2016) “Minnesota Managed Care Longitudinal Data Analysis,” *Report prepared for Office of Disability, Aging and Long-Term Care Policy*. Available at: <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>

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Long-Term Quality Alliance

Long-Term Quality Alliance (LTQA) is a community of organizations aimed at improving outcomes and quality of life for persons and their families who are managing functional limitations due to chronic health conditions. It draws member organizations from the full range of health care and social services delivery systems involved in provision, administration, innovation, policymaking, and advocacy for quality long-term services and supports (LTSS).

Organizations come together in the Alliance to share knowledge and experience needed to advance development and continuous improvement of high-quality systems of integrated, person- and family-centered LTSS. The Alliance serves as a convener of disparate private-sector and governmental organizations, with an eye to identifying and resolving the most significant challenges and advancing the replication of successful models that demonstrate the potential for more widespread adoption of person-centered LTSS integration.

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*Advancing high-quality, person- and family-centered,
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