County-Based Purchasing: Integration, Advocacy, Care

Heather A. Goodwin, Senior Health Services Manager
SNP Alliance 13th Annual Leadership Fall Forum
Washington, DC – November 2, 2017: 4:15pm – 5:15pm
• Began operations in 2001
• Owned by 11 rural Minnesota Counties
• Serves approximately 42,000 members
• Must be eligible for Medicaid
• Minnesota Medicaid Managed Care Organization and Medicare Advantage
Product Offerings

**Medicaid**
- (2) Families and Children
- (2) Disabled, 18-64 years
- (1) Seniors (65 years +)

**Medicare Advantage**
- (2) FIDE SNPs
- Disabled, 18-64 years
- Seniors (65 years +)
FIDE SNPs

- SeniorCare Complete – Minnesota Senior Health Options (MSHO) product

- AbilityCare – Special Needs Basic Care (SNBC) product
  - Full duals with zero cost share
  - Certified Disabled or developmentally disabled, 18-64 years old, eligible for Medicare Parts A and B, eligible for Medicaid
As of October 2017:

- Total Enrollment: 599
- Highest average claim costs in age band 50-59 years
- Males 44%
  Females 56%

### AbilityCare Age Breakdown

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24 years</td>
<td>5</td>
</tr>
<tr>
<td>25-29 years</td>
<td>25</td>
</tr>
<tr>
<td>30-39 years</td>
<td>101</td>
</tr>
<tr>
<td>40-49 years</td>
<td>129</td>
</tr>
<tr>
<td>50-59 years</td>
<td>235</td>
</tr>
<tr>
<td>60-64 years</td>
<td>104</td>
</tr>
</tbody>
</table>
AbilityCare Characteristics

- 35% have an intellectual disability diagnosis
- 51% is enrolled in a home and community-based services (HCBS) waiver
- 78% has a household income of less than $20,000 per year
- 87% have a psychosocial condition
## AbilityCare Characteristics

### Utilization Data

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2+ ED visits in 3 months</td>
<td>7.88%</td>
</tr>
<tr>
<td>Catastrophic Claims (&gt; $100,000)</td>
<td>2.45%</td>
</tr>
<tr>
<td>Readmit in 30 days</td>
<td>1.40%</td>
</tr>
<tr>
<td>3+ Hospitalizations in 3 months</td>
<td>2.28%</td>
</tr>
<tr>
<td>6+ Chronic Conditions</td>
<td>50.96%</td>
</tr>
<tr>
<td>Polypharmacy (10+ active ingredients)</td>
<td>52.19%</td>
</tr>
<tr>
<td>Inpatient Stay &gt; 4 days</td>
<td>6.13%</td>
</tr>
</tbody>
</table>
Care Model

• All enrollees are assigned a Care Coordinator
• Unique relationship with our counties and is able to offer a comprehensive care coordination program at a local level.
• South Country utilizes county-based care coordinators to provide the overall care coordination of the enrollee’s needs.
Care Model

• Care Coordinators work within the county system where the enrollee resides.
  – Required to be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician.
  – Wealth of experience regarding service coordination and direct access to other county services, e.g. Veterans Services, Income Maintenance, etc....
Care Model

• Ensure access to and integration of all Medicare and Medicaid
  – preventive, acute, post-acute, rehabilitative, mental health, and long-term services and supports including home care (e.g. skilled nurse visits and home health aide).
  – Knowledgeable of the services available within each community beyond the limitations of the Medicaid and Medicare benefit sets.
Biggest challenges for the Care Model:

– Focus on basic needs for enrollees so they can then focus on their health care needs.

– Needing more frequent and complex medical care and coordination of care; hi-touch, face-to-face care coordination

– Needing formal in-home, community-based services and supports for personal care or physical/mental assistance plus a range of medical and informal community services.
Healthy Pathways

- Lean on county expertise to solve problems
- Development led by county partners
- Started in July 2015
- Funded through South Country’s surplus
- Early Intervention for enrollees that present with mental health symptoms
- Work with enrollee where they are at
- Build trust; advocate
<table>
<thead>
<tr>
<th>Before Healthy Pathways</th>
<th>After Healthy Pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Multiple Incarcerations</td>
<td>• Found housing in the community</td>
</tr>
<tr>
<td>• Many treatment stays for chemical use</td>
<td>• Obtaining appropriate pain management treatment</td>
</tr>
<tr>
<td>• Children in foster care</td>
<td>• Children returned to her custody</td>
</tr>
<tr>
<td>• High Utilization of Emergency Room</td>
<td>• Remains free of illegal drugs</td>
</tr>
<tr>
<td>• Involved in Drug Court</td>
<td>• Appropriately using prescribed drugs</td>
</tr>
</tbody>
</table>
Why Healthy Pathways works

Enrollee

Healthy Pathways Worker

Care Coordinator

Probation Officer

Waiver Case Manager

Primary Care Provider

Human Services Worker

Therapist

Housing Authority
Important Lessons

• Communication is critical. Need to create culture and systems to support easy exchange of information.

• Can’t rely on the typical tools – must take a tool and modify to fit the need of the population.

• Health Plan must understand the local resources beyond traditional health care services.
• Wrap in our Health Information Exchange (HIE) to connect behavioral and medical health care with the health plan.

• Exploring Integrated Care Systems Partnership in 2018 with largest behavioral health center that serves 3 out of 12 counties.
QUESTIONS???

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