Case Management Redesign: Stakeholder Vision Template

Please feel free to adapt this template to your organization's needs; this is meant only as a helpful tool.

Minnesota Council of Health Plans

1. Description of the Minnesota Council of Health Plans

The Minnesota Council of Health Plans (Council) brings some of our country's top health insurance companies together to solve problems. The Council is where our member insurers put aside competitive concerns and work together with partners across the state to make medical care more effective and less expensive for everyone. Our seven member companies serve local policyholders, not shareholders on Wall Street. The member companies involved in this work include: Blue Cross Blue Shield/Blue Plus of Minnesota, HealthPartners, Medica Health Plans, Metropolitan Health Plan, and UCare.

2. Roles played by members of your organization in Medicaid case management:

Health plans administering State Public Programs offer varying degrees of case management and care coordination. Minnesota's long history of successful managed care programs has prompted health plans to provide care coordination above and beyond the scope of traditional health plan disease and case management functions. Some plans provide these varying degrees of support through their own hired health plan staff, though many also provide care coordination services through delegation agreements contracting with county public health and social services staff, community agencies, and care system staff. The complexity of the Minnesota Senior Health Options (MSHO) program has been an incubator for partnership innovation (with care coordination delegates as well as other providers) and has encouraged health plans to offer more than simple third-party administrator services with telephonic disease and case management programs. The robust care coordination structure offered by Minnesota health plans administering public programs is a cornerstone of MSHO's success. Below is a high-level breakdown of the varying degrees of Minnesota managed care coordination.

Minnesota Senior Health Options (MSHO)

May 2016 program total: 35,619. Members must be eligible for Medicare A and B and Medicaid, and be over 65 years old. MSHO includes seniors eligible for the Elderly Waiver. In 2014, health plans managed 92% of all Elderly Waiver members in the state.

MSHO comprises the most intensive care coordination model per DHS contract requirements as well as each health plan's CMS-required Model of Care (due to Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan (FIDESNP) status). Each member has a designated nurse or social worker care coordinator assigned that follows, assesses and coordinates care across the continuum through face-to-face visits as well as other forms of intervention. This type of care coordination requires a highly skilled and trained individual who can manage Medicaid, Medicare, Elderly Waiver and health plan benefits effectively.

Minnesota Senior Care Plus (MSC+)

May 2016 program total: 13,669. Members must be eligible for Medicaid (although greater than 80% have Medicare, with which the care coordinator must coordinate), and be over 65 years old. MSC+ includes seniors eligible for the Elderly Waiver. In 2014, managed care organizations health plans managed 92% of all Elderly Waiver members in the state.

MSC+ is an intensive care coordination model per DHS contract requirements. Members are not required to have a care coordinator (who are nurses or social workers), though most health plans have the same or a very similar MSHO care coordination model implemented for MSC+. Care coordinators are required to be assigned for all MSC+ members open to the Elderly Waiver and the care coordinator follows and coordinates care across the continuum through face-to-face visits/assessments as well as other forms of intervention. This type of care coordination requires a highly skilled and trained individual who can manage Medicaid, Elderly Waiver, health plan benefits and coordinate with Medicare effectively.

Special Needs Basic Care (SNBC)

May 2016 program total: 51,456. Members must be eligible for Medicaid, certified as disabled by Minnesota or CMS, and be age 18 to 64.

SNBC is a less intensive care coordination model per DHS contract requirements. Some health plans also offer SNBC as an integrated Medicaid-Medicare program in which case there may be additional CMS Model of Care care coordination requirements that apply. Health plans are required to complete a health risk assessment, care plan, offer a face-to-face visit annually, and coordinate extensively with other formal and informal supports. SNBC care coordination functions are not reimbursed in the payment DHS pays health plans, so it is unclear if the work of the Case Management Redesign would, or should, have any impact on SNBC. Regardless, health plans invest many resources in these care coordination models and the comments made above about using delegates applies to SNBC as well.

Prepaid Medical Assistance Program (PMAP) for Families and Children

May 2016 program total: 702,304. Members must be eligible for Minnesota Medicaid and be age 0 to 64.

In most cases, there are care coordination requirements in the DHS contract for PMAP. Some health plans still administer intensive programs though there is no Medicaid payment to health plans for this benefit. There may be additional requirements for health plans and this program in the future related to care coordination due to new requirements recently published by CMS in the May 2016 Medicaid Managed Care final rule ("Mega Reg").

3. The legislature identified eight goals that the Case Management Redesign Project should address. Please discuss these goals as to their importance to your organization.

- Increase opportunities for choice of case management service provider

Health plans highly value choice of care coordinators in our programs though this choice must be within the options available in the health plan's network of care coordinators. Options of entities that may provide the care coordination function must remain within the purview of the

health given the longstanding health plan public programs approach in which the health plan is at full financial risk for the member. Choice at this level has been documented by CMS as being acceptable, and it is difficult to see how a system could work otherwise.

- Define the service of case management to include the identification of roles and activities of a case manager to avoid duplication of services

  Health plans are in support of further effort to address duplication of services. Plans have collaborated with DHS for a very long time on opportunities to improve coordination and linkage to other supports and supportive workers and would continue to support these efforts.

- Provide guidance on caseload size to reduce variation across the state

- Develop a statewide system to standardize case management provider standards, which may include establishing a licensure or certification process

  Health plans have had a representative participate in the last few years of Case Management Reform Stakeholder groups and have consistently been in support of DHS pursuing standards for Medicaid case management. Research done through the last Case Management Reform Stakeholder group indicated that, in general, the standards for health plan care coordinators are higher – and the amount of oversight, auditing, and member satisfaction inquiries going out to health plan members significantly higher – than what is occurring in the state's fee-for-service systems.

- Develop reporting measures to determine outcomes for case management services to increase continuous quality improvement

  Health plans are in support of these efforts continuing. In the Case Management Reform Stakeholder group, other stakeholders were very interested in hearing of the reporting and oversight in place with health plans around care coordination. Plans are willing to continue to be a part of this discussion and share their requirements and oversights in place.

- Establish rates for the service of case management that are transparent and consistent for all medical assistance-paid case management

  This will be a challenging goal if DHS includes health plan-paid case management. As previously stated, health plans are at financial risk for membership and need to have the ability to modify reimbursement strategies to align with alternative contracting and other practices that impact change and health care reform in general.

- Develop information for case management recipients to make an informed choice of case management service provider

  Health plans are in support of these efforts and were considered to deliver a "best practice" regarding information we currently make available to members (in writing about a member's right to appeal a decision or voice a grievance) during the past Case Management Reform Stakeholder group. Plans are willing to continue to be a part of this discussion to provide information on their requirements and approach.

- Provide waiver case management recipients with an itemized list of case management services provided on a monthly basis

4. List the principles or values that should drive the case management redesign planning process

- Please be clear about what is and is not in scope, then respond accordingly and commensurately to the populations and entities (counties, health plans, tribes, etc.) impacted. The project description Executive Summary made very little mention of managed care **though currently health plans are providing care coordination to potentially 100,000+ individuals enrolled in Minnesota Medicaid programs.**
- The project description indicates research will be pursued to look at how other states structure Medicaid case management. The Council of Health Plans strongly urges DHS to look at states that have similar managed care programs to those that have been as successful as Minnesota. To do comparisons to states that do not have developed Managed Long-term Services and Supports (MLTSS) programs would not be useful or relevant if the scope of this workgroup includes managed care.
- It is important that the DHS leaders of the next Case Management Reform effort understand CMS requirements that would impact health plan Medicaid case management if this is within the scope of the work. This would include understanding CMS Models of Care, MLTSS policy, and the changes that were just published in the Medicaid Managed Care final rule.
- Stakeholders should come up with a list of current best practices that future reform efforts should not inadvertently undo. We are appreciative of the clearly articulated intent to review all the previous Case Management Reform reports to the legislature as a starting point and encourage you to garner all the best practices you can from those reports. Additionally, we recommend that DHS ask people (representative of the number and type of case managers you are discussing) today what best practices entail as health care and public programs are changing very quickly and the information in those reports will become dated quickly.
- Ensuring high quality services is important. Previous brainstorms in the Case Management Reform Stakeholder group contemplated massive alignment into a one-size-fits-all Medicaid case manager. Given the complexities of Minnesota's public programs, it seems that the one-size-fits-all would result in a watering down of expertise as it would be extremely difficult for an individual to be an efficient and effective care manager across all programs and payers.

5. List the changes that your members want to see in case management, or the aspects of case management that they want to maintain

- Health plan MSHO and MSC+ models are very strong and have been proven to be successful. Our hope is that this effort will not have a negative impact on those models.
- The health plan SNBC model is newer and has some opportunity to improve targeting of case management efforts and include a revenue stream for entities providing the case management work.
- A previous vision held that individuals with high levels of personal care assistance would also receive some form of case management. This seems like an avenue worth exploring as well as assessing the program changes the Community First Services and Supports program would offer.

If these changes offer a similar type of support, that would negate the need to figure out a different Medicaid case management support for this population.

6. List one or two main messages that your group wants to communicate to everyone involved in case management planning.

- Thank you for your thoughtful approach to resuming this important work. We appreciate the opportunity to be part of the discussion and consideration if DHS is including managed care in scope. If managed care is included, there were several significant details specific to managed care programs not included in the Executive Summary that you will hopefully learn more about as you proceed.