

What Works in Rebalancing: The Aging Network's Role in Managed Care and Care Coordination

**Richard Browdie, MBA
Linda S. Noelker, Ph.D.**

**Benjamin Rose Institute on Aging
11900 Fairhill Road, Suite 300
Cleveland, OH 44120**

**Presented at the annual meeting of the American
Society on Aging, San Francisco, CA, April 27, 2011**

Objective 1

To further the understanding of managed care and care coordination approaches states are using to rebalance long term care by expanding HCBS

Aging Strategic Alignment Project

Cooperative Agreement: BRI & AoA (2007-2010)

On-line and phone surveys of 48 State Units on Aging (SUAs)

Purpose: to examine strategies and approaches states are using to rebalance long term care and expand home- and community-based services (HCBS)

States Have HCBS Program(s) Run by Managed Care Health Plans

- Arizona
- California
- Florida
- Idaho
- Maryland
- Massachusetts
- Minnesota
- Missouri
- New Mexico
- New York
- Rhode Island
- Texas
- Virginia
- Washington
- Wisconsin

Arizona

- “The Medicaid program is a managed care model—Arizona Long Term Care System (ALTCS)”
- First state to implement a capitated mandatory managed care program for individuals who require acute and Medicaid long-term care services and are at risk of institutionalization
- Does not cover Medicare payments for Medicare-covered services used by dually eligible beneficiaries
 - Their services are not coordinated

Arizona (continued)

- Coordinated and managed by a network of eight program contractors
- 1115 Demonstration Waiver:
 - “Since 1989, [this has been] a managed care program that incorporates acute, behavioral health, institutional, in-home and alternative residential settings. It serves people with DD (intellectual disabilities), physically disabled and elderly. It is all-inclusive.”

Minnesota

- “Minnesota’s Elderly Waiver is now administered through managed care health plans.”
 - Elderly Waiver (Medicaid)
 - “[Waiver participants] use managed care more frequently than those on disability waivers.”
 - “Managed care organizations case manage acute care for their clients.”
 - “Counties, tribes, managed care organizations are all lead agencies that perform functional assessments to determine eligibility...”
- Minnesota Senior Care Plus (CMS-funded)
 - “...it’s a managed care waiver...it’s a Medicaid assistance managed care product.”

Minnesota (continued)

- Minnesota Senior Health Options (CMS-funded)
 - “MSHO is a managed care program that...coordinates health care as well as social service needs.”
 - “Combines Medicare, Medicaid and waiver funding for functionally eligible clients; managed by eight managed care organizations throughout the state...available in all but four counties.”
 - “Acute care coordination/case management is done by the managed care organizations. Case management of waiver services ... is sometimes contracted by managed care organizations for waiver clients.”
 - “Clients who are functionally eligible can receive waiver services through MSHO as part of their care managed service package. County staff are frequently sub-contracted by managed care organizations to perform the case management for this portion of the service package...”

New Mexico

- Coordination of Long Term Services (CoLTS) is currently being implemented under a 1915(b)/(c) combination
- Includes HCBS for older adults and people with disabilities (includes brain injury but not DD)
- Intended to manage long-term services and acute care services for certain Medicaid populations:
 - Adults receiving personal care options benefits
 - Individuals receiving Disabled and Elderly Waiver services
- Coordinates Medicaid and Medicare benefits for dually eligible participants

New Mexico (continued)

- Coordinated between the New Mexico Human Services Department/Medical Assistance Division and the New Mexico Aging and Long-Term Services Department/Elderly and Disability Services Division
- As of June 30, 2009, approximately 38,000 individuals were expected to have been transitioned into the CoLTS program
- “Everybody is being moved into managed care.”

New York

- State has Medicaid managed care
- Monroe County Long Term Care Council
 - Plan: Provide single point of entry into long-term care, coordinate services through data sharing across 50 agencies, and prevent unnecessary hospital care
 - Alternate Level of Care Study
<http://www.monroecounty.gov/Image/Monroe%20County%20Alternate%20Care%20Study.pdf>
 - Key recommendation: Link all hospital ER and SW depts. with LTC providers using PeerPlace, in cooperation with Regional Health Information Organization (RHIO) in Rochester

Virginia

- Acute and Long-Term Care Integration (ALTC Phase I):
- As of September 1, 2007, individuals who are enrolled in Medicaid managed care prior to becoming eligible for HCBS are allowed to stay in their managed care organization (MCO) for their primary and acute care services and receive their long-term care services through fee-for-service.

Wisconsin

- “So far the care managed programs are non-profit.”
- Family Care/Family Care Partnerships (Medicaid waiver)
 - “In counties that have moved to managed care, Family Care is the primary program model under which HCBS are becoming an entitlement.
 - These counties no longer have waiver programs.
 - Under Family Care, all waiver and state plan HCBS are managed.
 - Under Family Care Partnership, all health care (including Medicare for dual-eligibles) and HCBS are managed.”

Wisconsin (continued)

- Money Follows the Person
 - Managed care organizations use an inter-disciplinary team (consumer, social worker, nurse, others at consumer request)
- Community Options Program (state-funded)
 - For counties transitioning to managed care, this will only be available to individuals who do not have nursing home level of care needs
 - It will no longer be available for older adults with too much income for Medicaid

Objective 2

To discuss how SUAs and AAAs can strengthen their roles in the expansion of HCBS under the Patient Protection and Affordable Care Act; learn about and apply care transition and coordination models

Impact of Patient Protection & Affordable Care Act on Chronic Care Coordination

- Articulated goal: achieving better **care coordination** for persons with multiple chronic conditions
- Includes strategies to better align Medicare and Medicaid policies for duals
- Enhance linkages between health care and Long Term Services & Supports (LTSS)
- Improve provision of primary care to those with multiple chronic conditions
- Smooth transitions from one care setting to another

Federal Coordinated Health Care Office

- New office within CMS
- Charged with broad agenda to improve coordination between Medicare and Medicaid programs on behalf of duals
- Eight statutory goals range from a beneficiary focus on improving quality of health care, care transitions, and LTC services to administrative focus on eliminating regulatory conflicts between Medicare & Medicaid programs

Federal Coordinated Health Care Office

Some examples of Office's responsibilities:

- Provide tools to better align Medicare and Medicaid benefits to SNPs, MDs, states and other entities
- Support states efforts to **coordinate health care and LTSS for duals**
- Provide support for coordination of contracting and oversight by states and CMS related to integration of Medicare and Medicaid programs
- Required: annual report to Congress by Secretary on recommendations for legislation to improve **care coordination** and benefits for duals

Medicare Special Needs Plans

BACKGROUND

- January 2009: 697 SNPs; 405 designated as dual eligible plans
- Not all of the 405 plans have contracts with Medicaid agencies
- Those that do have wide variations in scope of benefits

Medicare Special Needs Plans

Under PPACA:

- SNPs are reauthorized through December 2013
- Maintains current moratorium on geographic expansion of SNPs for duals that do not have Medicaid contracts through December 2012
- Authorizes new risk adjustment and enforces enrollment criteria that better align SNP plans with members' characteristics
- By 2012 SNPs are required to be approved by the National Committee for Quality Assurance

Medical (Health) Homes

- Federal grant program to establish interdisciplinary community health teams that support patient-centered medical homes (enhanced model of primary care)
- Teams must contract with primary care providers to deliver LTSS
- January 2011 States can opt to amend their Medicaid state plans to fund medical home services including **care coordination**, transitional care, health promotion and others

Medical (Health) Homes

- State-wide and comparability requirements can be waived
- States will receive an enhanced FMAP of 90% for medical home services expenditures during the first two years

Medical (Health) Homes

- Eligibility requirements are at least two chronic conditions or one condition and at risk for another or have a serious and persistent mental health condition
- Hospitals in state Medicaid program required to refer patients seen in ER who meet criteria to a medical home
- Hospitals required to track avoidable readmissions and calculate savings from referral to medical home for improved **care coordination**

Independence at Home Demonstration Program

- Purpose: test the use of independence at home medical practices (primary care teams of MDs, nurse practitioners and others)
- Teams deliver care to high need populations at home and **coordinate care** across all treatment settings
- Eligibility criteria: Medicare beneficiaries with two or more chronic conditions; had a non-elective hospitalization in past 12 months; received rehab services in a SNF or received skilled home care services; have two or more ADL limitations

Community Based Care Transitions Program

- New Medicare demonstration (2011-2016): to provide transition services at competitively selected locations to beneficiaries at high risk of re-hospitalization or substandard transition to post-acute care
- Community-based organizations together with hospitals that have high readmission rates can apply to CMS for funding to provide expansive transition supports that exceed hospital discharge planning

Accountable Care Organizations (ACOs)

- Medicare Shared Saving Program established
- Purpose: to provide ACOs with financial incentives to reduce growth of Medicare expenditures and improve health outcomes
- ACOs: groups of MDs, other providers, and suppliers that have legal relationships to distribute any financial incentive payments awarded under program
- ACOs: accountable for quality, cost, and care of Medicare fee-for-service beneficiaries

Accountable Care Organizations (ACOs)

- Responsibilities: include enough PCPs to serve assigned Medicare beneficiaries, define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and **coordinate care**.
- Shared savings payments awarded for meeting quality standards based on measured changes in Medicare expenditures in relation to performance target model; a partial capitation model; or any other approach to performance payment development by the Secretary

Implementing Care Coordination for Dual Eligibles

Care Coordination

Definition:

- Person-centered, assessment-based, interdisciplinary approach
- Integrates health care and social support services in a cost-effective manner
- Incorporates individual's preferences
- Provides a comprehensive care plan
- Has a designated lead care coordinator
- Services are monitored by an evidence-based process

Basic Components of Care Coordination

1. Targeting those at risk of hospitalization and Nursing Facility Care
2. In-person contacts
3. Timely info on hospital and ER use
4. Close tie between Care Coordinators and PCPs

Basic Components of Care Coordination

5. Key services: assessment, care planning, education, monitoring, and coaching clients on self management along with social supports (e.g., transport, ADL assistance)
6. Staffing: care coordinator qualifications vary widely by state; interdisciplinary teams with designated member for care coordination vital and nurse/social worker pairs have shown success

Thank you!

For information on Benjamin Rose Aging Policy Projects and Reports go to:

www.benrose.org → Policy → Projects & Reports
Aging Strategic Alignment Project
Strengthening the Direct Care Workforce for
Long Term Services and Supports

For more information or questions contact:

Rich Browdie rbrowdie@benrose.org

Linda Noelker ln Noelker@benrose.org