



## **National Trends in Integrated Care Delivery**

**Presented To:**

**Vermont Department of Disabilities, Aging and Independent Living**

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**August 14, 2007**

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# Topics

- ◆ National and State trends
- ◆ Medicare Special Needs Plans (SNP) and PACE Updates
- ◆ Measuring National Progress Towards Rebalancing
- ◆ National Picture of Dual Eligibles and Unmet Needs
- ◆ Integrated State Models and What Works
- ◆ Understanding the Target Population/Need in Vermont
- ◆ Considerations for Business Planning

# National and State Trends

# Federal Legislation

## Rebalancing LTC in DEFRA 2005

- ◆ Long-term care partnership
  - New opportunities for states to participate
- ◆ Money-follows-the-person demonstration
  - Competitive grant program to transition people from institutions to the community
- ◆ Home- and community-based services (HCBS)
  - New options to provide HCBS without waiver
- ◆ Cash and counseling
  - New option to permit consumer direction without waiver

## States in Action

- ◆ Despite great interest in managed long-term care (LTC) among states, enrollment has grown slowly
- ◆ There is now a resurgence of interest among states:
  - Managed care as a means to manage costs and improve outcomes
  - LTC insurance
  - System transformation and rebalancing LTC
  - Consumer direction overriding
  - States are pursuing new opportunities created by Medicare Special Needs Plans (SNP)

## Coming Soon...A New Medicaid

### *Old Medicaid:*

- ◆ Institutionally based benefit/entitlement
- ◆ Provider-centered and provider-driven
- ◆ Federally defined benefit based upon legal obligations
- ◆ No budget caps
- ◆ Mandates to states
- ◆ Open delivery system

### *New Medicaid:*

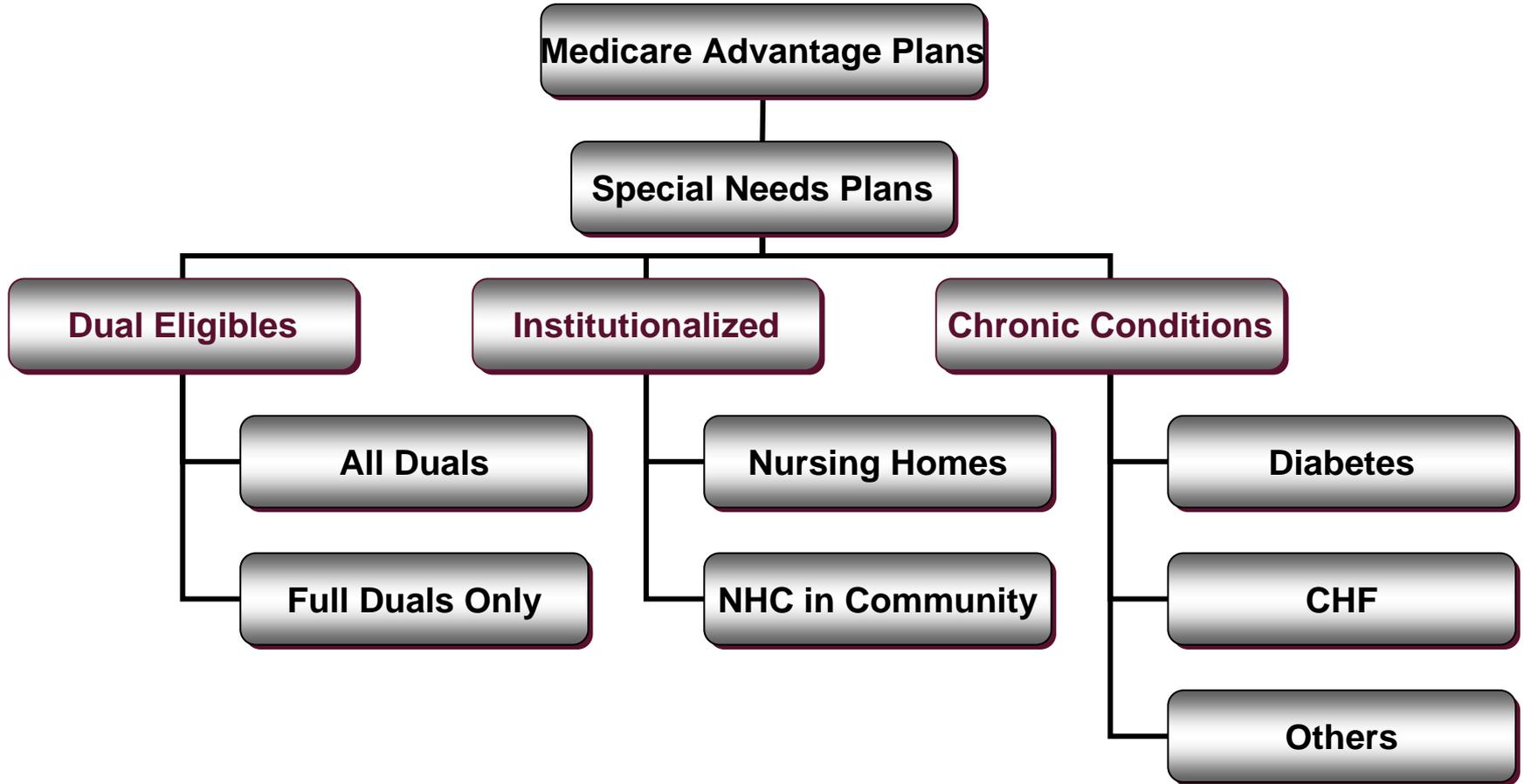
- ◆ Continuum-based benefit/support
- ◆ Person-centered and consumer controlled
- ◆ State controlled benefit with fewer federal requirements
- ◆ Cost certainty/budget caps
- ◆ State flexibility
- ◆ Managed care system

# Vermont is Leading the Way to the New Medicaid

- ◆ PACE
- ◆ Global commitment waiver (1115 Waiver)
- ◆ MyCare Vermont (Real Systems Choice Grant)
- ◆ Choices for Care (1115 Waiver)
- ◆ Attended Services Program
- ◆ Consumer directed models of care
- ◆ Adult Resource and Disability Centers

# Medicare Special Needs Plans and PACE Updates

# Types of Medicare SNPs



# Medicare SNP Enrollment as of June 2007

<b>SNP Type</b>	<b>Number of Contracts</b>	<b>Number of Plans</b>	<b>Sub-total Enrollment</b>
Chronic or Disabling Condition	43	73	93,346
Dual-Eligible	205	321	670,499
Institutional	65	84	143,012
<b>Totals</b>	<b>313</b>	<b>478</b>	<b>906,857</b>

Source: CMS Health Plan Management System, May 2007

# Medicare SNP Updates

- ◆ CHAMP ACT of 2007 (House)
  - Reduce Medicare Advantage (MA) rates from county levels to FFS, resulting in substantial MA rate reductions
  - Dual Eligible and Institutional SNPs will be extended through 2011
  - By 2011, plans would be required to have state capitated contracts
  - Bill still needs to be reconciled between the House and Senate
- ◆ Future MA rate reduction is concern for Medicare SNPs

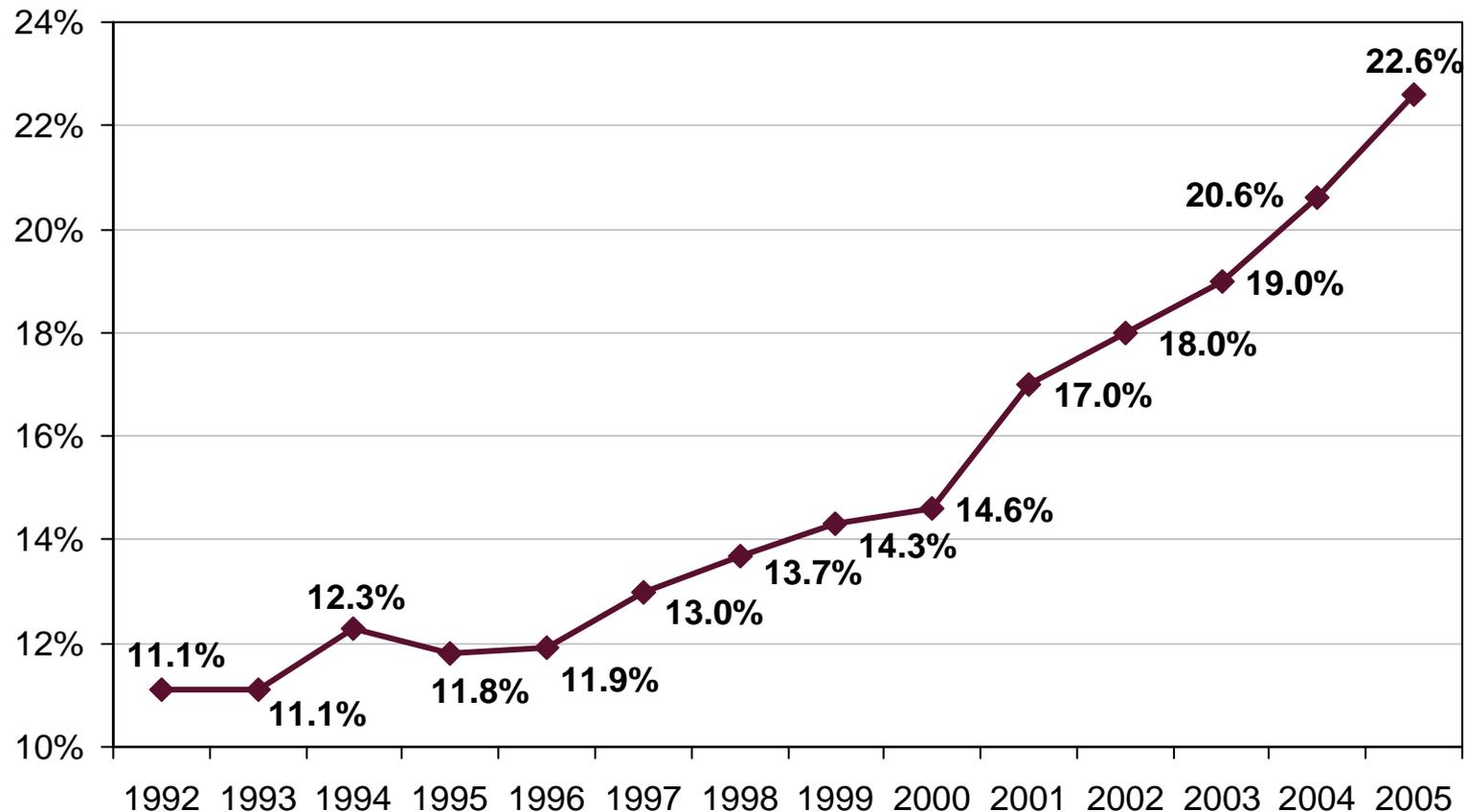
## PACE Updates

- ◆ CHAMP Act of 2007 exempts PACE organizations from MA payment reductions between 2009-2011 which would result from reducing county rates to FFS levels
  - Bill still needs to be reconciled between the House and Senate
  - Rate reductions would negatively impact all PACE providers, particularly rural start-up programs with less ability to absorb rate reductions
- ◆ All 15 Rural PACE federal grantees are moving towards receiving grant funding
- ◆ Vermont is the first operational rural PACE site

# Measuring Progress Towards Rebalancing LTC Across the Nation

# Medicaid LTC Devoted to HCBS for Aged and Disabled Grew Significantly Since 2000

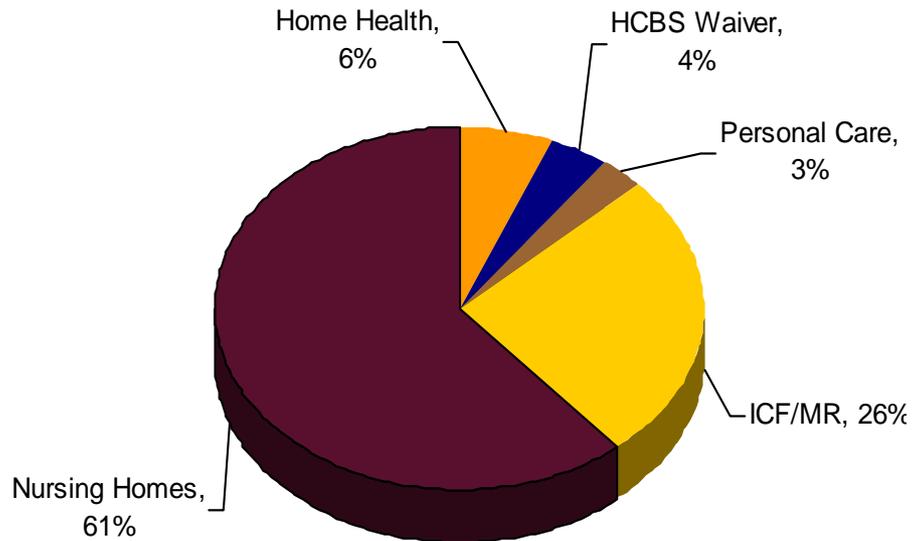
## Proportion of Medicaid LTC Spending for HCBS Among Aged and Disabled



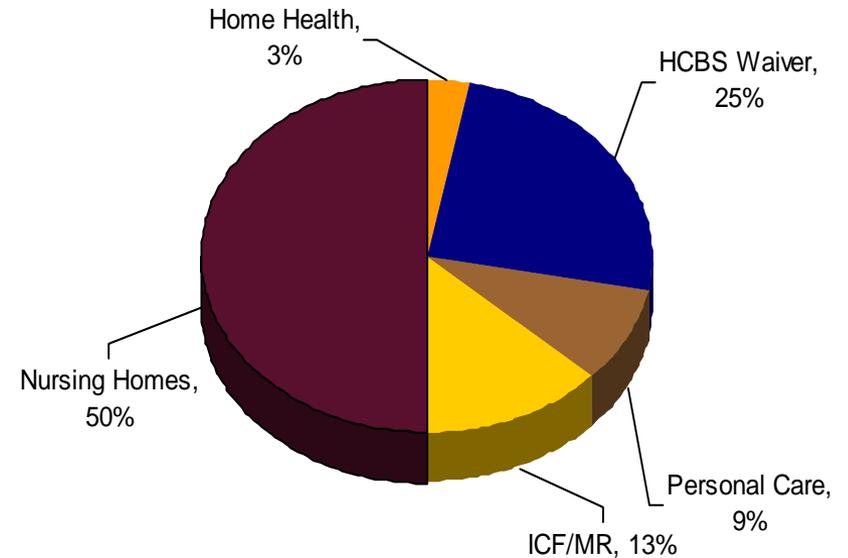
Source: 2005 MedStat LTC Data, Lewin Analysis. Long-term care includes nursing facility, state plan personal care and home- and community-based waivers for the aged and disabled.

# Decline in Medicaid Spending for Nursing Facility Care

**1993**

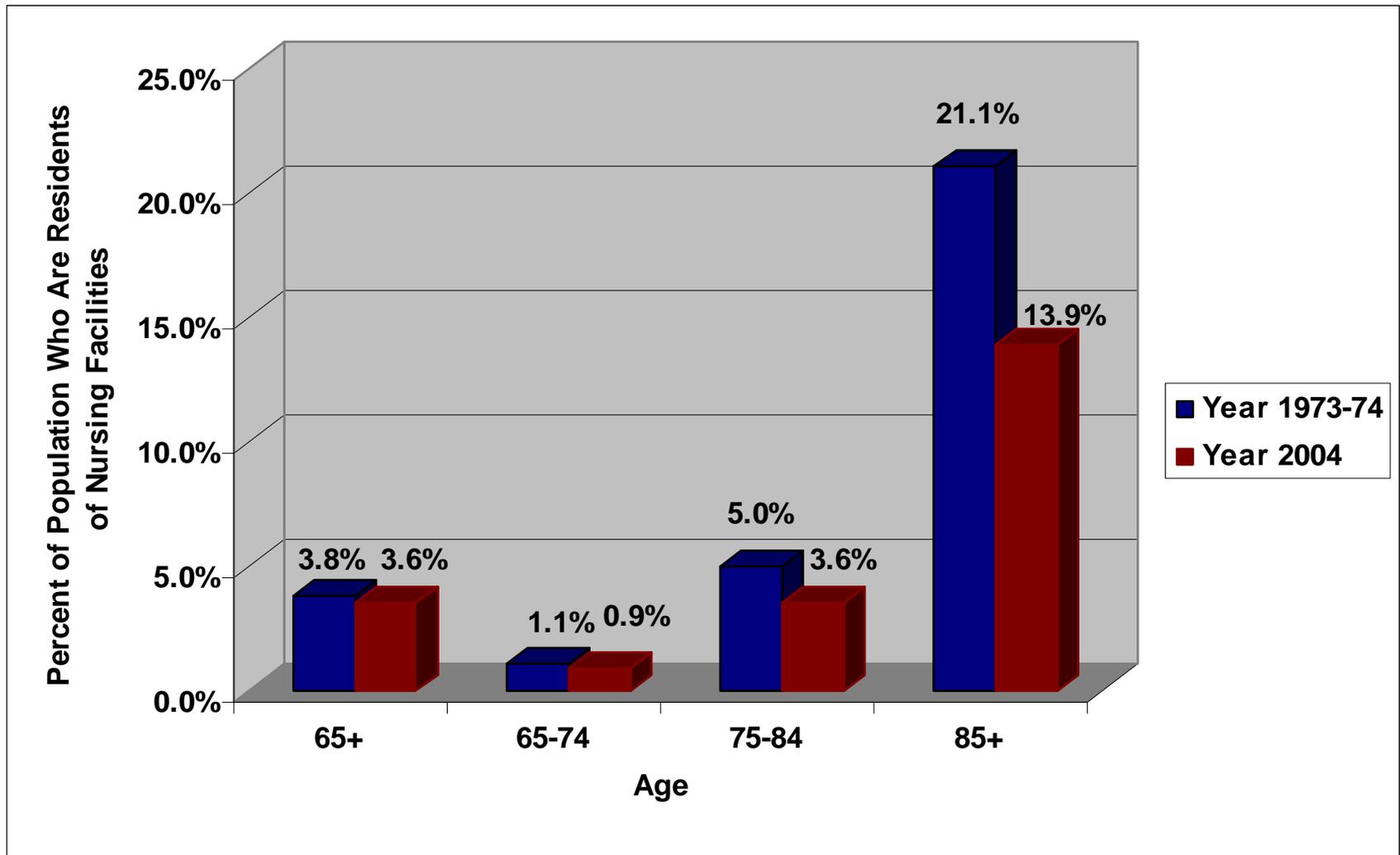


**2005**



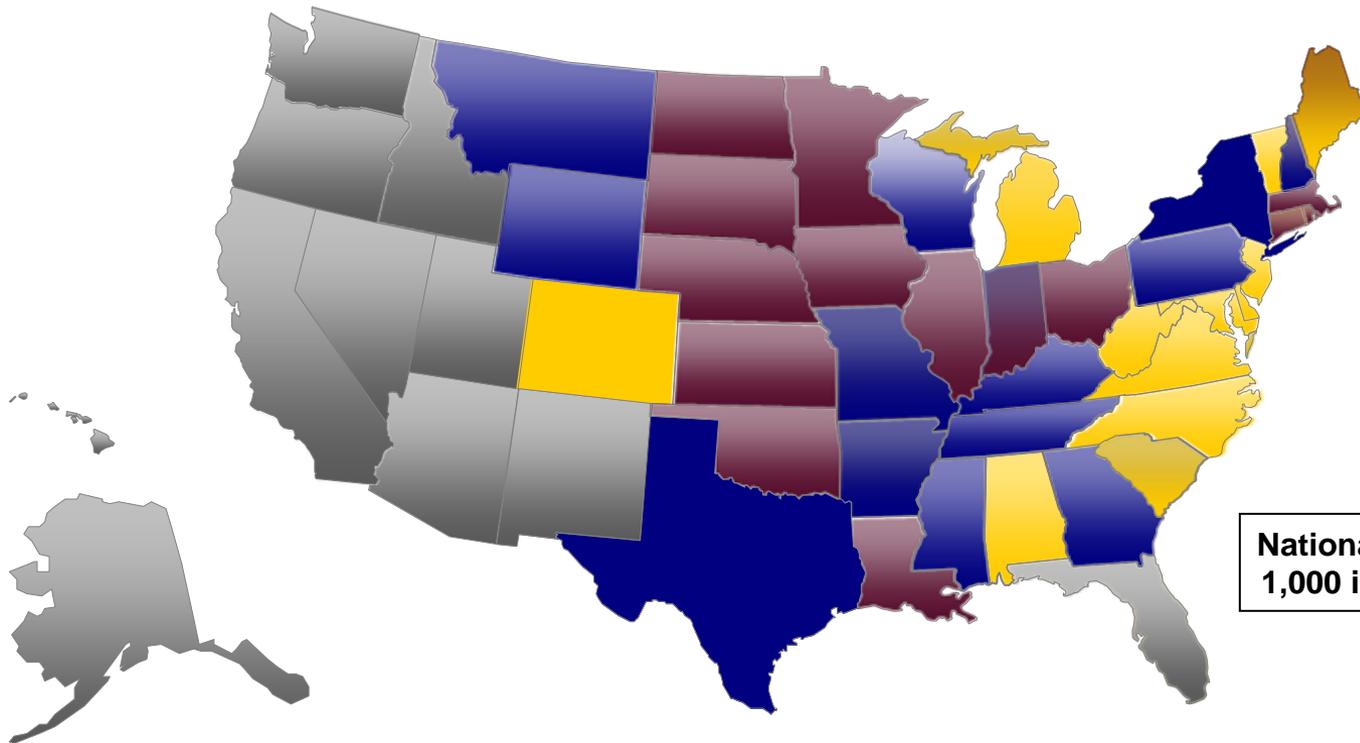
Source: Avalere analysis using MEDSTAT Group data.

# Percent of Population Who Are Residents of Nursing Facilities



Source: *A Progress Report on Shifting the Balance in the United States*. The Lewin Group, March 6, 2007

# Nursing Facility Residents Per 1,000 Individuals Age 65+ in 2005



**National Average = 40 per  
1,000 individuals age 65+**

**14 – 30 res. Per 1,000**

Alaska  
Arizona  
California  
Florida  
Hawaii  
Idaho  
Oregon  
Nevada  
New Mexico  
Utah  
Washington

**31 – 40 res. Per 1,000**

Alabama  
Colorado  
Delaware  
Maine  
Maryland  
Michigan  
New Jersey  
North Carolina  
South Carolina  
Texas  
Vermont  
Virginia  
West Virginia

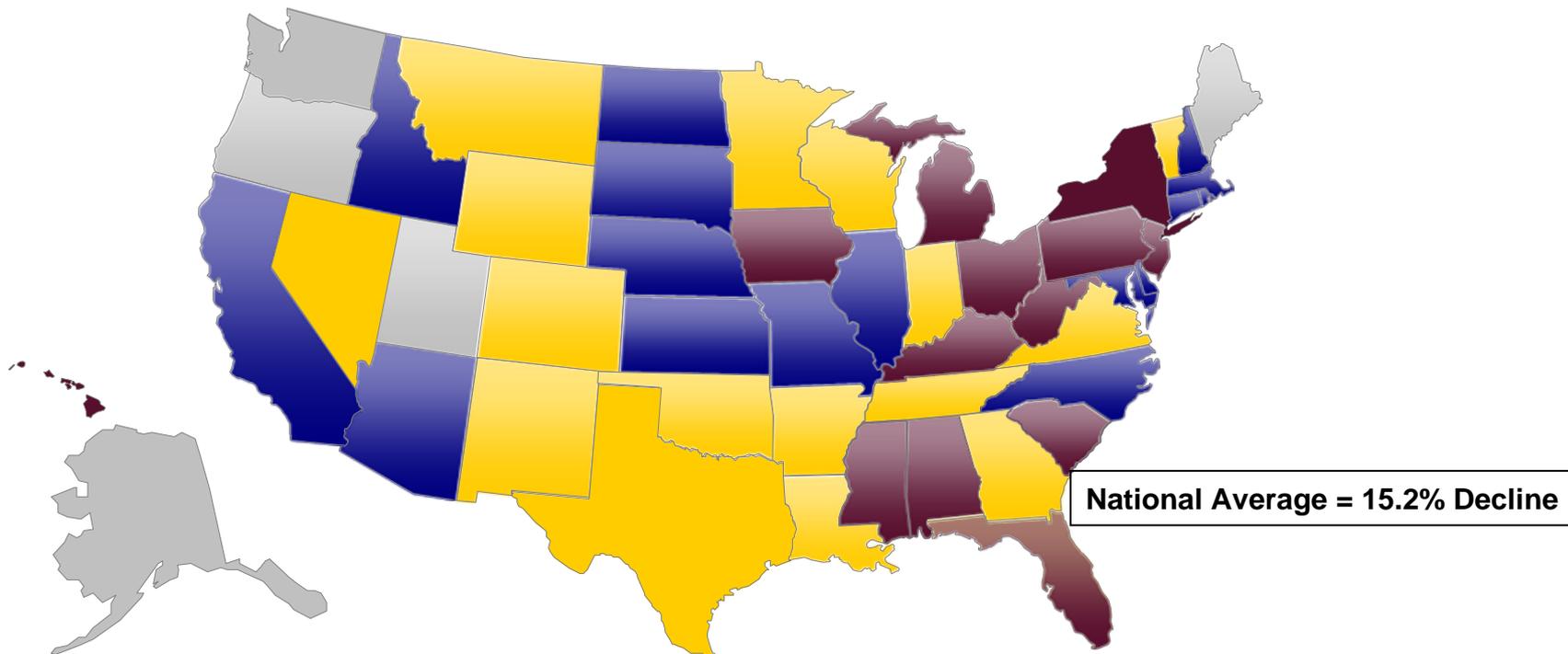
**41 – 49 res. Per 1,000**

Arkansas  
District of  
Columbia  
Georgia  
Kentucky  
Mississippi  
Missouri  
Montana  
New Hampshire  
New York  
Oklahoma  
Pennsylvania  
Tennessee  
Wisconsin  
Wyoming

**52 – 65 res. Per 1,000**

Connecticut  
Illinois  
Indiana  
Iowa  
Kansas  
Louisiana  
Massachusetts  
Minnesota  
Nebraska  
North Dakota  
Ohio  
Rhode Island  
South Dakota

# Change in Per Capita Medicaid Nursing Facility Residents (1995-2005)



National Average = 15.2% Decline

**30% or More Decline**

- Alaska
- Maine
- Oregon
- Washington
- Utah

**20% to 30% Decline**

- Arkansas
- Colorado
- Georgia
- Indiana
- Louisiana
- Minnesota
- Montana
- Nevada
- New Mexico
- Oklahoma
- Tennessee
- Texas
- Vermont
- Virginia
- Wisconsin
- Wyoming

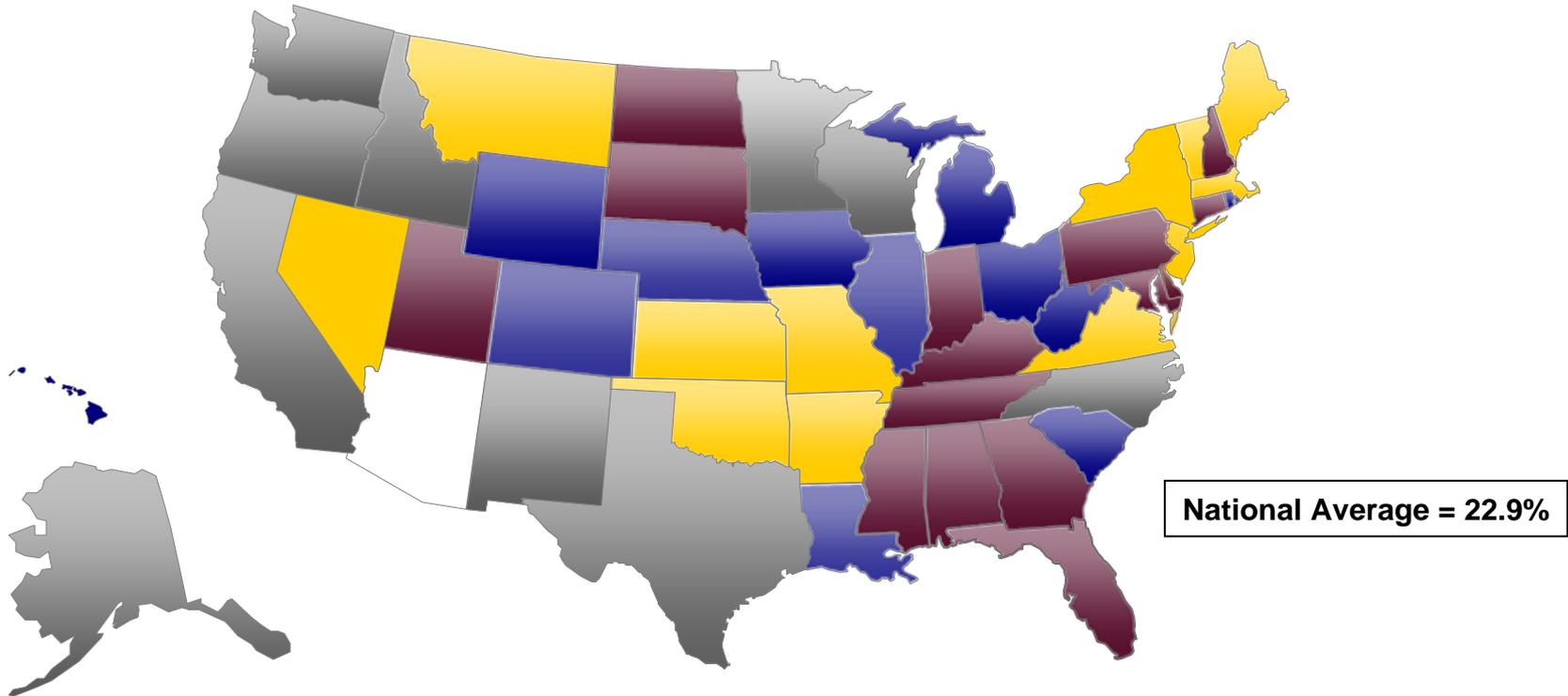
**10% to 20% Decline**

- Arizona
- California
- Connecticut
- Delaware
- Idaho
- Illinois
- Kansas
- Maryland
- Massachusetts
- Missouri
- Nebraska
- New Hampshire
- North Carolina
- North Dakota
- Rhode Island
- South Dakota

**Less than 10% Decline**

- Alabama
- District of Columbia
- Florida
- Hawaii
- Iowa
- Kentucky
- Michigan
- Mississippi
- New Jersey
- New York
- Ohio
- Pennsylvania
- South Carolina
- West Virginia

# Percent HCBS of Medicaid LTC Among Aged/Disabled (2005)



National Average = 22.9%

**HCBS 35 – 54%**

- Alaska
- California
- Idaho
- Minnesota
- New Mexico
- North Carolina
- Oregon
- Texas
- Washington
- Wisconsin

**HCBS 20 – 32%\***

- Arkansas
- Maine
- Missouri
- Nevada
- New York
- Vermont
- Kansas
- Massachusetts
- Montana
- New Jersey
- Oklahoma
- Virginia

**HCBS 10 – 19%**

- Arkansas
- District of Columbia
- Georgia
- Kentucky
- Mississippi
- Missouri
- Montana
- New Hampshire
- New York
- Oklahoma
- Pennsylvania
- Tennessee
- Wisconsin
- Wyoming

**HCBS <10%**

- Connecticut
- Illinois
- Indiana
- Iowa
- Kansas
- Louisiana
- Massachusetts
- Minnesota
- Nebraska
- North Dakota
- Ohio
- Rhode Island
- South Dakota

## Managed Long-term Care Enrollment

- ◆ Managed long-term care enrollment remains small relative to the significant need and costs
- ◆ In 2004, less than 3 percent of persons received their long-term care through a managed care program
- ◆ PACE has a total current enrollment of about 14,000
- ◆ More substantial growth possible with Medicare SNP/Medicaid integration

# Fully Integrated Programs Operational Today

- ◆ PACE is the only fully integrated Medicaid and Medicare program combining all benefits
- ◆ Several states have been leading the way towards Medicare and Medicaid integration, but these projects are all demonstration projects:
  - Wisconsin (partnership), includes both senior and disabled populations
  - Massachusetts (SCO), seniors only
  - Minnesota (MSHO and MnDHO), includes both senior and disabled populations

# Medicaid Only Managed Care Programs

- ◆ Existing Medicaid managed long-term care:
  - Washington (MMIP Integration)
  - Texas (Texas Star)
  - Arizona (AHCCCS) is statewide
  - New York Managed Long-Term Care Plans
  - Florida Diversion and Frail Elder Project
- ◆ Other states considering or developing Medicaid managed long-term care programs:
  - Hawaii, California, Washington, Maryland

# New Medicare Demonstration Projects

- ◆ Medicare demonstration projects:
  - Evercare, which became the basis for the current SNP program
  - Social HMOs, which still operates as a demonstration
- ◆ New Medicare demonstration projects:
  - Medicare Advantage Program sponsored by Erickson, a Continuing Care Retirement Community, operates in multiple states
  - Erickson already has primary care physicians, nurse practitioners, physician assistants, outpatient rehabilitation, home health, home health support, and consulting physicians at each location
  - United HealthCare and Erickson share risk



# Creating Integrated Care Through Medicare SNPs

- ◆ Medicaid managed care plans serving dual eligibles may develop SNPs and provide all Medicare- and Medicaid-covered services
- ◆ States are using this approach to create integrated managed care plans that can serve larger numbers of dual eligible/disabled populations
- ◆ In the future, a degree of integration between Medicaid managed care plans and Medicare SNPs may be required for Medicare SNPs
- ◆ States such as Virginia are considering PACE expansion and Medicare SNP/Medicaid managed care integration simultaneously

# National Picture of Dual Eligibles and Their Unmet Needs for Long-term Care

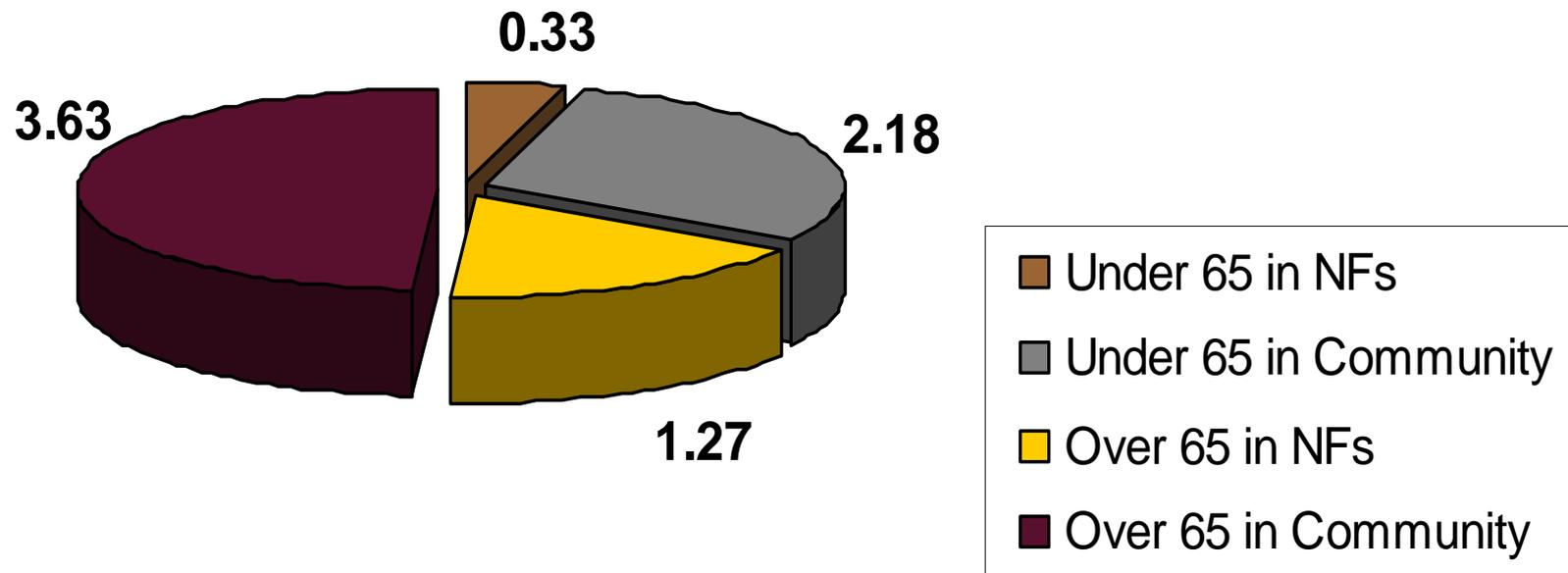
## Dual Eligibles Overview

- ◆ Dual eligibles are a diverse group, of all ages, with chronic needs residing in the community and in institutions
- ◆ The following tables show the dual eligible population by age, chronic conditions, and health care utilization
- ◆ These data reveal the different care needs of each type of SNP plan/target SNP population
- ◆ Most PACE programs have not cared for the under-55 disabled population living in the community or in nursing homes who incur the highest health care utilization

# Dual Eligibles in the Nation

In 2003, there were 7.4 million dual eligibles in the nation

## Total Dual Population (Millions)

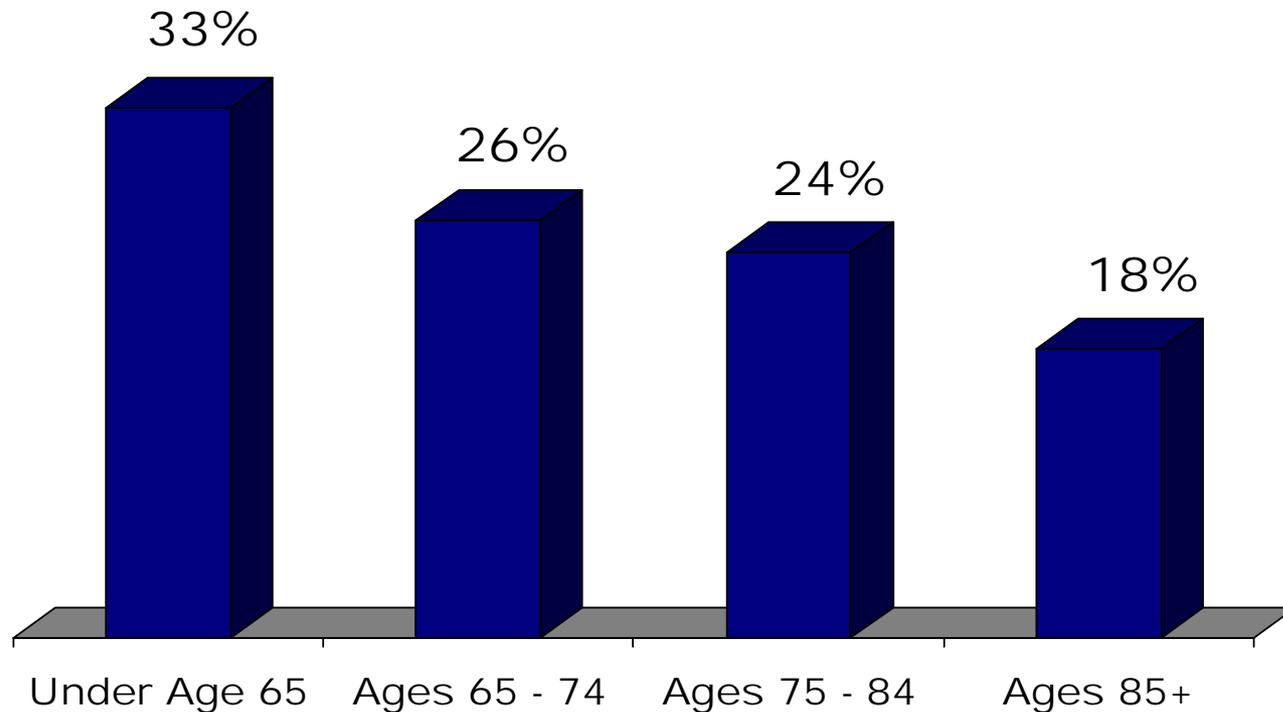


Source: Kaiser Foundation

## Dual Eligibles Age Diversity

Medicare SNPs must enroll any dual eligible individual regardless of age

Age Distribution of Dual Eligibles - 1999



Source: Kaiser Foundation

# Dual Eligibles Suffer From Multiple Chronic Conditions

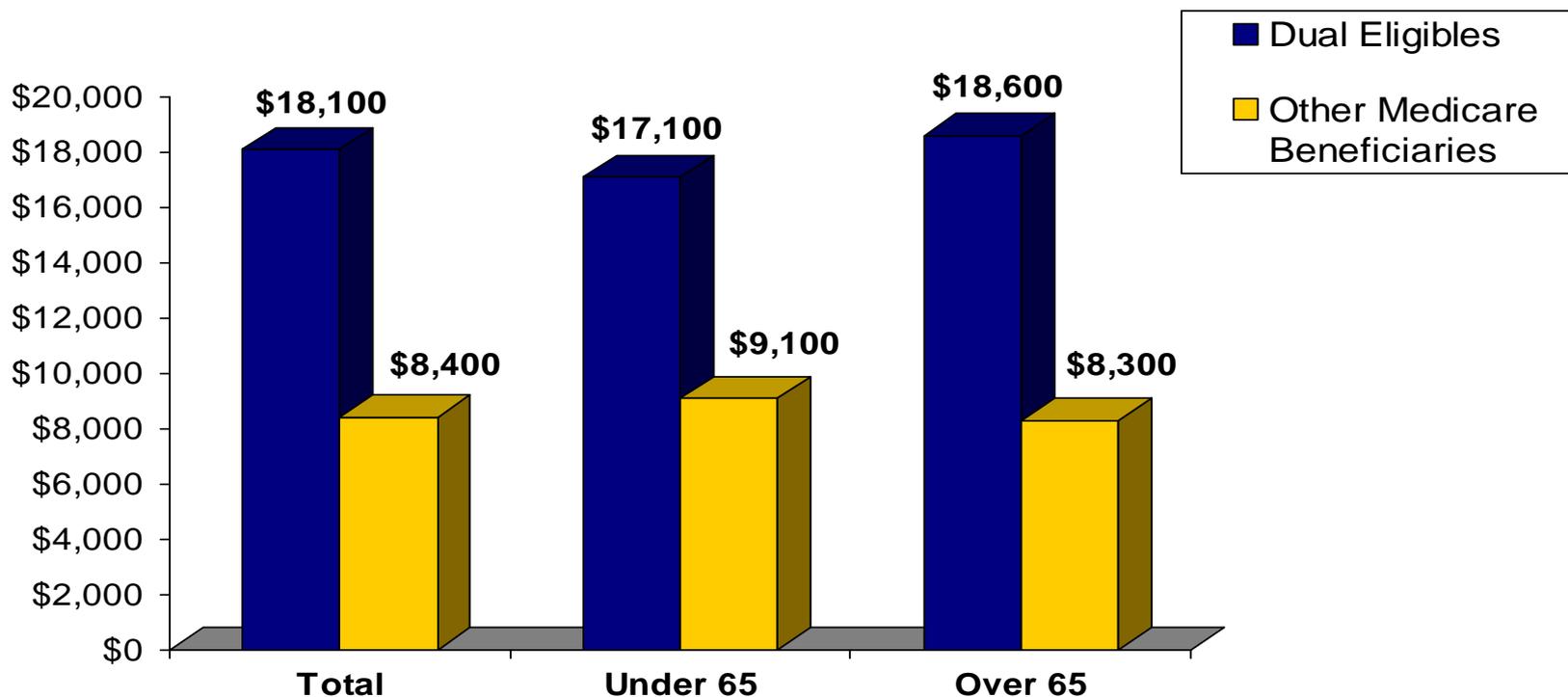
## Prevalence of Chronic Conditions Among Dual Eligibles 2000

<b>Condition</b>	<b>Under Age 65</b>	<b>Over Age 65</b>
Hypertension	63%	46%
Heart Disease	45%	63%
Stroke	11%	16%
Diabetes	20%	25%
Arthritis	44%	60%
Pulmonary Disease	23%	18%
Mental Disorders	59%	12%

*Source: Kaiser Foundation*

# Dual Eligibles Per Capita Total Health Care Expenditures

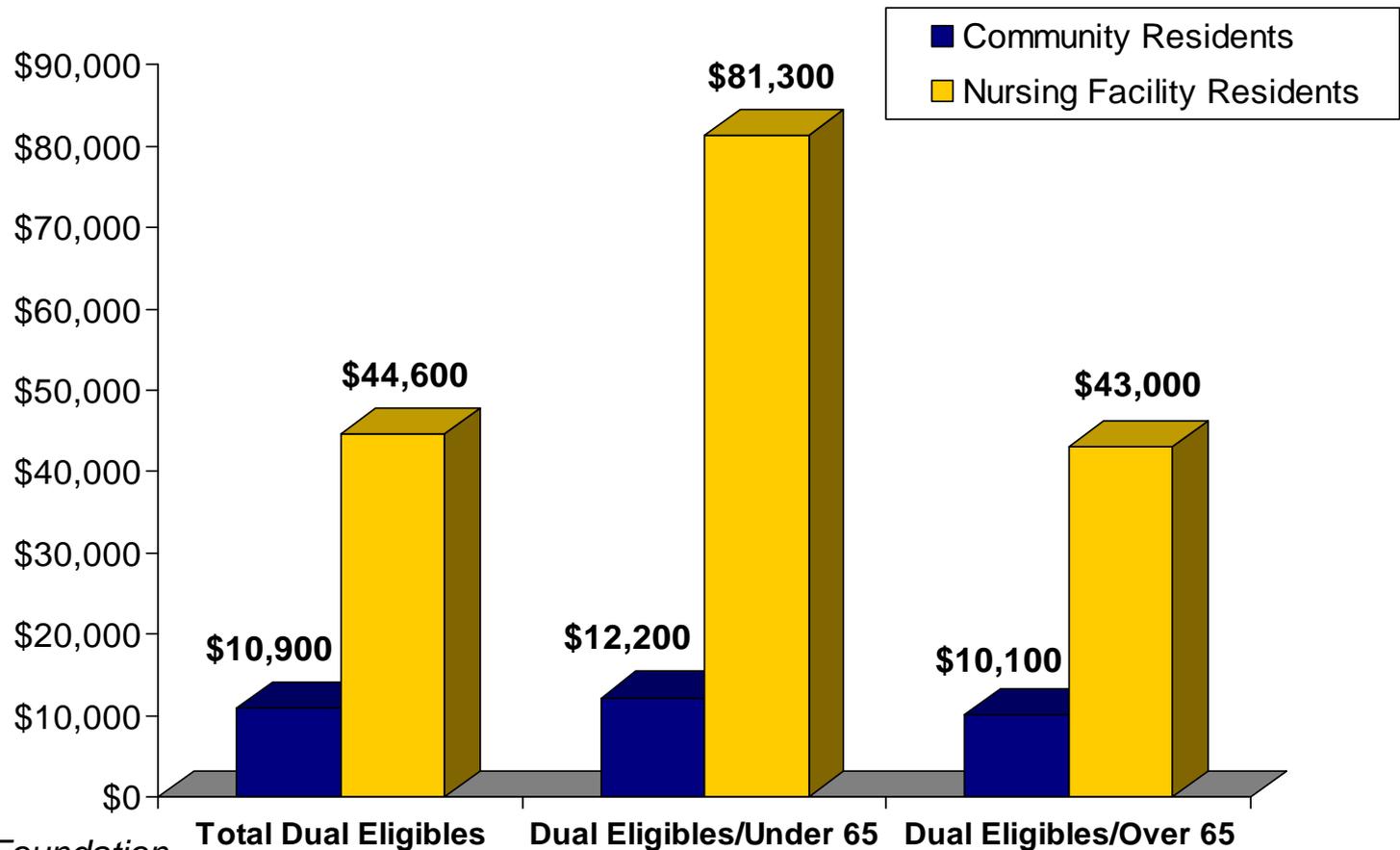
Dual Eligibles have substantially higher average per capita total health care expenditures as compared to other Medicare beneficiaries



Source: Kaiser Foundation

# Dual Eligibles Average Per Capita Total Health Care Expenditures

Average per capita total health care expenditures for dual eligibles vary greatly by age and residence



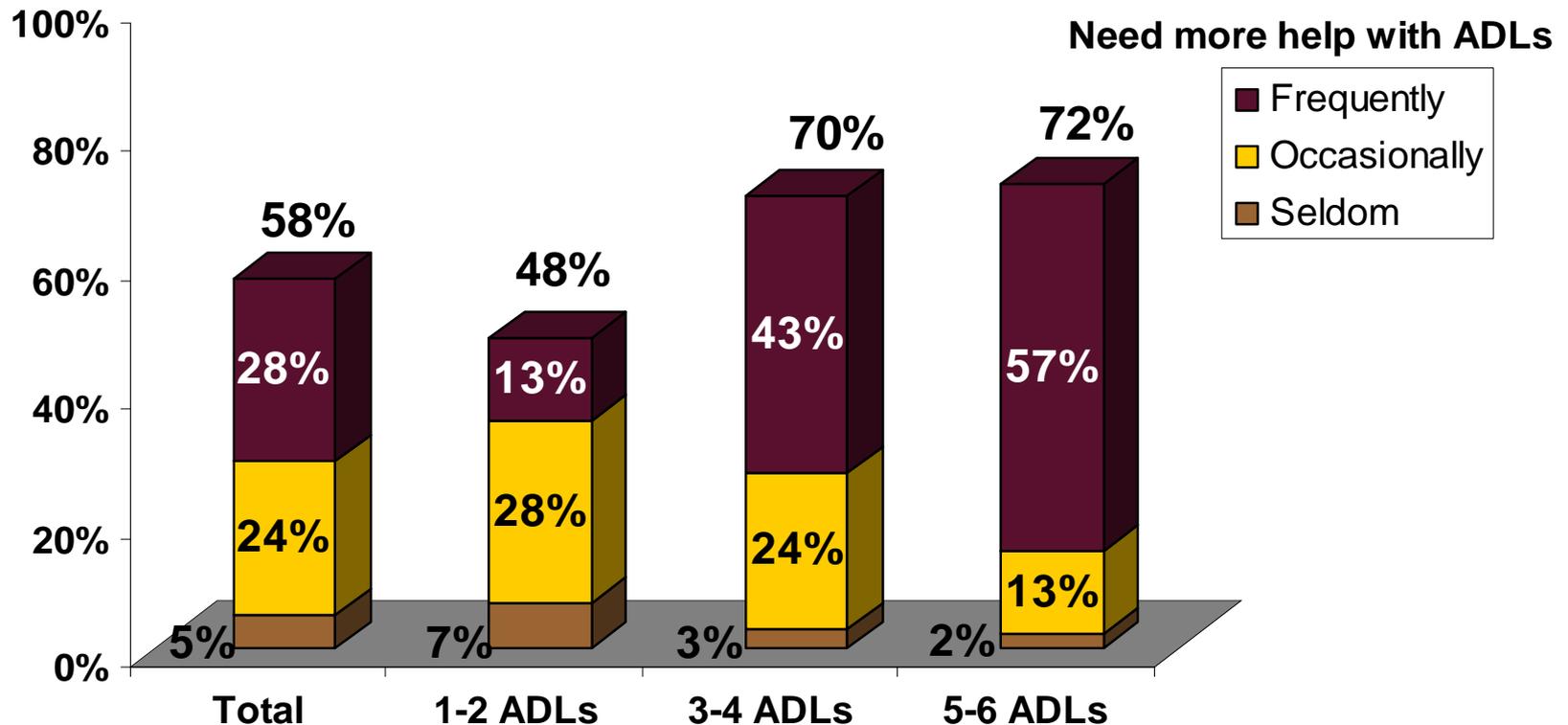
Source: Kaiser Foundation

# Unmet Long-term Care Needs of Dual Eligibles

- ◆ The unmet long-term care needs of dual eligibles are well documented
- ◆ Most community-based dual eligibles with long-term care needs are women; live alone or with people other than a spouse; and are in poor or fair health
- ◆ 40 percent are age 80 and older, and a similar percent live alone
- ◆ Two-thirds are in poor or fair health, and more than half used the hospital in the past year
- ◆ The vast majority of dual eligibles are able to get medical care. Those that require assistance with basic care often have their needs unmet, and their quality of life and health is placed at risk

# Unmet Long-term Care Needs of Dual Eligibles

Unmet need is more likely among people with greater levels of disability. More than half of community-based, elderly dual eligibles who need assistance with ADLs report unmet needs



# State Integrated Care Models Common Features and What Works

# State Integrated Care Models

	Minnesota Senior Health Options	Minnesota Disability Health Options	Wisconsin Partnership Plan	Massachusetts Senior Care Organization
Contracting Health Plans	Large non-profits	Large non-profit	Small, specialized non-profits	Small and large for-profits and non-profit
Target Market	<ul style="list-style-type: none"> <li>◆ Community residents (NHC and non-NHC)</li> <li>◆ Nursing home residents</li> </ul>	Community residents (NHC only)	Community residents (NHC only)	Community residents (NHC and non-NHC)
Age Groups Served	65+	Under 65	Under and over 65	65+
Care Coordination Model	Nurse or social worker care coordinator	Nurse-social worker team	Multidisciplinary team	Nurse-social worker team

Source: Brandeis University, March 2007

# Minnesota Senior Health Options: Program Features

- ◆ Minnesota Senior Health Options (MSHO) program was implemented in 1997 and is now statewide
- ◆ Open to all dual eligibles and Medicaid-only seniors as an alternative to Medicaid-only managed care plan
- ◆ Large nonprofit health plans contract with a variety of *care systems* for service delivery
- ◆ Service integration is through a care manager who is either a nurse or social worker
- ◆ The state handles all enrollment, grievances, and review of marketing material for both Medicare and Medicaid
- ◆ Single contract between the state and MSHO for Medicare and Medicaid

# Minnesota Disability Health Options Plan: Program Features

- ◆ MnDHO was implemented in 2001
- ◆ One of the MSHO health plans also offers a MnDHO program for adult disabled beneficiaries
- ◆ Service integration occurs through the use of a nurse/social worker team
- ◆ *More detailed description of disability programs will occur in the presentation by Lisa Edstrom*

# Wisconsin Partnership Program: Program Features

- ◆ Open only to community residents who are NHC and who reside in participating counties
- ◆ Four small, nonprofit, specialized health plans contract with individual providers for services
- ◆ Integration occurs through interdisciplinary teams, including a nurse practitioner who works closely with physicians
- ◆ Two of the plans enrolls only elders, one enrolls only adult disabled, and one enrolls both. One of the plans also operates a PACE program

## Wisconsin Partnership Program

- ◆ Partnership model was not used as the basis for comprehensive redesign of the long-term care system
- ◆ The State has moved forward with Wisconsin Family care which involves Medicaid capitation for long-term care only
- ◆ Under the Family Care Program, counties serve as the managed care contractor, accepting risk for meeting the needs of all persons requiring long-term care in the county

# Massachusetts Senior Care Organization: Program Features

- ◆ Open to all dual eligibles and Medicaid-only seniors in the service area, NHC and non-NHC
- ◆ Three health plans developed SCOs: two for profit and one not for profit
- ◆ The SCOs subcontract with a variety of providers including a community health center and two PACE programs
- ◆ Integration is through nurse/social worker teams
- ◆ Social workers are called Geriatric Support Services Coordinator and must be contracted from the local Area Agency on Aging
- ◆ Access to an electronic centralized record was mandated
- ◆ Risk sharing with state during start-up period

## Models of Care Coordination

- ◆ MSHO (Single coordinator) – either a nurse or SW managed community care coordinates with physicians and others in the acute care system
- ◆ Nurse/social worker team (SCO and MnDHO) – team of social workers managed care community care and the team nurse coordinates with medical care. Physicians are formal heads of teams
- ◆ Interdisciplinary team (WPP) – team includes nurse, social worker, therapists, and nurse practitioner. The nurse practitioner works closely with physicians
- ◆ WPP and MnDHO programs consistently and closely integrated community care and medical care. Low caseloads required for coordinating staff

## Common Features

- ◆ These common features can serve as a foundation for an integrated SNP to service dual eligibles:
  - Voluntary enrollment
  - Assumption of financial risk by health plans
  - Inclusion of Medicaid capitation to cover community services
  - Full coverage of prescription drugs
  - Special efforts at coordination of medical and social services

## Other Features for Consideration

- ◆ Involvement of the Aging Network
- ◆ Use of an electronic medical record
- ◆ Limitation of nursing home risk through rate setting or length of stay
- ◆ Acceptance of risk at the county level
- ◆ Risk sharing during start-up and initial operations (remember PACE risk sharing for demonstration)
- ◆ Limited experience in rural areas

# Promoting Collaborative Relationships: What Works

- ◆ Factors affecting collaboration among the plan, physicians, and acute care:
  - Interest of the individual physicians
  - Having a critical mass of patients in the physician's practice
  - Co-location of the care manager in the practice
  - Presence of a physician champion in the practice
  - Use of nurse practitioners (WPP) or nurses (MnDHO) to accompany patients on visits

## Marketing: What Works

- ◆ Waiver programs targeted for referrals but were not actually good referral sources. Competition?
- ◆ Word of mouth from patients, family, friends, and staff
- ◆ Signing up medical groups with large numbers of dual eligibles
- ◆ Referrals from other professionals, discharge planners, home health agencies, senior center, and advocacy groups
- ◆ For MN only, internal plan referrals

# Innovations in Delivery of Integrated Care

- ◆ Personal Care Attendant Pool (WPP)
- ◆ Collaboration among plans on care coordination, training, practices, and reporting (MSHO)
- ◆ Web-based centralized enrollee record (SCO)
- ◆ Community care coordinators “at the table” with medical care (all)
- ◆ Formula for integrating delivery: physician champion, critical mass of patients in clinic, access to medical record, and clinic-based coordinator (MSHO, MnDHO, SCO)

## Innovations in Delivery of Integrated Care

- ◆ Resource allocation committee to make policy on benefit expansion (WPP)
- ◆ Individualized dosing, re-packaging, home delivery, and support for prescriptions (WPP)
- ◆ Bi-lingual community resources coordinator on the team as first line for after-hours calls, as well as member relations and marketing (SCO)

# Understanding the Target Population and Need in Vermont

# State of Vermont by Region



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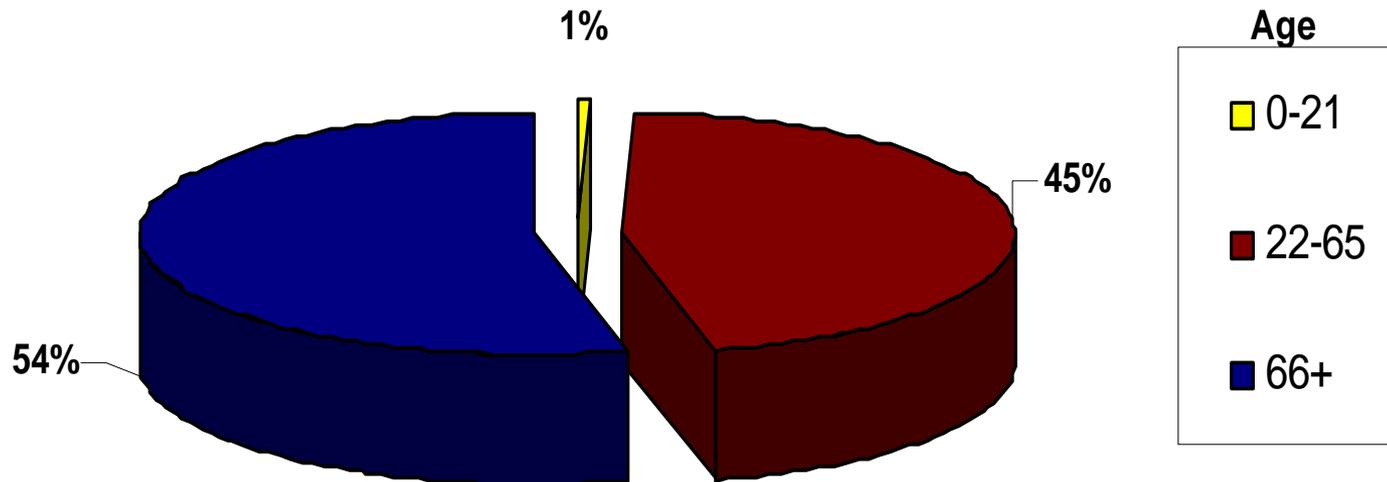
# Demographic Summary of Region

Region	Counties	Nursing Facility	HCBS	Other	Total Duals	% of Nursing Facility and HCBS Total Duals
Champlain Valley	Addison, Chittenden, Franklin and Grand Isle	713	505	2,329	3,547	34%
Central Vermont	Lamoille, Orange and Washington	495	190	1,356	2,041	34%
Northeast Vermont	Caledonia, Essex and Orleans	349	104	1,160	1,613	28%
Southwest Vermont	Bennington and Rutland	716	158	1,713	2,587	34%
Southeast Vermont	Windham and Windsor	468	220	1,237	1,925	36%
Out of State		0	0	16	16	0%
<b>Grand Total</b>		<b>2,741</b>	<b>1,177</b>	<b>7,811</b>	<b>11,713</b>	<b>33%</b>

Source: State of Vermont, Office of Vermont Health Access & Department of Disabilities, Aging and Independent Living, 2006

# Eligibles by Age

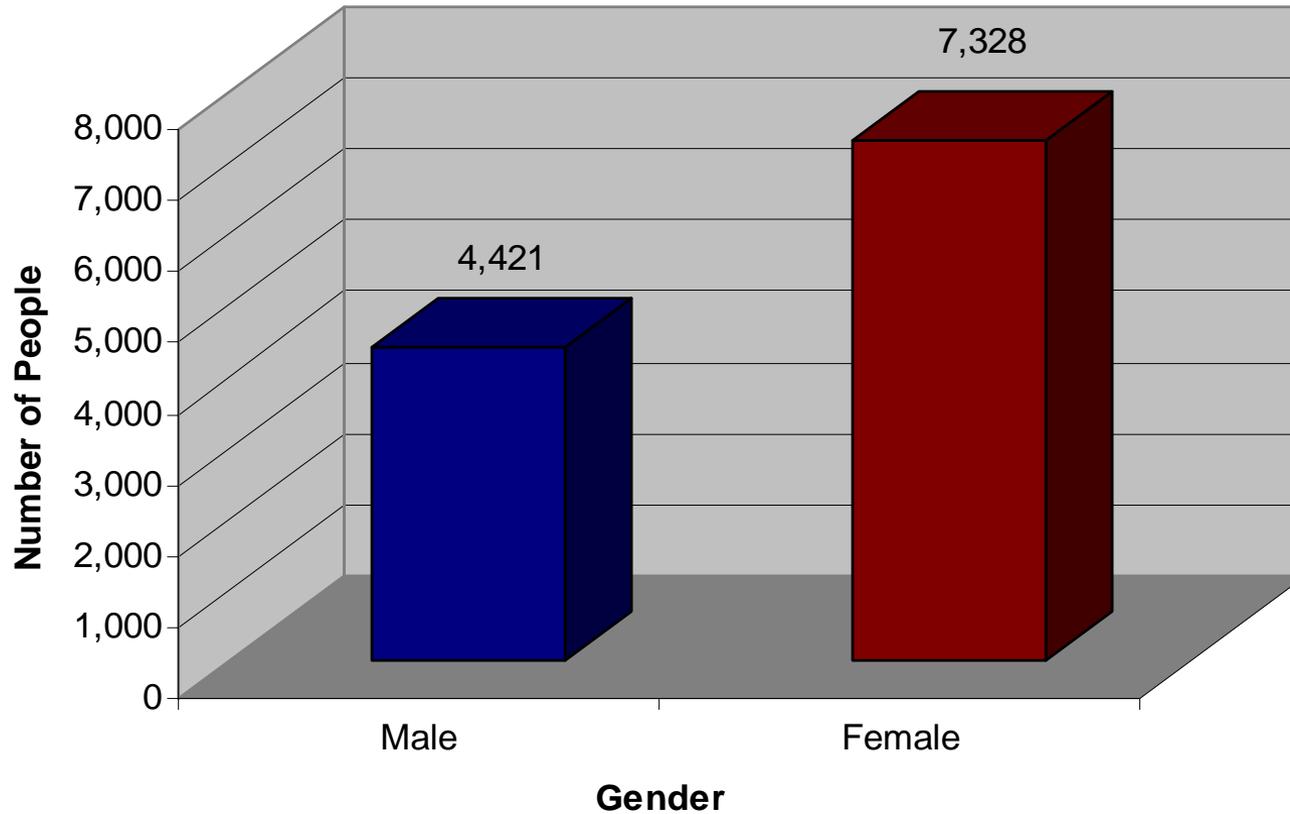
## Average Number of Eligibles by Age



Source: State of Vermont, Office of Vermont Health Access & Department of Disabilities, Aging, and Independent Living, 2006

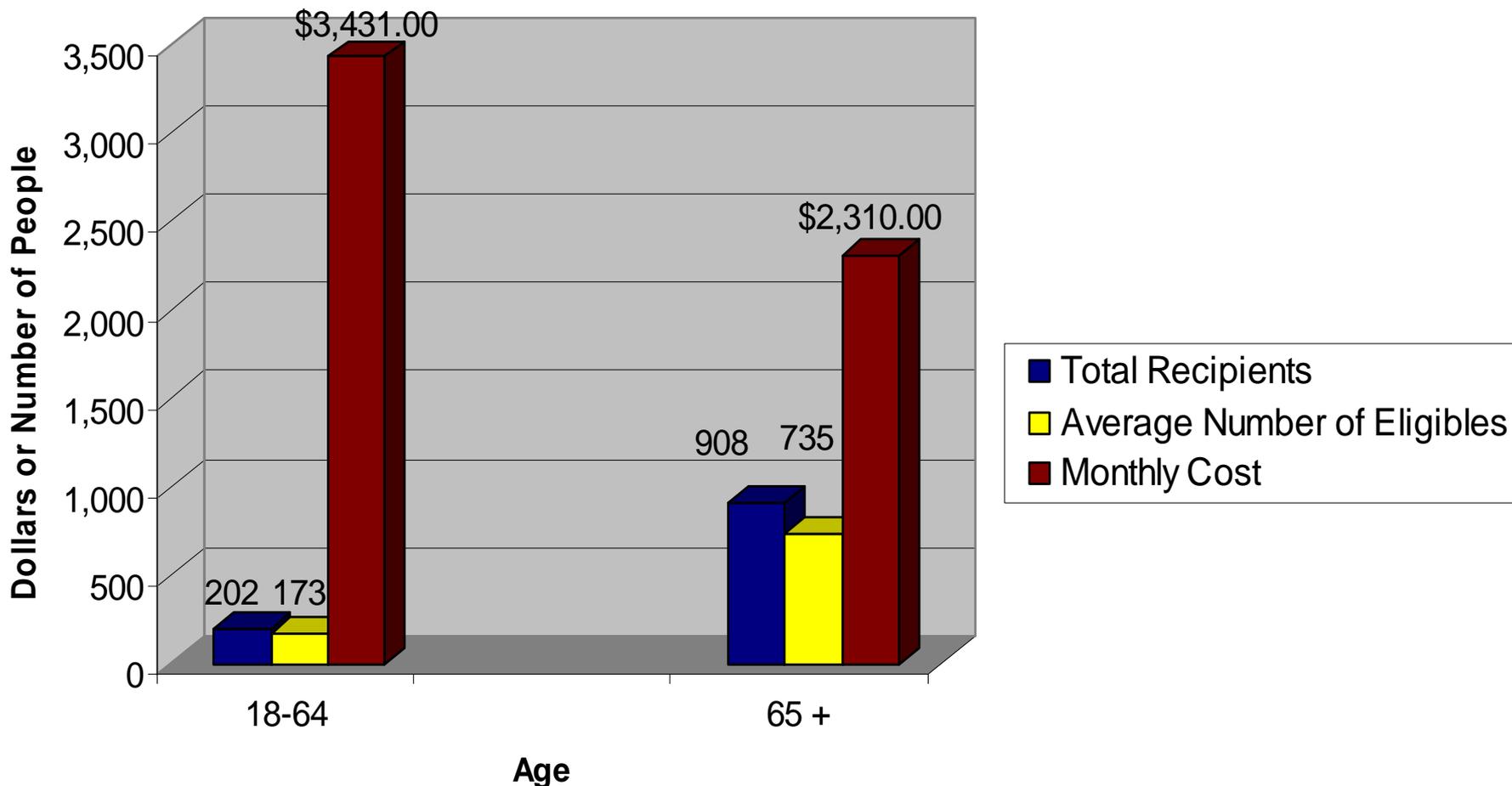
# Eligibles by Gender

### Average Number of Eligibles by Gender



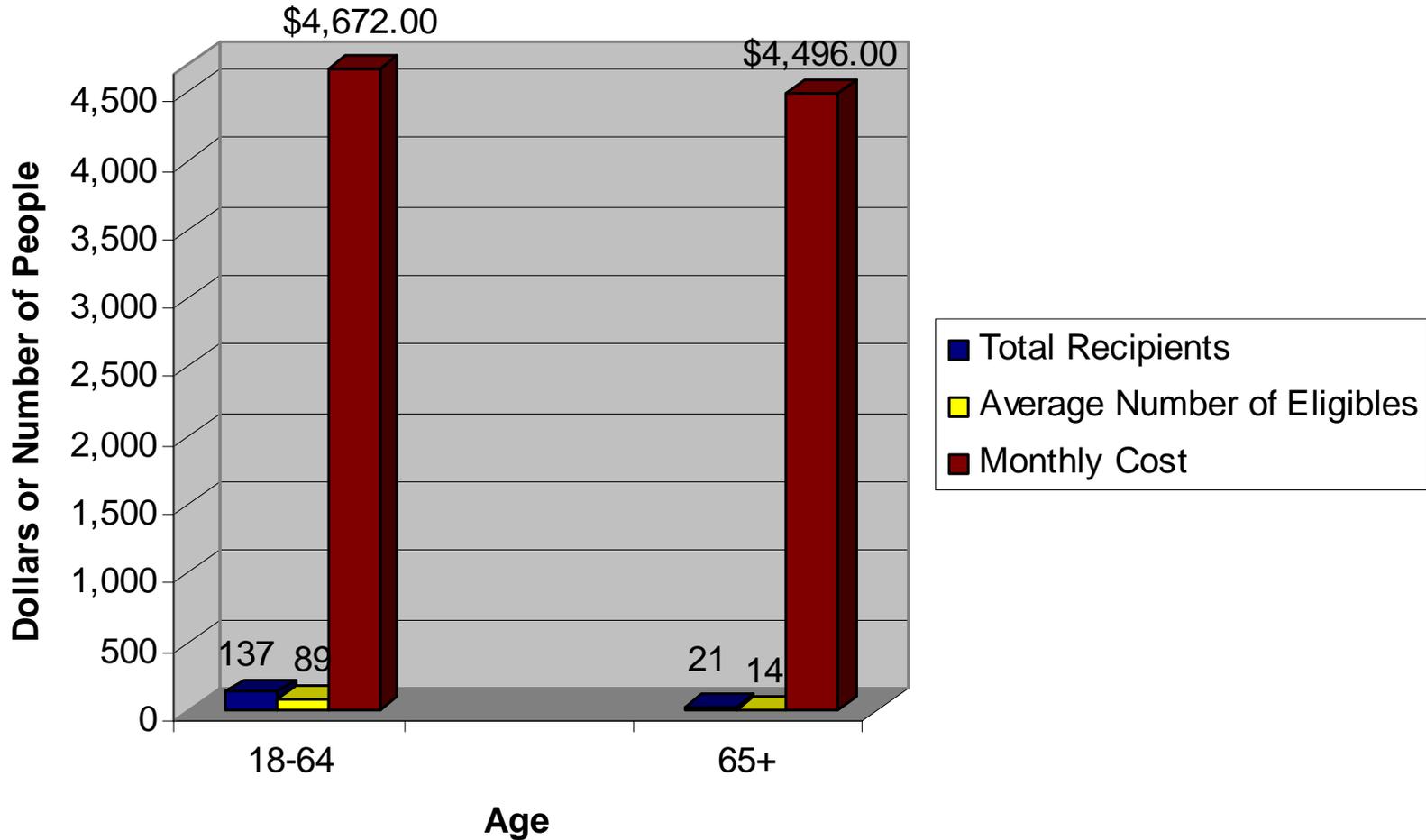
Source: State of Vermont, Office of Vermont Health Access & Department of Disabilities, Aging, and Independent Living, 2006

# Dual Eligibles Receiving Long-term Care Living in the Community



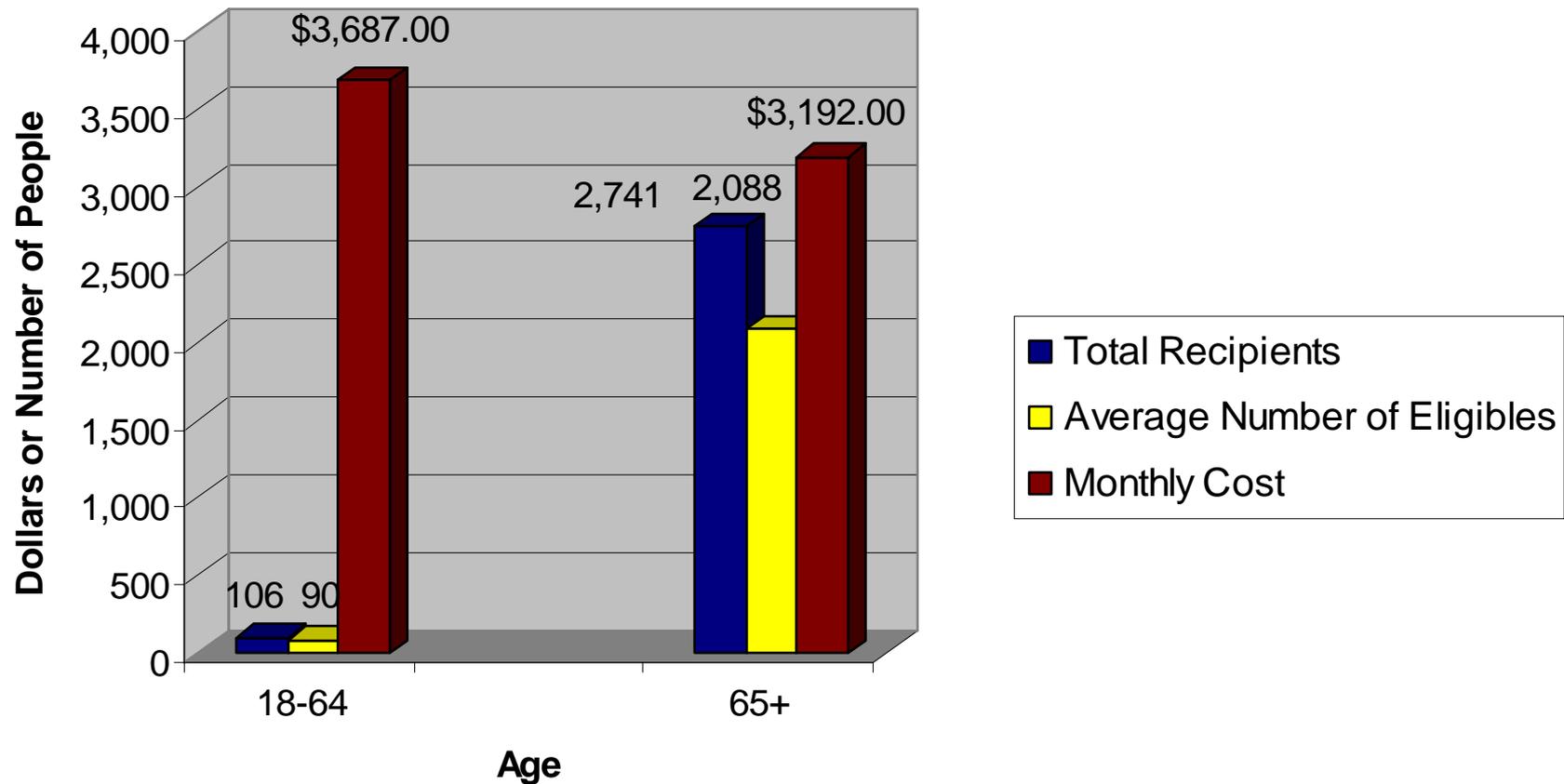
Source: State of Vermont, Office of Vermont Health Access & Department of Disability, Aging, and Independent Living, 2006

# Medicaid Only Receiving Long-term Care in the Community



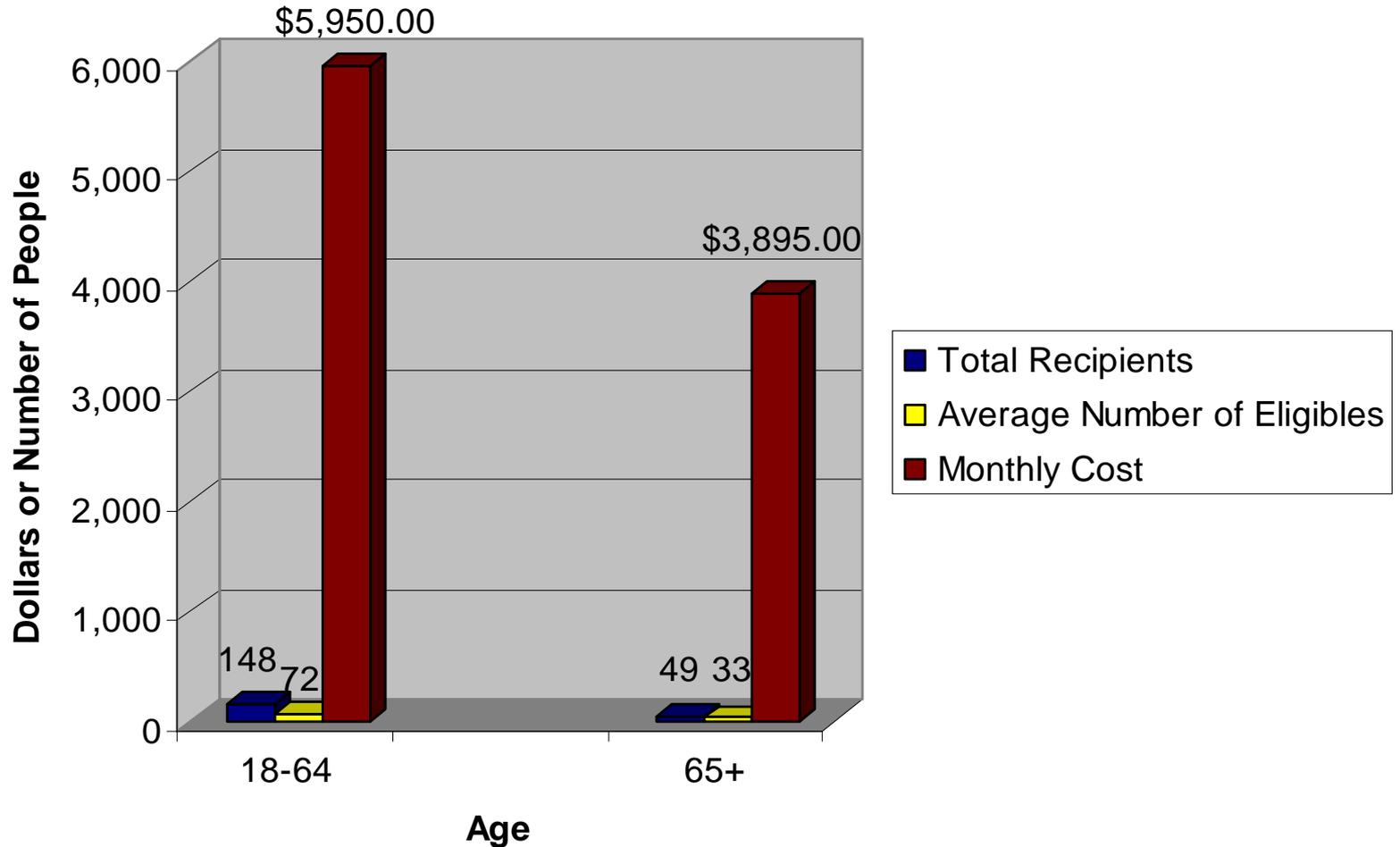
Source: State of Vermont, Office of Vermont Health Access & Department of Disability, Aging, and Independent Living, 2006

# Dual Eligibles Living in Nursing Facilities



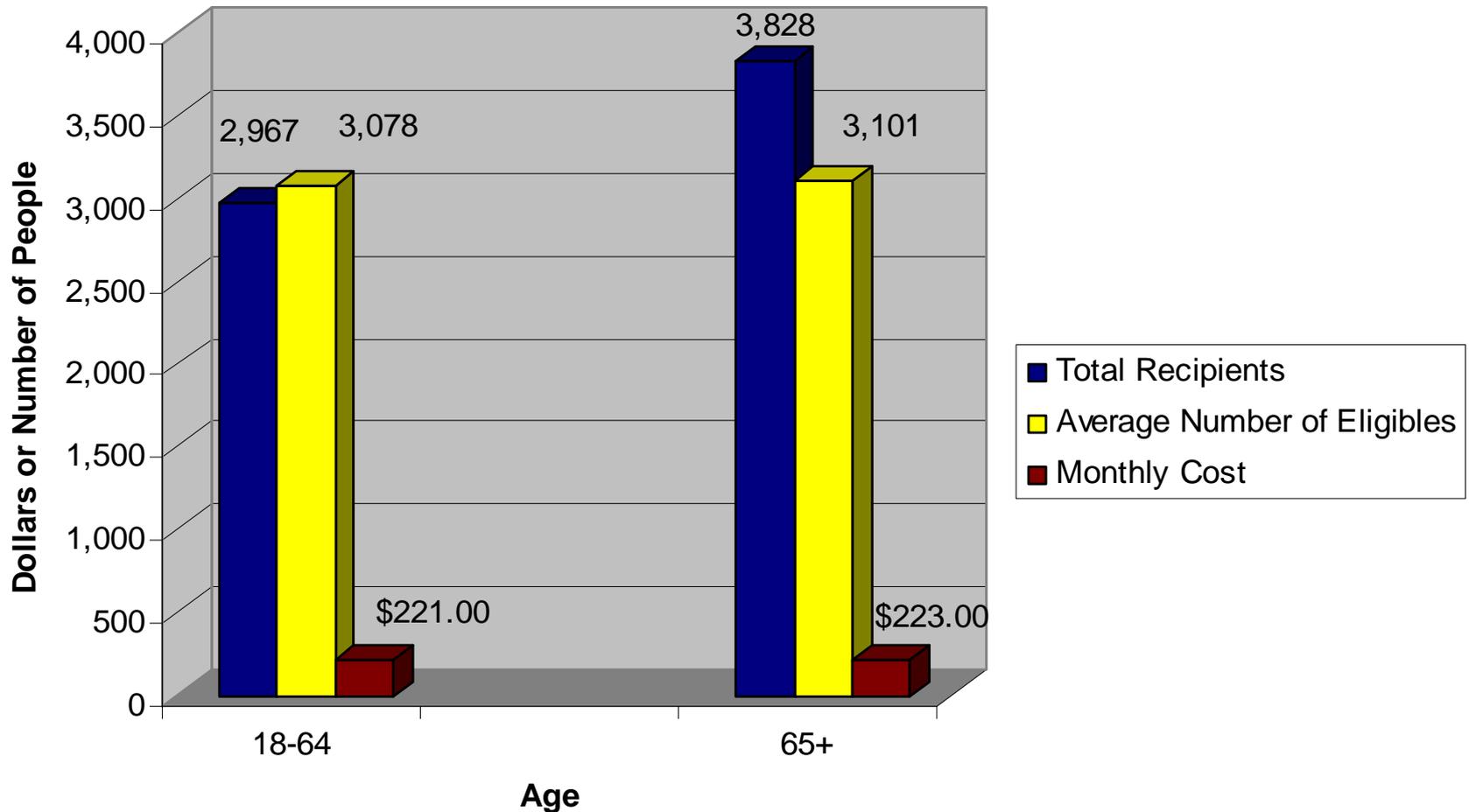
Source: State of Vermont, Office of Vermont Health Access & Department of Disability, Aging, and Independent Living, 2006

# Medicaid Only Living In Nursing Facilities



Source: State of Vermont, Office of Vermont Health Access & Department of Disability, Aging, and Independent Living, 2006

# Dual Eligibles Not Receiving LTC, Developmental Services, or CRT Services



Source: State of Vermont, Office of Vermont Health Access & Department of Disability, Aging, and Independent Living, 2006

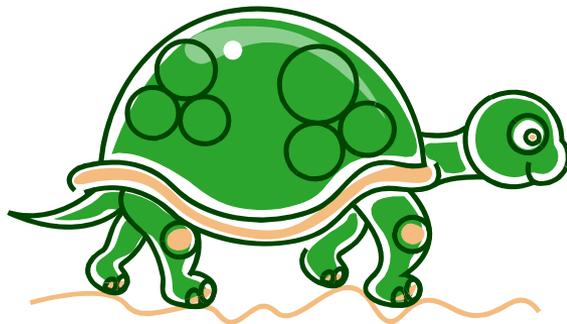
# Considerations for Business Planning

# Considerations

- ◆ Is your organization meeting the need and fulfilling its mission?
- ◆ Should your organization be serving additional and/or new populations?
- ◆ Should your organization be developing new programs?
- ◆ Are you leveraging your partnerships?
- ◆ Does your business plan need adjustment in order to **develop** your successful future?
- ◆ Are you telling yourselves the truth? Will you be successful?
- ◆ Are you willing to take the necessary risk?

**Behold the turtle. He only makes progress when he sticks his neck out.**

*James Bryant Conant*





**Thank You!**

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**Supplemental Information**

**From Brandeis University**

**Medicare Special Needs Plans**

**Lessons from Dual Eligible Demonstration for  
CMS, States, Health Plans and Providers**

**March 2007**

# Enrollee Characteristics in 2005

	Minnesota Senior Health Options (65+)	Wisconsin Partnership Plan (65+)	Massachusetts Senior Care Organization (65+)	Plans for <65 Disabled Beneficiaries
Total enrollees	1,000-2,948	400-486	341-606	211-305
<b>Demographics</b>				
Average age	80	76-79	75-76	47-52
% NHC	19%-26%	87%-95%	22%-49%	88%-99%
% Institutional	44%-47%	5%-13%	0-1%	1%-10%
% Non-NHC community	30%-34%	0	51%-77%	0-3%
<b>Utilization</b>				
Hospital days/member/year	1.7-2.2	2.9-5.1	2.4-5.8	4.6-6.8
Prescriptions/member/year	85	109-177	39-87	108-190
% with personal care attendant	17%	38%-94%	6%-26%	44%-85%
<b>Medicare Risk Factors</b>				
CMS-HCC risk scores	1.43-1.56	1.91-2.36	1.51-2.05	1.53-2.28
Frailty factors	0.15-0.21	0.39-0.45	0.30	0.45-0.70
Total risk scores	1.58-1.77	2.30-2.88	1.81-2.35	2.24-2.73

Source: Brandeis University, March 2007

# Integrated Special Needs Plans

Service areas, Plan Types, and Enrollees served	Service Area	Profit Status	Enrollees Served
<b>Minnesota</b>			
UCare	Twin Cities Area	Non-profit	65+
Metropolitan Health Plan (MHP)	Hennepin Co (Minneapolis)	Non-profit	65+
Medical	Twin Cities Area	Non-profit	65+
UCare & AXIS Healthcare	Twin Cities Area	Non-profit	Adult disabled
<b>Wisconsin</b>			
Eldercare of Wisconsin (ECW)	Dane Co. (Madison)	Non-profit	55+
Community Care for the Elderly (CCE)	Milwaukee & Racine	Non-profit	65+
Community Health Partnership (CHP)	3 rural counties near Eau Claire	Non-profit	65+ & Adult disabled
Community Living Alliance (CLA)	Dane Co. (Madison)	Non-profit	Adult disabled
<b>Massachusetts</b>			
Commonwealth Care Alliance (CCA)	Metro Boston, Springfield	Non-profit	65+
Senior Whole Health (SWH)	Metro Boston	For-profit	65+
Evercare SCO (ESCO)	Metro Boston, Fall River	For-profit	65+

Source: and Providers. Brandeis University, March 2007

# Community Care Service Contracting and Management

	Minnesota MSHO/MDHO	Wisconsin WPP	Massachusetts SCO
<b>HCB Waiver Services</b>			
Targeting	<ul style="list-style-type: none"> <li>◆ NHCs</li> </ul>	<ul style="list-style-type: none"> <li>◆ NHCs</li> <li>◆ Beneficiaries who lose NHC status are disenrolled</li> </ul>	<ul style="list-style-type: none"> <li>◆ NHCs</li> </ul>
Care Management and Service Contracting	<ul style="list-style-type: none"> <li>◆ Two plans self-managed</li> <li>◆ One plan contracted with county waiver program</li> <li>◆ All added some services beyond waiver package</li> </ul>	<ul style="list-style-type: none"> <li>◆ All plans self-managed</li> <li>◆ Three plans produced their own HCB services, e.g., personal care attendants and adult day</li> <li>◆ All added services beyond waiver package</li> </ul>	<ul style="list-style-type: none"> <li>◆ One plan self-managed</li> <li>◆ Two plans contracted with waiver programs</li> <li>◆ All plans got team social worker through contract with waiver programs</li> </ul>

Source: Brandeis University, March 2007

# Payment Approaches

	Minnesota MSHO/MDHO	Wisconsin WPP	Massachusetts SCO
<b>Medicare Capitation</b>			
NHC-AAPC Frailty-adjusted CMS-HCC	<ul style="list-style-type: none"> <li>◆ Phasing out</li> <li>◆ Phasing in (55 and older only)</li> </ul>	<ul style="list-style-type: none"> <li>◆ Phasing out</li> <li>◆ Phasing in (55 and older only)</li> </ul>	<ul style="list-style-type: none"> <li>◆ Phasing out</li> <li>◆ Phasing in</li> </ul>
<b>Medicaid Capitation</b>			
HCB waiver services	◆ Yes	◆ Yes	◆ Yes
Personal care services	◆ Yes	◆ Yes	◆ Yes
Custodial NH services	◆ 180 days risk	◆ Unlimited risk	◆ Full risk, but offset by transition to three-tier nursing home rates

Source: Brandeis University, March 2007

# Integration of Acute Care and Community Care

	Minnesota MSHO/MDHO	Wisconsin WPP	Massachusetts SCO
<b>65 and Over Plans</b>			
Care management links to physicians	<ul style="list-style-type: none"> <li>◆ Nurse or social worker care coordinators work for the HMO or the contracted acute care system</li> <li>◆ Links with physicians vary by clinic, health system, and plan based on “what works”</li> </ul>	<ul style="list-style-type: none"> <li>◆ Multidisciplinary team works for plan</li> <li>◆ Team nurse practitioners go to physician visits with patients</li> <li>◆ Teams proactively manage medications</li> <li>◆ Two sites package and deliver all medications</li> </ul>	<ul style="list-style-type: none"> <li>◆ Nurse and contracted social worker teams</li> <li>◆ Links with physicians vary by plan, practice, and level of enrollee need</li> <li>◆ Nurse stationed in medical offices that serve many enrollees (two plans)</li> <li>◆ Electronic centralized enrollee record</li> </ul>
Special features	<ul style="list-style-type: none"> <li>◆ Cross-plan collaboration in training, reporting, and quality initiatives for coordinators</li> </ul>	<ul style="list-style-type: none"> <li>◆ Attention to team process and leadership</li> </ul>	<ul style="list-style-type: none"> <li>◆ Standardized risk screening and care recommendations (two plans)</li> <li>◆ Clinical leadership from medical director in coordination and practice improvement (one plan)</li> </ul>
<b>Under-65 Disabled Plans</b>			
Care management links to physicians	<ul style="list-style-type: none"> <li>◆ Nurse, social worker, member rep teams work for sub-contracted management</li> </ul>	<ul style="list-style-type: none"> <li>◆ Same as elder care plans</li> </ul>	(Not applicable)

Source: Brandeis University, March 2007

# Marketing

	<b>Minnesota MSHO/MDHO</b>	<b>Wisconsin WPP</b>	<b>Massachusetts SCO</b>
The product	<ul style="list-style-type: none"> <li>◆ Comprehensive acute and long-term care benefits</li> <li>◆ Better care coordination</li> <li>◆ Keep your own doctor (except MnDHO)</li> <li>◆ Prescriptions without copays</li> </ul>	<ul style="list-style-type: none"> <li>◆ Same</li> </ul>	<ul style="list-style-type: none"> <li>◆ Same</li> </ul>
Primary sources of members	<ul style="list-style-type: none"> <li>◆ Internal HMO market</li> <li>◆ Word of mouth and sign up medical groups serving the disabled (MnDHO)</li> </ul>	<ul style="list-style-type: none"> <li>◆ Professional referrals and word of mouth</li> <li>◆ Internal HCB programs market (one site)</li> </ul>	<ul style="list-style-type: none"> <li>◆ Sign up medical groups with many duals, e.g., community health centers</li> </ul>
Secondary sources	<ul style="list-style-type: none"> <li>◆ Waiver programs</li> <li>◆ Outreach to immigrants</li> </ul>	<ul style="list-style-type: none"> <li>◆ Waiver programs</li> <li>◆ Sign up medical groups with many duals</li> </ul>	<ul style="list-style-type: none"> <li>◆ Waiver programs</li> <li>◆ Outreach to immigrants</li> </ul>
Special features	<ul style="list-style-type: none"> <li>◆ Passive enrollment from Medicaid HMOs into SNPs (2006 only)</li> </ul>		
Special issues	<ul style="list-style-type: none"> <li>◆ Assessments can slow enrollment</li> <li>◆ Selectivity on PCA users</li> </ul>	<ul style="list-style-type: none"> <li>◆ Same</li> </ul>	<ul style="list-style-type: none"> <li>◆ Same</li> </ul>

Source: Brandeis University, March 2007

# Glossary

**AAPCC**- Adjusted Average Per Capita Costs

**ASAP**- Aging Services Access Points

**CMS**- Centers for Medicare and Medicaid Services

**GSSC**- Geriatric Support Services Coordinator

**HCC**- Hierarchical Condition Categories

**MA**- Medicare Advantage

**MMA**- Medicare Modernization Act of 2003

**MSHO**- Minnesota Senior Health Options

**MnDHO**- Minnesota Disability Health Options

**NHC**- Nursing Home Certifiable

**PACE**- Program of All-inclusive Care for the Elderly

**PIP**- Performance Improvement Plan

**PCA**- Primary Care Attendant

**PCP**- Primary Care Physician

**PMAP**- Prepaid Medical Assistance Plan

**PMPM**- Per Member Per Month

**RN**- Registered Nurse

**SCO**- Senior Care Options

**SNP**- Special Needs Plan

**WPP**- Wisconsin Partnership Program