AARP Public Policy Institute

Care Management Practices in Integrated Care Models for Dual Eligibles

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Research Report

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AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

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EXECUTIVE SUMMARY

This study examined the care management practices in four health plans that serve persons who are dually eligible for Medicare and Medicaid, commonly referred to as "dual eligibles." The project case studied two health plans in the Massachusetts Senior Care Options program (SCO)—Commonwealth Care Alliance and Senior Whole Health—and two in the Arizona Long Term Care System (ALTCS)—Mercy Care Plan and SCAN Long Term Care.

The objective of the study is to understand how health plans operationalize their integrated care management approaches. We are particularly interested in learning how care management is practiced at the point of service delivery. Our goal is to look beyond each state's particular program design and identify common care management practices employed by plans to manage both Medicare- and Medicaid-covered benefits for dual eligibles.

We focus on dual eligibles because this group of beneficiaries is particularly susceptible to fragmented care. Compared to persons who are eligible for Medicare only, dual eligibles are much more likely to be in poor health, not have a spouse, have impairments in activities of daily living, have less than a high school education, and suffer from cognitive impairments or mental disorders. The 8.1 million persons who are dual eligibles represent disproportionate spending in both programs. They make up 18 percent of the Medicaid population but represent 46 percent of Medicaid expenditures. In Medicare, they comprise 16 percent of the population but account for 27 percent of all expenditures.

Dual eligibles are a prime target for improved care management models. The care management challenges of dual eligibles are magnified by the fact that they receive care from two separate public financing systems, with differing benefits, provider networks, payment incentives, and policy objectives. Many dual eligibles require long-term care services, which are financed under Medicaid, while most of their medical care is financed under Medicare. Medicare and Medicaid services are often provided to dual eligibles through parallel but separate delivery systems with few formal linkages between the two.

STUDY METHODOLOGY

We conducted two-day site visits to the four plans in December 2009 and January 2010. During each visit, we interviewed senior management at each of the plans. We also interviewed care managers both one-on-one and in groups. In several cases, we attended care management conferences, during which multidisciplinary teams discussed particularly challenging cases, shared patient information, and discussed alternative intervention strategies. With the consent of members, we participated in home visits: at least four from each plan. We observed interactions between members and their designated care managers in the member's residence, which could be a private residence, apartment, adult foster home, or assisted living facility. In many cases, family members were present during the visit, and in some cases, the member's personal care provider was also present.

The home visits were a key component of the data collection process. We observed how care managers conducted assessments and developed individual care plans. We also observed how care managers identified and addressed medical, social, and behavioral

health issues. In some plans, we observed care managers using tools onsite, such as laptops with satellite-based Internet service, cell phones, interpreter services, and portable printers. We observed the interaction between care managers and members.

In additional to interviews and home visits, we asked each plan to self-evaluate its performance and to highlight areas in which improvements could be made. We did not evaluate the plans on whether or how their care management model improved health outcomes, reduced unnecessary hospitalizations, or delayed institutional use, or along other dimensions of outcomes.

COMMON FRAMEWORK FOR CARE MANAGEMENT

The four plans we visited approached care management with their own unique structures, roles, and processes. Despite these differences, we identified five key components of care management employed by all four plans:

- **Supportive Services.** As integrated care plans providing both Medicare and Medicaid services, each plan's care management model includes the management of long-term supportive services and coordination of these services with members' medical benefits. Social services coordination is handled quite differently by the two states largely because of differences in the basic state program designs.
- **Primary Care.** All four plans noted enhancing primary care as a key objective. Each plan had unique strategies for strengthening primary care.
- **Medical Management.** All four plans engaged in the management of clinical services, such as the management of chronic conditions. The primary care physician (PCP) plays a key role, with support from medical directors, nurse care managers, concurrent (hospital) review departments, pharmacy consultation, and other services provided by clinically trained individuals.
- **Behavioral Health Management.** All four plans indicated that behavioral health services are used extensively by their dually eligible members. All plans have tools and strategies in place to coordinate behavioral health needs.
- **Member Services.** Member services play a more prominent role in the care management models of integrated care plans than is typical in a traditional health plan because the population enrolled in integrated plans is more frail, diverse, and faces more complex issues than in traditional health plans.

COMMON THEMES ACROSS CARE MANAGEMENT PRACTICES

Home Visits. All plans are contractually required to visit members in their homes at specified intervals and, from our observations, all were committed to doing so as much as possible. Home visits were considered essential for evaluating, and a more reliable assessment of, the member's total health, social, and emotional condition. Home visits are also more likely to create an affiliation between the plan and the member.

Team Approach. The care management cultures of the four health plans embodied a team approach to supporting their dually eligible members. The plans engaged PCPs in setting the overall clinical direction of their members' care, working through the care manager to

share patient information between the PCP and other providers and to coordinate medical care and long-term services and supports.

Many Touches. The plans held a common philosophy of "touching" their members at frequent intervals. By "touching" we mean some kind of contact—in person, by phone, by mail, and so on. Many "touches" of members allowed the plans to take a more proactive approach to care management, to stay ahead of the game, and to prevent avoidable acute care events whenever possible.

Decentralized Decision Making. The four plans were remarkably decentralized in their decision-making authority regarding the allocation of resources. Care managers had broad authority to authorize service plans in accordance with the member's needs, to increase services in accordance with health status changes, to make referrals to specialists, and to authorize alternative therapies.

Self-Directed Services. All four plans supported self-direction of personal care services within the context of overall care management. This was available in two forms at all four plans: (1) an agency model, in which a member selects a personal care worker (often a family member) who becomes an employee of the agency providing personal care services; or (2) one that involves a fiscal employer agent, with whom the member contracts directly for personal care and attendant services.

Shift in Resources to Primary/Preventive Care. All plans reported that they use the flexibility of capitation payments to invest additional resources in primary and preventive care services.

A Focus on Transitions of Care. A common focus of all four plans was to manage care transitions more effectively across care settings, such as hospital discharges to the community. All four plans recognized that care management processes in the traditional health care system tend to fail when patients transition from one care setting to another.

Supporting Care Managers with Information Technologies. The plans have invested in technology support that allows care managers to be as productive in the field as possible, since much of their time is spent out of the office.

Targeted Initiatives. The plans also implement special initiatives, beyond what is offered in their "standard" care management models, to enhance quality; such as, reducing preventable hospital readmissions. Plans use a variety of approaches, such as designating a hospital discharge nurse whose sole job responsibility is work with members, hospital staff, and "regular" care managers when members are in the hospital, being discharged, and post discharge. Another approach includes matching behavioral health services to the needs of members with serious psychiatric illnesses to maintain members at the highest level of independence possible.

Flexible Benefit Packages. Plans have some flexibility to offer additional benefits over traditional Medicare- and Medicaid-covered services. Plans in the Massachusetts SCO program provide a broad benefit package for their members, particularly for those who qualify for home and community-based services to help them stay in their homes. In general, given the program structure in each state, SCO plans are allowed greater flexibility than the Arizona plans.

COMMON CHALLENGES ACROSS PLANS

Overlapping Roles. All four plans acknowledged some overlap in care management functions between their nurse care managers and other entities involved in the care and coordination of members. As a result, the plans noted that they engaged in ongoing and iterative refinements of the care manager's role.

Noncomprehensive Health Information Technology. All four plans have electronic care management systems that provide access to claims and other member information. None of the plans has an actual electronic medical record with real-time information, however. Because care management for dually eligible persons involves multiple providers, the lack of an interoperable health information system likely reduces efficiency.

Administrative Duplication. In general, all plans describe having to work with two major funders (the state for Medicaid and the Centers for Medicare & Medicaid Services (CMS) for Medicare) as a significant administrative burden. In care management, for instance, both the Medicare Special Needs Plan regulations (by which the four plans are regulated) and Medicaid state contracts have distinct and separate requirements regarding needs assessment, care planning, and monitoring. The plans must assure each funder that its separate requirements are met, while offering a unified, integrated product to members.

RECOMMENDATIONS

- **Conduct more rigorous evaluations of cost and quality outcomes.** The four plans all claimed that their internal analyses show significant improvements in Medicare and Medicaid utilization patterns, including increased use of primary and preventive care services, reduced readmission rates post hospital discharge, reduced psychiatric admissions, and reduced use of nursing homes for persons with severe functional limitations. They also claimed significant improvements in quality, both on health care status measures and quality of life measures, for their members. These programs and others like them should be evaluated through a rigorous analysis of cost and quality outcomes, adjusting for differences in case mix across comparison populations. These outcomes should be compared to those of persons served through multiple, uncoordinated programs.

- **Expeditious development of new opportunities for Medicare and Medicaid integration.** CMS should create more opportunities for states to work with the federal Medicare program to expand integrated care models and to streamline the process. Only about 120,000 of the 8.1 million dual eligibles are currently enrolled in some kind of integrated p and these programs took a number of years to develop because the programs involved had to coordinate their efforts with both state and federal contracting authorities. Under the Patient Protection and Affordable Care Act, Congress established the Federal Coordinated Health Care Office to integrate Medicare and Medicaid benefits more effectively for dual eligibles. Expeditious development of new structures for Medicare-Medicaid integration will be highly beneficial to the more than 8 million dual eligibles.

INTRODUCTION AND BACKGROUND

A major theme of the Patient Protection and Affordable Care Act (ACA) is the effort to improve care management practices for persons with complex medical conditions. The ACA makes increased investments in primary care services, provides new resources to improve the coordination of care across health and long-term care providers, and supports new delivery infrastructures, such as medical/health homes, that are better equipped to manage the care of complex populations. These investments reflect a recognition that new care management models are needed to manage the care of high-cost populations.

The quest for more effective care management models for persons with multiple chronic illnesses and complex medical needs is not new. Indeed, over the past decade, the search for care management models that could achieve improved clinical outcomes as well as program savings has been pursued with considerable vigor. In some cases, the search has fallen short of expectations. For example, the Medicare Coordinated Care Demonstration, a large initiative sponsored by CMS, produced only minimal reductions in hospital readmissions and no reductions in Medicare expenditures.[1] Consequently, the search has at times been likened to the "search for the holy grail."[2]

Persons who are dually eligible for Medicare and Medicaid, commonly referred to as "dual eligibles," are particularly susceptible to poor care management practices. Compared to persons who are eligible for Medicare only, dual eligibles are much more likely to be in poor health, not have a spouse, have impairments in activities of daily living,[3] have less than a high school education, and suffer from cognitive impairment or mental disorders.[4][5] The 8.1 million persons who are dual eligibles represent disproportionate spending in both programs. They make up 18 percent of the Medicaid population but represent 46 percent of Medicaid expenditures.[6] In Medicare, they comprise 16 percent of the population but account for 27 percent of expenditures.[7]

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[1] D. Piekes, A. Chen, J. Schore, and R. Brown, "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials," *JAMA* 301, no. 6 (February 11, 2009): 603–18.

[2] National Health Policy Forum, *Coordinating Care for Adults with Multiple Chronic Conditions: Searching for the Holy Grail* (Washington, DC: George Washington University, March 27, 2009).

[3] Activities of daily living (ADLs) are daily activities that individuals perform for self-care (such as feeding, bathing, dressing, grooming), work, homemaking, and leisure. Health professionals routinely refer to the ability or inability to perform ADLs as a measurement of a person's functional status.

[4] T. Coughlin, T. Waidmann, and Watts M. O'Malley, *Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2009), accessed February 28, 2010, at http://www.kff.org/medicaid/7895.cfm.

[5] Medicare Payment Advisory Commission, "Dual-eligible Beneficiaries," in *A Data Book: Healthcare Spending and the Medicare Program* (Washington, DC: Medicare Payment Advisory Commission, June 2010), Section 3, pp. 32–39.

[6] Center for Health Care Strategies, Supporting Integrated Care for Dual Eligibles, accessed February 10, 2010, at http://www.chcs.org/usr_doc/Integrated_Care_Policy_Brief.pdf.

[7] Medicare Payment Advisory Commission, 2010.

Dual eligibles are a prime target for improved care management models. The care management challenges of dual eligibles are magnified by the fact that they receive care from two separate public financing systems, with differing benefits, provider networks, payment incentives, and policy objectives. Many dual eligibles require long-term care services, which are financed under Medicaid, while most of their medical care is financed under Medicare. Medicare and Medicaid services are often provided to dual eligibles through parallel but separate delivery systems with little formal linkage between the two.

For these reasons, increasing attention is being paid to fashioning program models that bring the Medicare and Medicaid programs closer together for the benefit of dually eligible beneficiaries. A fair amount has been written about the design of these models from a financing and program structure viewpoint, but little has been written about how these models actually affect the care that dual eligibles receive.[8] Recognizing this gap in the literature, AARP commissioned this study to examine care management practices in four health plans that serve dually eligible beneficiaries—two in the Massachusetts Senior Care Options program (SCO), and two in the Arizona Long Term Care System (ALTCS). The SCO and ALTCS programs have some key differences. For example, SCO was designed specifically for dually eligible beneficiaries who are 65 or older, and enrollment is voluntary. ALTCS was designed as a mandatory Medicaid program for adults of all ages who have long-term care service needs, with a subset of enrolled members choosing to have their Medicare benefits managed by their ALTCS plan. Our objective was to look beyond the program design differences to identify common care management practices and strategies being employed to better manage care for dual eligibles.

STUDY PURPOSE AND METHODOLOGY

To date, a fair amount has been written about the "promise" of integrated care models for dually eligible beneficiaries. Most of the literature on integrated care models focuses on global design and implementation issues; in particular, on the different approaches that states have taken to integrate the financing of Medicare and Medicaid benefits. None of these studies, however, focus on how health plans operationalize their integrated care management approaches. This report studies four health plans and describes their care management practices at the individual member level—that is, at the point of service delivery. How do specific care management practices serve to make care more person-centered and seamless? What specific strategies are employed to make Medicare and Medicaid services work together better?

We chose to study four health plans in two state programs. The programs were intentionally chosen for their contrasting program designs. Massachusetts SCO was designed specifically as an integrated care model for dually eligible older persons. In operation since 2004, SCO enrolls dually eligible beneficiaries ages 65 and older on a voluntary basis. SCO began with three contractors, and added a fourth in 2009.

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[8] For example, see B. Edwards, S. Tucker, and B. Kluz, *Integrating Medicare and Medicaid: State Experience with Dual Eligible Medicare Advantage Special Needs Plans* (Washington, DC: AARP Public Policy Institute, September 2009).

Care for dual eligibles in Arizona has a different history. ALTCS was designed as a mandatory Medicaid managed long-term care services program for all adults certified to need nursing facility level of care, and has been in operation for more than 20 years. Since 2006, Arizona has required all Medicaid plans participating in ALTCS to also offer an integrated care option to dually eligible members through a companion Dual Eligible Special Needs Plan (SNP). Dually eligible ALTCS members can choose to have their Medicare benefits managed through the companion SNP, although it is not mandatory that they do so.

We selected two plans in Massachusetts—Commonwealth Care Alliance and Senior Whole Health—and two in Arizona—Mercy Care Plan and SCAN Long Term Care. More information about each of these plans, and about the state programs under which they operate, can be found in the following section.

We conducted two-day site visits to the four plans in December 2009 and January 2010. During each site visit, we interviewed senior management at each of the plans. We interviewed chief executive officers, chief financial officers, chief operations officers, medical directors, directors of quality management services, long-term care operations managers, directors of care management services, directors of information technology, behavioral health clinicians, directors of pharmacy services, and other plan administrators and staff. Because we were most interested in care management practices at the consumer level, we also conducted numerous interviews with staff who interacted directly and routinely with members. In general, these staff were the individuals designated as “care managers.” They could be social workers, nurses, geriatric nurse practitioners, behavioral specialists, or nondegreed individuals with several years of case management experience. We interviewed care managers both one-on-one and in groups. In several cases, we also attended care management conferences, during which multidisciplinary teams discussed particularly challenging cases, shared patient information, and discussed alternative intervention strategies.

Most important, with the consent of members, we participated in at least four home visits at each plan. All four health plans had contractual requirements to conduct face-to-face home visits with members at regularly scheduled intervals. We observed interactions between members and their designated care managers. The visits occurred in the member’s home, which could be a private residence, apartment, adult foster home, or assisted living facility. In many cases, family members were present during the visit, and in some cases, the member’s personal care provider was also present.

The home visits were a key component of the data collection process. We were able to observe how care managers conducted assessments and developed individual care plans. We also observed how care managers identified and addressed medical, social, and behavioral health issues. In some plans, we observed care managers using tools onsite, such as laptops with satellite-based Internet service, cell phones, interpreter services, and portable printers. We observed the interaction between care managers and members: At home visits, members often discussed their opinions of the quality of services they were receiving, what additional services they thought they needed, or what services they were receiving that they thought were not necessary. They also frequently commented on the quality of their everyday lives, their health and social status, their emotional well-being, and whether or not they were satisfied with their current living situation. Home visits appear extremely beneficial in providing information or feedback to the plan on how the

plan's services were or were not supporting the overall quality of life of members. Since these plans are responsible for providing both medical benefits and supportive services, they adopt a broader focus than traditional health plans, which includes maintaining the functional independence and overall well-being of their members.

The methodological approach was entirely qualitative and designed to observe practices, not to evaluate outcomes. We observed care managers during home visits and asked plan administrators to self-report on their care management practices. We asked plans to self-evaluate their performance and to highlight areas in which improvements could be made. We did not evaluate the plans on whether or how their care management model improved health outcomes, reduced unnecessary hospitalizations, or delayed institutional use, or along other dimensions of outcomes. Our objective was to observe and document what systems, tools, and techniques were available to care managers and how they used these resources to manage the broad range of Medicare and Medicaid services for which their members were eligible.

DESCRIPTIONS OF STATE PROGRAMS AND SELECTED PLANS

This section provides overviews of the four plans selected for the study, and the state programs in which they operate. Table 1 provides data on selected characteristics of the four plans.

Table 1
Descriptive Characteristics of Selected Plans in Massachusetts and Arizona

	Commonwealth Care Alliance (MA)	Senior Whole Health (MA)	Mercy Health Plan (AZ)	SCAN Long Term Care (AZ)
Year Started	2003	2003	2000	2006
Corporate Status	Nonprofit	For-profit	Nonprofit	Nonprofit
Total 2009 Revenue	$110 million	$240 million	$350 million*	$117 million*
Voluntary/Mandatory Enrollment	Voluntary	Voluntary	Mandatory Medicaid Voluntary Medicare	Mandatory Medicaid Voluntary Medicare
Enrollment January 2010	2,438	6,111	8,400	3,022
Percentage Over Age 65	100%	100%	60%	77%
Percentage Nursing Home Certifiable	64%	35%	100%	100%
Percentage in NH	4%	10%	26%	24%
Percent in ALFs	0%	0%	41%	41%
Percent in HCBS	86%	58%	33%	34%
Percentage Enrolled in both Medicaid and Medicare Plans	93%	91%	42%	48%
English Not Primary Language	62%	61%	NA	NA
Percentage Female	68%	70%	63%	NA
Average Age	77	78	69	75

*Medicaid capitation payments only. Does not include Medicare revenues in companion SNPs.

Note: NH =nursing home; HCBS =home and community-based services; ALF = assisted living facility.

MASSACHUSETTS SENIOR CARE OPTIONS PROGRAM

The Massachusetts Senior Care Options program was designed to integrate the full range of Medicaid and Medicare benefits for dually eligible beneficiaries 65 and older. The program offers a combined package of Medicaid and Medicare benefits that includes primary and acute care, behavioral health services, prescription drugs, and long-term services and supports. Older persons who have Medicaid coverage only are also eligible for the program.

The program is offered through four SCOs: Commonwealth Care Alliance, a Boston-based nonprofit; Evercare, a national subsidiary of the publicly traded UnitedHealth Group; NaviCare, a product of the nonprofit, Worcester-based Fallon Community Health Plan; and Senior Whole Health, an investor-owned, for-profit company that was formed specifically to participate in the SCO program and has since expanded to New York State. NaviCare began enrollment in 2009. The other three SCOs began enrollment at program inception in 2004. The plans have overlapping service areas, and collectively cover most parts of central and eastern Massachusetts, from Springfield to Boston. As of January, 2010, total enrollment across the four plans was 13,165 members.

Enrollment in SCO is voluntary. In order to enroll, a person must be at least 65 years old, receive Medicaid, and live in a service area where the program is offered. When they choose SCO, dually eligible beneficiaries agree to have all of their Medicare and Medicaid services delivered through the SCO's network. This includes behavioral health services, prescription drugs, and the full range of community-based and institutional long-term services and supports. Members may disenroll from or switch SCO plans on a month-to-month basis.

Rather than using a competitive procurement process, Massachusetts offered SCO participation to any qualified organization that could demonstrate capacity to meet program specifications. SCOs have two contracts. They provide Medicaid services through a contract with MassHealth (the state's Medicaid agency), and Medicare services through a separate contract with CMS as a Medicare Advantage Special Needs Plan.[9] They receive capitated Medicare payments from CMS and capitated Medicaid payments from MassHealth. They enroll members into two separate enrollment systems, meet two sets of quality standards, have two sets of reporting requirements, and so on.

As they work to meet dual contract requirements administratively, the SCO plans we interviewed said they use care management to make service delivery as seamless as possible for members. Care management provisions in the contract with MassHealth include a primary care locus, individualized care plans, and centralized enrollee records. All enrollees must receive an initial assessment, and those found to have complex care needs must have a primary care team (PCT), consisting of the primary care physician, a

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[9] When the SCO program began, it featured an innovative three-way contract with the state, CMS, and the SCO. That practice was discontinued with implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). CMS has required all national dual eligible demonstration programs to convert to Medicare Advantage Special Needs Plans, which were authorized by the MMA.

geriatric support services coordinator employed by an aging services access point,[10] and a registered nurse, nurse practitioner, or physician's assistant. All members of the PCT must have geriatric experience. Within these parameters, SCOs are free to create care management structures and processes unique to their organizations.[11]

We visited two SCOs: Senior Whole Health and Commonwealth Care Alliance.

Senior Whole Health

Senior Whole Health (SWH) is a private, for-profit company founded in 2003 to participate in the SCO program and to expand its model of care to other states. This is reflected in the organization's vision statement: *Establish a successful national system of Senior Care Organizations that will unify health care financing to provide caring, respectful and comprehensive services to seniors.*

Senior Whole Health was conceived by a group of individuals with experience in Medicaid and the Massachusetts long-term services system, who were capitalized by investors. In January 2010, it was the largest of the four SCOs, with about 6,000 members. It operates in seven counties from central to eastern Massachusetts (Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties). SWH believes that the Massachusetts program has demonstrated financial viability and scalability (ability to grow in volume without altering the model's key attributes). The company is making efforts to transfer its model to other states. In 2007, the company entered the New York State market, where it began operating a plan in New York's Medicaid Advantage Plus (MAP) program, which targets a somewhat different population than SCO.[12]

Senior Whole Health's Approach to Care Management

Senior Whole Health's care management model uses nurse care managers to extend the capacity of the primary care physician (PCP) and to act as a central point of coordination for members. The nurse care manager synthesizes information from several sources and prepares individualized care plans in consultation with members, PCPs, and other team members. The nurse care manager is usually, but not always, an employee of SWH.[13]

Senior Whole Health receives little information about new members in advance of their enrollment, so one of its immediate tasks is to screen new members to assess their needs. Within a few days of enrollment, a SWH community resource coordinator makes a

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[10] The Aging Services Access Point, or ASAP, is an entity that contracts with the Massachusetts Executive Office of Elder Affairs to manage home care programs and perform case management and other activities related to long-term services and supports. Most ASAPs are also designated as Area Agencies on Aging under the federal Older Americans Act. SCOs are required to contract with an ASAP for geriatric support services coordinators for all members found to have complex care needs.

[11] SCOs must ensure that they also meet separate Medicare Advantage SNP Model of Care requirements that took effect January 1, 2010, and that are similar to, but not exactly the same as, the MassHealth requirements. For example, both MassHealth (Medicaid) and CMS (Medicare) contracts require individualized care plans, but the MassHealth contract calls for primary care teams, whereas the Medicare SNP contract calls for an interdisciplinary team.

[12] The New York MAP program targets persons 21 years and older who are certified for nursing home–level care, making the target group in New York quite different from the SCO target group. For more on the New York MAP program, see Edwards et al., *Integrating Medicare and Medicaid*.

[13] Senior Whole Health sometimes delegates the nurse care manager role to certain large primary care practices in its network.

welcome call to the new member and administers a brief, standardized, telephonic health risk screening. Although this initial screening is not required contractually by Medicaid or Medicare, the plan finds early telephone screening an important and effective method for identifying any pressing needs of its new members before a more thorough initial assessment can be completed.

As required by the SCO contract, SWH ensures that every member has a PCP, who is responsible for establishing the overall clinical direction for each member. SWH also schedules an initial assessment of need within 30 days of enrollment and follow-up assessments at least every six months, as required by the MassHealth contract. One of the nurse care manager's roles is to ensure that timely assessments are conducted.

The SCO contract requires SWH (and all SCO vendors) to contract with the State's Aging Services Access Points (ASAPs) for geriatric support services coordinators (GSSCs). The GSSCs determine members' needs for community long-term services and supports, and coordinate the provision of those community services. The GSSCs' recommendations are uploaded into SWH's Center Enrollee Record. Nurse care managers retrieve this information from the centralized record system and use it in creating individualized care plans for members with long-term care needs.

The nurse care manager synthesizes all relevant information from the welcome call screening, the initial and ongoing assessments, the GSSC's recommendations, and other sources to create an individualized care plan.

For relatively "well" members, the nurse care manager's role is less intensive, and includes periodically monitoring the individualized care plan and responding to requests from the member, PCP, and other team members.

Commonwealth Care Alliance

Commonwealth Care Alliance (CCA) is a private, nonprofit health plan that specifically focuses on serving dually eligible beneficiaries. It is a mission-driven organization led by a physician, Dr. Robert Master, whose entire professional career has been devoted to developing and operating better care models for the most vulnerable segments of the health care system—older persons of low income and persons with disabilities. [14]

Commonwealth Care Alliance was formed in 2003 by a coalition of health care advocacy organizations that focus on improving health care for the poor. CCA refers to itself as a "consumer-governed" organization, with the members of its board chosen by its coalition of founding organizations. CCA is also an outgrowth of the Boston Community Medical Group, a coalition of providers who came together in 1998 as a network of health care practitioners with a common mission to improve the quality of medical and social services to poor people in Boston.

[14] R. Master and C. Eng, "Integrating Acute and Long-Term Care for High-Cost Populations," *Health Affairs* 20, no. 6 (November/December 2001): 161–72.

The SCO program is currently the only managed care product CCA offers. However, CCA is in negotiations with the state to expand its membership to dually eligible beneficiaries with disabilities under the age of 60.

Commonwealth Care Alliance's Approach to Care Management

The CCA care management model is unique among the four plans in its extensive use of nurse practitioners as care managers. CCA employs 58 nurse practitioners at various sites around Massachusetts, each of whom is assigned a caseload of approximately 50 members (newly employed nurse practitioners build up their caseloads gradually). CCA reported that its nurse practitioners are given broad decision-making authority regarding the care management of members, in alignment with scope of practice guidelines permitted under Massachusetts state law. Working within the overall clinical direction outlined by the PCP, the role of the nurse practitioner is to significantly extend the reach of primary care through the care management process. The plan reported that because CCA promotes a strong collaborative relationship between PCPs and nurse practitioners in its care management model, it is selective in recruiting new primary care sites to participate in its network. The primary care physicians in the CCA network must be comfortable with CCA's collaborative model and work well in a team environment. Although CCC's enrollment increased about 40 percent annually in 2007 and 2008, it remains small relative to Senior Whole Health. CCA senior staff believe that its strong adherence to its care management model has forced it to grow more slowly than it otherwise could. CCA invests almost no resources in a formal marketing program, instead relying on the word of mouth of its members and referrals from its primary care sites for membership growth.

ARIZONA LONG TERM CARE SYSTEM

The two Arizona plans selected for the study operate within the Arizona Long Term Care System (ALTCS). ALTCS is the long-term care component of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program.[15] AHCCCS, which has been operating under a Section 1115 waiver authority since its inception in 1980, provides medical assistance to Arizonians with low incomes under terms and conditions that differ somewhat from the usual Medicaid statutory requirements. One way AHCCCS differs from other state Medicaid programs is that all medical assistance is provided through a managed care framework. There is no fee-for-service system in the Arizona Medicaid program, only managed care.

ALTCS is the long-term care component of AHCCCS and is a mandatory managed care program. In order to receive publicly financed long-term care benefits in Arizona, one must apply directly to ALTCS. If determined eligible, an individual must then enroll in one of the health plans selected by the state to participate in ALTCS. In most areas of the state, due to low population densities, only one contractor is selected per county. In Maricopa County (Phoenix), where more than 60 percent of the population of Arizona resides, four contractors participate in the ALTCS program, and persons who are newly

[15] AHCCCS, the Arizona Health Care Cost Containment System, is the name of Arizona's Medicaid plan for primary and acute care.

eligible for ALTCs may choose from among three of them.[16] Figure 1 shows the distribution of the ALTCS membership across the four health plans that provide long-term care services in Maricopa County.

In counties with only one managed care plan, persons eligible for long-term care benefits must enroll in that ALTCS plan to receive benefits. In Maricopa County, members who are dissatisfied with their plan may switch to another plan during the open enrollment period. However, the number who switch plans during open enrollment is very small. The plans primarily compete with one another during the member's initial enrollment. Plans distinguish themselves by their long-term care (and acute care) networks, their reputation for quality services, and, to some degree, the distinct nature of their models. However, because all of the ALTCS plans operate under relatively detailed program requirements specified by their contracts with the state, the differentiation of their care management models is not as great as in the Massachusetts SCO program.

ALTCS, unlike the Massachusetts SCO program, is not designed as a fully integrated Medicare-Medicaid program. ALTCS members are not required to receive both their Medicaid benefits and their Medicare benefits through the same health plan.[17] However, the state currently requires all ALTCS contractors to have a companion Medicare SNP product, or "have an association with a SNP," through which a member may receive Medicare services. All four ALTCS contractors in Maricopa County have companion SNPs and attempt to enroll as many of their dually eligible members into their SNPs as possible. In Maricopa County, about half of all ALTCS recipients are also enrolled in the companion SNP. ALTCS members are not required to select the companion SNP and may choose an entirely different SNP or a different Medicare Advantage Plan, or to receive Medicare services under the fee-for-service system.[18]

[16] One of the four plans did not win a renewal contract in the last round of bidding, and is presently closed to new membership.

[17] CMS prohibits mandatory enrollment of Medicare beneficiaries into managed care plans (either Medicare Advantage plan or a SNP); consequently, Medicaid recipients receiving services under ALTCS mandatory managed care system must be allowed to choose where to receive Medicare services. The Massachusetts SCO program does not face the same issue because enrolling in the SCO managed care plan is optional for Medicaid; however, choosing to do so implies also choosing to receive Medicare services under the SCO.

[18] The project did not focus on dual eligibles who chose to receive Medicare benefits outside of the companion SNP to the ALTCS plan from which they receive Medicaid services. Persons receiving services from two disparate systems might face particular challenges in coordinating care.

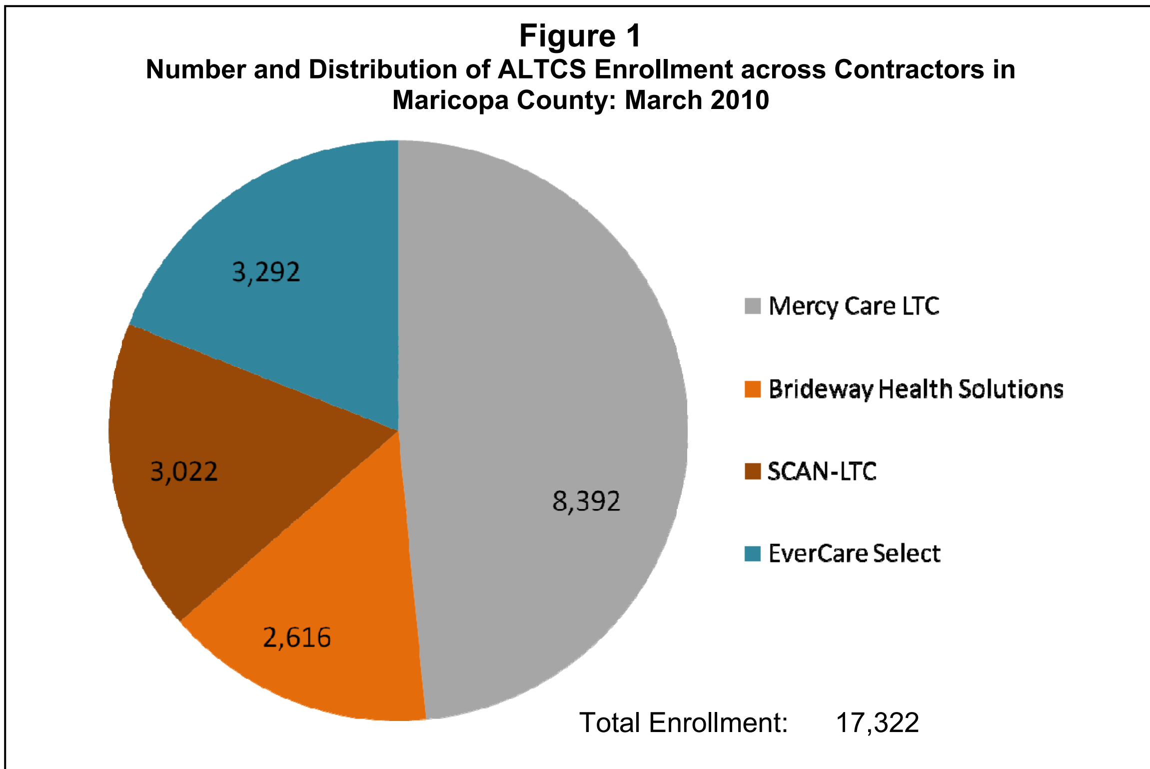

Figure 1
Number and Distribution of ALTCS Enrollment across Contractors in Maricopa County: March 2010

Mercy Care Plan

Mercy Care Plan is a not-for-profit managed care organization created in 1985 by Catholic Healthcare West and Carondelet Health Network. It is administered by Schaller Anderson, a for-profit company owned by Aetna. It has offered primary and acute AHCCCS plans since 1985, and has been an ALTCS contractor in Maricopa County since 2000. Its entry into ALTCS occurred as part of a transition in Maricopa County, which had previously operated the ALTCS program. Key Mercy Care executives and several care management staff moved to Mercy Care's ALTCS plan (Mercy Care Long Term Care) from Maricopa County's now defunct plan.

Mercy Care Plan's affiliation with St. Joseph's Hospital & Medical Center, the oldest hospital in Phoenix, gives it strong brand appeal in the Arizona market. Mercy Care Plan is the state's largest Medicaid contractor in both the AHCCCS and ALTCS programs. It offers AHCCCS plans in five counties and has more than 300,000 of the state's 1.1 million AHCCCS members. Mercy Care's ALTCS plan has about 8,400 members in Maricopa County, making it the largest ALTCS contractor in both the county and the state.[19] Eighty percent of Mercy Care ALTCS members are dually eligible for Medicare and Medicaid; the remainder are eligible only for Medicaid.

[19] The combined membership of the three other ALTCS contractors in Maricopa County is about 6,600. Total statewide enrollment of older persons and persons with physical disabilities into ALTCS is around 25,000. The next largest ALTCS plan after Mercy Care is the Pima Health System Plan (operated by Pima County), with about 4,000 members.

Mercy Care began offering a Medicare plan in 2006. Mercy Care Advantage is authorized by CMS under the Medicare Advantage program as a Dual Eligible Special Needs Plan, and is offered in Maricopa, Pima, and Santa Cruz counties. Mercy Care Advantage has about 14,000 members, 3,700 of whom are also enrolled in Mercy Care Long Term Care.

Mercy Care Plan's Approach to Care Management

We were primarily interested in how Mercy Care approaches care management for its dually eligible members who are concurrently enrolled in Mercy Care Long Term Care and Mercy Care Advantage. The ALTCS case managers are responsible for coordinating overall care, including acute, long-term, and behavioral health care; prescription drugs; and informal supports. Case managers work with the PCP to authorize clinical services, initiate and monitor services, and complete long-term care assessments and individualized care plans in members' homes. Most of the 155 case managers are nonclinical, with degrees and experience in social work and related fields.[20] The team includes six nurses who are available for consultation and are assigned medically complex members, and twelve behavioral health case managers who are all master's degree level clinicians.

On average, case managers carry a caseload of about 55 members each. Specific caseload ratios are mandated by setting in the ALTCS contract: 1:48 for home-based long-term care members, 1:60 for members in assisted living facilities, and 1:120 for members in skilled nursing facilities. Case managers tend to be assigned by setting.

Mercy Care Long Term Care extends its clinical capacity through a contract with Inspiris, a national company that specializes in providing intensive primary care in home and facility settings. Case managers can refer high-risk members who consent (particularly those who have trouble accessing primary care) to Inspiris. A physician or nurse practitioner from Inspiris is assigned as the PCP. PCPs visit members in their homes (once per month, on average), create care plans with them, and coordinate with case managers to order services and coordinate other aspects of care. Inspiris provides 24/7 coverage to its members. Between home visits, members can access nurses at Inspiris with any ongoing medical concerns.

When members are hospitalized, the case manager works closely with concurrent review nurses from the Mercy Care Advantage plan, and at discharge, with the staff from the Mercy Care Advantage "Welcome Home" Program, a telephonic intervention designed to reduce the chance of readmission by ensuring compliance with discharge instructions, improving communication with the PCP, and providing support with nonmedical issues.

SCAN Long Term Care

SCAN Long Term Care of Arizona is an expansion of SCAN Health Plan of California, which began as a not-for-profit community agency in 1977, and was later selected to be one of the sites for the national social health maintenance organization (SHMO)

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[20] Many migrated to Mercy Care from the Maricopa County health system, where they had worked when Maricopa County was the ALTCS contractor.

demonstration in 1984.[21] Headquartered in Long Beach, California, SCAN is a Medicare Advantage Plan with multiple SNP products, serving close to 110,000 elderly residents in southern California.

SCAN was awarded an ALTCS contract in Maricopa County in early 2006, and began enrolling ALTCS members in October of that year. In 2007, SCAN implemented a Dual Eligible Medicare SNP plan in Maricopa County, and in 2009, it implemented a regular Medicare Advantage Plan. Thus, SCAN now operates three health plans in Maricopa County—its ALTCS plan, its Medicare Dual Eligible SNP plan, and a regular Medicare Advantage Plan.

Between March 2009 and March 2010, SCAN Long Term Care experienced growth of 26 percent, increasing enrollment to 3,022 ALTCS members. The plan is aggressively hiring new care managers to keep up with its enrollment growth—about one new care manager per month—and also expanding its network of long-term care providers.

SCAN's Approach to Care Management

SCAN's approach to care management in its Arizona plan is very much an evolution of the care management philosophy developed by SCAN over its many years as an SHMO plan, and later as a Medicare Advantage plan in California. The core of the care management team is the 85 case managers who are required under SCAN's contract with Arizona ALTCS to provide case management services to its ALTCS members. As in the Mercy Health Care Plan, SCAN case managers are mostly individuals with social work degrees and/or social work experience, although a few are registered nurses (RNs). The duties, functions, and responsibilities of SCAN's case managers, since they are highly specified in SCAN's ALTCS contract, are similar to those of the case managers at Mercy Care. Indeed, many of the SCAN case managers had previously been employed by Mercy Care, but moved to SCAN when SCAN won its first ALTCS contract in 2006.

However, SCAN's care management model also includes some unique features. First, SCAN had made significant investments in promoting the use of information technology among its case management team. All SCAN case managers are equipped with laptops and portable printers so that they can complete onsite assessments and care plans during home visits and obtain any required sign-offs from members before leaving the house. They also carry company cell phones so that they can make referrals, follow up on prescription orders, or order transportation services on the spot. The SCAN case managers stated that they often use their own personal cell phones simultaneously with their company phones. For example, a case manager may "receive" a problem from a member on one phone, then immediately "resolve" the problem through a call to a provider or to SCAN on the other phone. During our site visit, case managers were advocating for portable scanners as well, so they could scan and store members' documents on the spot.

In its member services department, SCAN has established a "Medi-Medi Personal Assistance Line (PAL)," a group of specially trained call specialists for its dually eligible

[21] SCAN was one of four original SHMO sites nationally. The SHMO demonstration tested the effectiveness of adding a limited long-term care benefit to Medicare through capitated Medicare health plans.

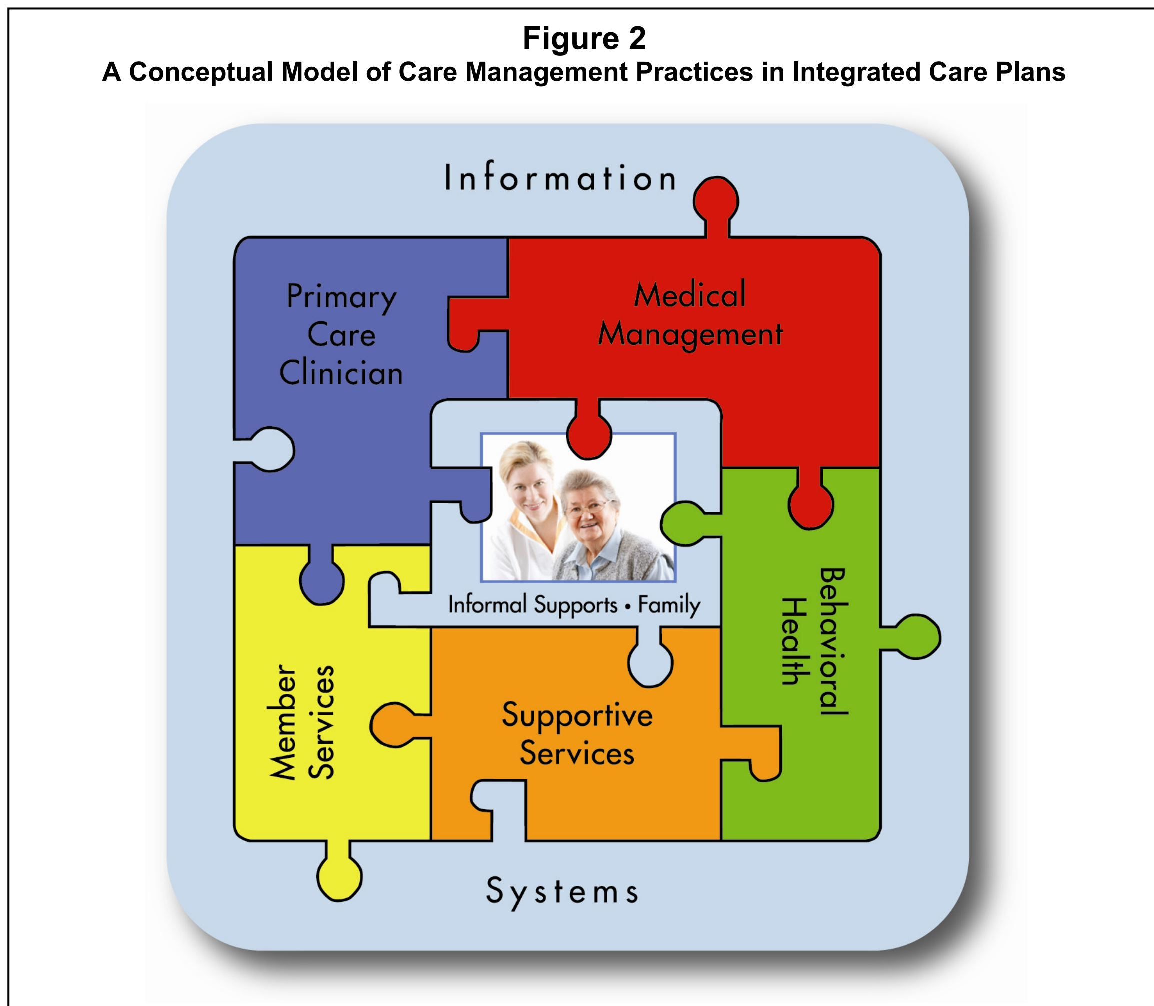
members. The PAL call center specialists are knowledgeable about both Medicare and Medicaid benefit policies and can therefore help members with issues related to either program. SCAN also employs a "case manager of the day" policy, so that a case manager is always available 24 hours a day to take calls from members.

SCAN case managers reported that they receive extensive information on their members' use of Medicare-covered benefits from the Medical Management department of SCAN's SNP. The case management team also includes an RN who is designated the "transitions coordinator," whose sole responsibility is to visit all members who are in the hospital and to follow them postdischarge to ensure a smooth transition back to the community. SCAN has adopted Eric Coleman's Care Transitional Model in managing hospital discharges and preventing avoidable readmissions whenever possible.

FRAMEWORK FOR DESCRIBING CARE MANAGEMENT PRACTICES ACROSS INTEGRATED CARE MODELS

Although each plan approached care management with its own unique structures, roles, and processes, we identified five areas that were key components of the care management models employed by all four plans: the primary care clinician, medical management, behavioral

Figure 2
A Conceptual Model of Care Management Practices in Integrated Care Plans



health management, supportive services, and member services. Figure 2 presents a framework for describing the key components of the care management practices that were observed across the four plans. The framework is far-reaching in scope, encompassing the broad set of medical and supportive service needs of dual eligibles

The conceptual model is presented in the form of a jigsaw puzzle—a structure of interconnected (and interdependent) parts. At the center of the model is the member, the member's family, and the member's informal support network. The member is a central component in the care management process, since his or her preferences, behaviors, and actions have a large impact how care is coordinated. Every plan is required by its contract with the state Medicaid agency to ensure member participation in care planning. Member participation is achieved primarily through regular in-home assessments and modifications to care plans, which members sign off on prior to implementation.

The care management components provided and coordinated by the health plan are characterized by the pieces of the jigsaw immediately surrounding the member. A discussion of each component follows.

SUPPORTIVE SERVICES

As integrated care plans providing both Medicare and Medicaid services to their members, each plan's care management model includes the management of long-term supportive services and coordination of these services with members' medical benefits. Plans receive Medicare and Medicaid capitation payments to pay for their members' medical and long-term services and supports.

Our goal was to describe the approach that each plan takes to integrate medical care and social services and supports. In the case of the two Massachusetts plans, this required distinguishing the role of the SCOs from that of the ASAPs (most of which are Area Agencies on Aging), with which SCOs are required to subcontract for GSSC services to all members with complex care needs. As a consequence, the role the two Massachusetts plans play in integrating and coordinating medical care and long-term services and supports for their members was less obvious than in the two Arizona plans.

The ASAPs play the lead role in providing case management services to persons receiving Medicaid-financed home care services in the Massachusetts fee-for-service system. This role was built into the design of the SCO program. When the state legislature mandated a role for the ASAPs in care management of SCO members, some thought that it would produce tensions in the overall care management process. One of the concerns of the SCOs was that they would be clinically and financially responsible for the member's care but one component of that care—home care services—would be primarily assigned to another entity (the ASAPs). At our site visits, we did not observe any such tensions. There appeared to be good collaboration, and mutual respect, between the SCO plans and their associated ASAPs. We visited two of the four SCO plans operating in Massachusetts, and two of the many ASAPS that participate in the SCO program. At the sites we visited, the nurse care managers and the ASAP GSSCs worked in tandem to provide care oversight for their SCO members. The nurse care managers took the lead on managing the member's medical needs, while the GSSCs took the lead for oversight of the member's long-term support services and general social condition. The nurse care manager and the GSSC generally timed their home visits with the member so as to not overlap. For example, if each was scheduled to conduct a home visit every

three months, they might space their home visits six weeks apart from each other. Based on our conversations, the GSSCs generally appreciated having someone with more medical knowledge with whom they could consult on medically related issues, while the SCO nurse care managers appreciated having the GSSCs to take the lead on their members' many socially related problems.

In some cases, the nurse care manager and the GSSC might work together on solving the same problem. For example, on one of our home visits, an SCO member had lost her primary care physician, who had decided to leave her practice and relocate to another state. The GSSC did a lot of the legwork in relieving the member's concerns about having to select another primary care physician in the network and discussing various options with her. The GSSC then worked closely with the nurse care manager to ensure that the member secured a replacement primary care physician of her choice.

Splitting care management responsibilities between the SCO and the ASAPs is not without its challenges. One weak link in the chain is the inability of the SCOs and the ASAPs to fully share information systems. For data security reasons, the ASAPs did not have full access to the electronic records maintained by the SCOs. Thus, they did not have access to case notes maintained by the other members of the SCO management team—the nurse care manager, the community resource coordinator, or the primary care physician. Communications between the ASAPs and the SCOs were primarily by phone or e-mail.

The two Arizona plans do not have a similar mandate to subcontract with a third party for social services; thus, the plan assumes the responsibility for providing and coordinating social service supports to its members. All ALTCS members are eligible for either nursing home or home and community-based services, and all members are assigned a designated case manager, who has overall responsibility for managing care across the spectrum of Medicare and Medicaid services. Some of the case managers employed by Mercy Health Plan and SCAN Long Term Care (LTC) Plan are nurses, but most have nonmedical degrees in counseling, social work, or related fields.

In summary, social services coordination is handled quite differently in the two states. In Massachusetts, the function is largely contracted out to the ASAPs, whereas in Arizona, where all members are nursing home certified, coordination of long-term care and related supports is a core function of the plan's lead case managers. This difference appears largely a function of the basic program designs (and thus driven by state policy) rather than the care management philosophies of the plans themselves.

Primary Care Clinician

Enhancing primary care is a key objective of all four plans we visited. People we spoke to at all levels of the plans (executives, supervisors, care managers) cited the importance of good primary care in promoting health and preventing admissions to hospitals. Each plan had unique strategies for strengthening primary care.

CCA has purposefully limited its network by contracting selectively with primary care sites that are committed to working closely with CCA's nurse practitioner care managers. Nurse practitioners are assigned to practices and, over time, they are viewed by the practice as an extension of the PCP, rather than an overlay imposed by the health plan. Senior Whole Health also uses nurse care managers extensively to interface with PCPs,

but with its larger network of about 650 PCPs, the nurse care managers interface with more practices but with less frequency within each practice. As a consequence, nurse care managers from SWH are generally more associated with the plan. In both cases, the nurse care managers cultivate relationships with PCPs and their staff through regular communication.

The level of systems integration between the SCO plans and PCPs to access patient records varies by practice. Some PCPs give nurse care managers direct access to their electronic patient records. Others receive hard copies of patient records, which they upload into the Centralized Enrollee Record that SCO plans are contractually required to maintain.

ALTCS plans employ primarily nonclinical staff as care managers. Their care managers also reach out to primary care clinicians. Both the Arizona plans have processes for supporting care managers when PCPs are not responsive to their contacts, such as having a supervisor, nurse, or medical director assist with the contact. Mercy Care in Arizona has also contracted with Inspiris, a specialty primary care company, to serve members with particularly complex needs or who have difficulty accessing the plan's PCP networks. Inspiris employs doctors and nurse practitioners who visit members in their homes and coordinate services through the ALTCS case managers.

All four plans said they place special emphasis on communicating with the PCP around transitions, particularly hospital discharges. With the rise of the hospitalist model,[22] hospitals often do not inform PCPs o when their patients are admitted or discharged. The plans are notified promptly, however, because the hospitals need to notify them for payment. Care managers from the plans in turn notify PCPs. When members are discharged, care managers work with PCPs to reconcile prescriptions, order home services as needed, and schedule follow-up visits for the members.

Other strategies used to strengthen primary care include the following:

- Care managers in one plan use a one-page form to help members prepare for PCP visits. The form serves as a crib sheet for the member, and also helps the member become more comfortable bringing up issues with the PCP.
- Some plans use electronic reminders to care managers in their electronic systems to prompt PCP visits, flu shots, and other priority events.
- Some plans contract with transportation organizations to provide transportation to medical appointments.
- All plans have staff conferences or other team mechanisms for solving particularly complex member problems. At least one plan sends the PCP a written summary with recommendations following a staff conference.
- Care managers work with PCP offices to facilitate durable medical equipment orders.

[22] Hospitalists are employed by hospitals to attend to admitted patients. In the past, PCPs followed their patients into the hospital to attend to them there.

Plans use a range of strategies to support primary care, but they all acknowledge the time demands placed on PCPs. The plans indicated that their objective is to complement the work of the PCP by conducting primary care interventions for which the PCP may not have time. Rather than trying to get PCPs to attend interdisciplinary team meetings, for example, the plans use care managers to interface with PCPs and, where available, electronic records to view the PCPs case notes, so they can ensure virtual, if not in-person, participation.

MEDICAL MANAGEMENT

Medical management is a term all the plans use to describe the management of clinical services. It applies to the management of chronic conditions, such as diabetes and lung disease, over time in the home, and also to acute episodes resulting in hospitalization. It includes services provided by medical directors (who, for example, call PCPs or participate in case reviews when the care manager has requested support), nurse care managers, concurrent (hospital) review departments, pharmacy consultation, and other services provided by clinically trained individuals.

The PCP plays a key role in medical management by providing overall clinical direction. When specialists are involved or a member is hospitalized, plans rely heavily on nurse care managers to coordinate across clinicians and settings.

All four plans have triage strategies for assigning nurse care managers to members who have medically complex conditions. In Massachusetts, the SCO contract requires that a nurse be part of a team whenever a member is determined to have complex care needs. Nurses are used less regularly in ALTCS plans, but both Mercy Care and SCAN have some nurse case managers who are assigned medically complex cases, and who are available to consult with nonclinical case managers as needed.

Medical management is activated universally across the plans in the event of a hospitalization. A utilization review (UR) nurse is often the first to hear about a member's admission, and will enter notes into an electronic case system and contact the care manager via an alert on the system, e-mail, or phone. In some plans, the UR nurse is the primary contact with the hospital and becomes involved with discharge planning. In other plans, a nurse care manager plays that role, but in either case, the plan's electronic record system is used to ensure that key parties within the plan are informed and are playing their designated roles.

Some of the plans have special transition staff who monitor members at discharge, ensure compliance with discharge orders, work with PCPs on medication reconciliation, and ensure that both formal and informal home supports are in place.

Plans also use various methods of supporting care managers through interdisciplinary case reviews. Managers use criteria to bring cases to weekly meetings, and care managers may ask that any of their cases be reviewed. All plans focus on members who have been hospitalized, and all report that they are exploring ways to identify them earlier, so case reviews can become more preventive in their focus. At least one plan uses clinical management software to review claims for high-risk cases, but the more typical practice appears to be using daily census reports to review members who have been hospitalized.

All four plans engage in patient self-management education. Some have formally adopted the Chronic Disease Self-Management Program (CDSMP) developed by the Stanford Patient Education Research Center in California, a model that has been adopted widely by health prevention and wellness initiatives across the country. The CDSMP entails six weekly sessions of two and a half hours each where members learn how to communicate effectively with their providers, appropriately administer medications, and receive exercise training and nutrition counseling.

Some plans have also implemented caregiver support programs. Plans use written materials, Web sites, phone communications, and formal classes to train informal caregivers about nutrition, personal care techniques, fall prevention, and how to use respite services effectively. The plans informed us that the objective of offering these support programs was to formally acknowledge the critical role of informal caregivers in care management activities, and to encourage informal caregivers to utilize the supports available through the plan in emergencies and crises.

To summarize, tools and strategies for medical management include the following:

- Electronic notification of the care manager when a member has been hospitalized
- Transition programs that focus on successful discharges to home
- Case conferences for high-risk members
- Member education about chronic disease management and caregiver support
- Assignment of nurses as care managers for medically complex members
- Medication reconciliation

BEHAVIORAL HEALTH

All four plans indicated that their dually eligible members use behavioral health services extensively. The approach to coordinating behavioral health services varies across plans. In at least one plan, behavioral health services are subcontracted through a behavioral health services company, and specialists at that company manage the behavioral health service portion of the care plan. In that model, the care manager works with the behavioral services manager to ensure that behavioral and health services are well coordinated. Other plans have behavioral health specialists on staff who are assigned as care managers for members whose needs are primarily behavioral. Those specialists are also available to consult with other care managers about members' behavioral health needs.

Tools and strategies used to coordinate behavioral health needs include the following:

- Sending a psychiatric nurse consultant to do an in-home assessment when a care manager has identified a need and the member has agreed to the visit
- Bringing behavioral health issues to regular case conferences for multidisciplinary input
- Conducting pharmacy review for members using psychotropic and other drugs related to behavioral health, and bringing issues to the care manager's attention

- Including behavioral health screening questions on regular assessments that are conducted on members
- Tracking members admitted to inpatient and residential behavioral health facilities
- Seeking public guardians and mental health power of attorney as appropriate

MEMBER SERVICES

Member services consist of the frontline staff of the health plan who answer members' phone calls and try to respond to their issues and problems. We surmise that member services play a more prominent role in the care management models of integrated care plans (not just the plans we interviewed) than is typical in a traditional health plan for a number of reasons. First, the plans serve a very vulnerable population with multiple chronic conditions and deficiencies in activities of daily living. Second, the members are more culturally diverse than those of a traditional health plan, with a high percentage not speaking English as their primary language. Consequently, effective communication with their members is particularly challenging for these plans. Third, member service departments traditionally deal with the myriad problems that members encounter with inappropriate billing, setting up medical appointments, getting prescriptions filled, arranging for transportation to medical appointments, and so on. In integrated care plans, they face a greater array of issues that include both health and long-term support issues. Long-term-support-related issues include addressing "no-shows" of personal care providers, housing-related problems, Medicaid eligibility issues, and problems with transportation.

Senior Whole Health plan has built a specialized Member Services department of 14 community resource coordinators (CRCs). All 14 CRCs are at least bilingual, and they possess a combined proficiency in 19 different languages. This language proficiency reflects the cultural and ethnic diversity of SWH's membership. The ability to speak to a member in his or her own language, be it Chinese, Russian, Portuguese, Laotian, Cape Verdean, Polish, or Hmong, was cited as a significant factor in supporting a better care management process.

CRCs at Senior Whole Health handle all initial requests from members that come directly to the plan. These include requests for additional services, education and support, questions about specific providers, pharmacy issues, and complaints. The CRCs all have access to SWH's Centralized Enrollee Record, and enter all telephonic contacts with members in the record. They work closely with the member's designated nurse care manager, as well as with the member's designated GSSC employed by SWH's contractors, the ASAPs. Because the CRC is considered an integral member of the care management team who is able to speak to the member in his or her own language, the CRC often serves as the main point of contact with the member in addressing the member's issues and problems. CRCs at SWH are also responsible for conducting new member welcome calls, orienting new members to the SWH plan, and performing a health-risk screening. Another responsibility is to help members retain their eligibility for Medicaid coverage at the point of eligibility redetermination—no small task.

Member services are also a prominent feature of Commonwealth Care Alliance's care management model. CCA indicated that it places a strong emphasis on including members in decision making.[23] As part of its effort to offer a more member-centered model, CCA organizes local consumer meetings to elicit feedback from its members. CCA employs a significant amount of effort to recruit members to attend these meetings. In 2008, CCA conducted eight consumer meetings in the local neighborhoods, and conducted the meetings in the members' own languages. CCA strongly believes that asking members what they think of the care they receive is essential to maintaining the high quality standards it strives to maintain.

INFORMATION SYSTEMS

The last feature of the conceptual model is information systems, represented in figure 2 as the border of the jigsaw puzzle that holds all of the other pieces in place. While all four plans have some kind of centralized electronic record that contains shared information on each health plan member, this centralized record was far from a comprehensive electronic medical record. In addition, care managers at times had to access information systems other than the centralized electronic record maintained by the plan to obtain information about a member. While the concept of a centralized electronic record of information that provides comprehensive medical and nonmedical data to all of those involved in care management activities is generally regarded as a gold standard, the reality is that the providers we interviewed (and medical information systems in general) are a long way from the gold standard. Instead, care managers rely on multiple information systems (not always electronic systems) to support their care management activities.

COMMON THEMES ACROSS CARE MANAGEMENT PRACTICES

Beyond similarities in their basic constructs, other common themes were evident across the four plans.

HOME VISITS

All plans are contractually required to visit members in their homes at specified intervals, and all appeared committed to doing so. This commitment was exhibited not only by frontline care managers, but often by PCPs as well. Plans were accountable for both the member's medical care *and* social support needs. Therefore, home visits were considered essential for evaluating the member's total health, social, and emotional condition. Care managers often commented on how assessments conducted in physicians' offices or other health care settings are often influenced by the members' desire "to put their best foot forward." Evaluations conducted in the member's own homes were considered more reliable assessments of a member's true condition. Home visits also create an affiliation between the plan and the member that is not possible when encounters always take place on the provider's "turf."

[23] CCA's 2008 Annual Report states, "Member participation and involvement are crucial elements of Commonwealth Care Alliance's organizational identity and model of care."

TEAM APPROACH

The care management cultures of the four health plans embodied a team approach to supporting their dually eligible members. The plans worked to engage the primary care physicians in setting the overall clinical direction of their members' care, working through the care manager to share patient information between the PCP and other providers, and to coordinate medical care and long-term services and supports.

Some plans, such as CCA, discussed how it was important to recruit physicians who are comfortable working in a team environment to join their networks. The team approach was also evident among the frontline care management staff. Care management staff would often engage in group problem-solving of individual cases, hold interdisciplinary meetings to discuss particularly challenging situations, and provide backup coverage when a person was on vacation or out sick. Plans operationalized a team approach despite having team members who were usually situated in different locations. Members of the team use electronic and traditional means to coordinate with one another on behalf of members.

MANY TOUCHES

The plans held a common philosophy of "touching" their members at frequent intervals. By "touching" we mean some kind of contact—in person, by phone, by mail, and so on. Contacts could be made by any member of the care management team, and information obtained during a contact would be shared through a centralized information system. Many "touches" allowed the plans to take a more proactive approach to the care management of their members, to stay ahead of the game, and to prevent avoidable acute care events whenever possible.

DECENTRALIZED DECISION MAKING

A common perception of managed care plans is that they control costs through a highly centralized decision-making structure that controls the allocation of resources to their members. From our observation, however, the four plans were remarkably decentralized in their decision-making authority regarding the allocation of resources. Care managers had broad authority to authorize service plans in accordance with the member's needs, to increase services in accordance with health status changes, to make referrals to specialists, and to authorize alternative therapies. Geriatric nurse practitioners at CCA have particularly broad authority, offered in part by their plan's care management model and in part because under Massachusetts state law, nurses can write prescriptions and perform other medical tasks normally limited to licensed physicians.

SELF-DIRECTED SERVICES

All four plans support self-direction of personal care services within the context of overall care management. This is available in two forms at all four plans. The first form is an agency model, in which a member selects a personal care worker (often a family member) who then becomes an employee of the agency providing personal care services. The second form involves a fiscal employer agent, with whom the member contracts directly for personal care and attendant services. Plans report high support for these approaches, since they often result in more reliable and readily available care than traditional agency-based services.

Shift in Resources to Primary/Preventive Care

All plans reported that they use the flexibility of capitation payments to invest additional resources in primary and preventive care services. These investments can be viewed as "bets" made by the plans that allocating increased resources to primary care services will yield returns through reduced utilization of higher cost, preventable services, including hospital admissions and nursing home stays. While documenting these kinds of returns on investment was not the focus of this study, all of the plans stated that they had achieved significant reductions in hospital and nursing home utilization relative to actuarial expectations at the plan's inception.

A Focus on Transitions of Care

A common focus of all four plans was to manage care transitions more effectively across care settings, such as hospital discharges to the community, nursing home admissions from hospitals, and transfers from one assisted living facility to another. All four plans recognized that care management processes in the traditional health care system tend to fail when patients transition from one care setting to another. Care managers in one plan had adopted Eric Coleman's Care Transitions Program, in which a transition coach is assigned to all members discharged from hospitals to ensure that necessary care management processes are coordinated and adhered to.

Supporting Care Managers with Information Technologies

The plans recognize that the success of their care management models depends to a great extent on the productivity of their frontline care managers. Thus, the plans have invested in technology support that allows care managers to be as productive as possible in the field, since much of their time is spent out of the office. For example, SCAN equips all of its care managers with corporate cell phones that are integrated with their land lines so calls can be received anytime, and voice messages all go to one system. SCAN also equips its care managers with portable printers, so that it they can conduct an assessment or complete a form, print it, and have the member sign the form, all in the same visit, rather than having to return to the office to complete the paperwork and obtain the requisite signatures by mail.

Targeted Initiatives

The plans also implement special initiatives, beyond what is offered in their "standard" care management models, to enhance quality through their care management practices. A common objective of special initiatives is reducing preventable hospital readmissions. The medical research literature finds that 20 percent of Medicare beneficiaries are readmitted to a hospital within 30 days of discharge. Further, the findings suggest that a high percentage of these hospital readmissions are attributable to poor continuity of care after the initial discharge and, by extension, may be preventable with adequate interventions.[24]

[24] S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* 360 (April 2, 2009): 1418–28.

High hospital readmission rates not only have a negative financial impact on plans, but can lead to further declines in health care functioning of plan members, high rates of nursing home placement postdischarge, and lost opportunities to maintain members in a community-based setting. To reduce hospital readmission rates, SCAN LTC Plan designates its own hospital discharge nurse, whose sole responsibility is to visit members while they are hospitalized, coordinate discharge planning with the hospital discharge planner, follow up with the member in the postdischarge period to ensure adherence with discharge plans, and work with the member's "regular" care manager to ensure that services are put in place to support the member's rehabilitative period.

Mercy Health Plan serves a large number of ALTCS members with serious psychiatric illnesses. Consequently, Mercy has a behavioral health unit of 12 care managers, each of whom has specialized behavioral health care training, to manage the 412 members in the plan with serious psychiatric needs. The unit has three "product lines" within behavioral health, reflecting three different levels of need for services and supervision, and is developing a network of providers, including residential providers, who match these need levels. The unit also focuses on developing a power of attorney for each member assigned to the behavioral health unit, in order to facilitate admissions to a Level I facility if members experience acute psychotic episodes. The goal of the behavioral health unit is to maintain members with psychiatric illnesses at the highest level of independence possible appropriate to the member's level of illness, while ensuring that members receive the level of support and supervision needed to ensure their health and safety.

FLEXIBLE BENEFIT PACKAGES

Managed care structures give health plans more flexibility over the benefit packages they offer than traditional fee-of-service arrangements. While the plans are contractually responsible for providing both traditional Medicare- and Medicaid-covered benefits, as would be provided in a fee-for-service system, these plans have some flexibility to offer additional benefits not typically provided by fee-for-service programs.

In general, the Massachusetts SCO plans are allowed greater flexibility in their benefit packages than the Arizona plans. Since the SCO program began as a demonstration program to test the integration of Medicare and Medicaid into a single plan, its history fosters an environment that is more conducive to innovation and experimentation. The ALTCS program, in contrast, is the mainstream program in Arizona and, therefore, is more tightly managed by the state. While Arizona does not discourage plans from providing services above and beyond what is contractually required in ALTCS, the focus is to ensure that the plans are adhering to the state's contract specifications.

Both Commonwealth Care Alliance and Senior Whole Health provide a very broad benefit package for their members, particularly those who are "nursing facility eligible" and qualify for home and community-based services. We were informed that the philosophy of SCO is to provide whatever supportive services members need to stay in their own homes, including hiring family members as personal care providers.[25] Transportation services are provided so that members can attend social events to become

[25] Payments to family members as personal care providers are also allowed in Arizona.

more engaged in their communities and relieve loneliness. Gym memberships are sometimes covered as a benefit to enable members to use swimming pools for exercise and physical therapy. Acupuncture treatments are also authorized to alleviate pain. Both CCA and SWH recently instituted a new benefit that reimburses members for the first $100 of over-the-counter medications and treatments purchased each quarter. This benefit is meant to encourage members to purchase these medications, if they need them. The SCO plans also cover skilled nursing facility stays without a prior hospital admission (which is not allowed under Medicare) as an alternative to hospitalization, or as a respite benefit for family caregivers who need relief from caregiving.

COMMON CHALLENGES ACROSS PLANS

The plans we visited also reported common challenges to care management when working with multiple providers and two different major funding sources (Medicare and Medicaid).

OVERLAPPING ROLES

All four plans acknowledged some overlap in care management functions between their nurse care managers and other entities involved in the care and coordination of members. As a result, the plans engage in ongoing and iterative refinements of the care manager's role. In Massachusetts, the mandated role of the ASAPs creates some overlap with the role of the nurse care managers. Both ASAP and plan representatives reported that the mandated relationship has worked much better than they thought it would when the program was being planned, but improvements could be made to delineate roles, coordinate home visits, and integrate assessments to minimize duplicative efforts and improve the flow of information between the SCO and the ASAP. In Arizona, when Mercy Plan assigns members to Inspiris, a subcontractor that provides primary care in member's homes, the respective roles of the Mercy case manager and Inspiris staff are not always clear.

NONCOMPREHENSIVE HEALTH INFORMATION TECHNOLOGY

All four plans have electronic care management systems that provide access to claims and other member information. None of the plans has an actual electronic medical record with real-time information, however. Because care management for dually eligible persons involves multiple providers, the lack of an interoperable health information system likely reduces efficiency. Data sharing between providers is accomplished largely by care managers who monitor and update patient records, which can potentially result in delayed or incomplete entries. Care managers we interviewed would like to see greater integration of information sources into one system. A fully interoperable health information system would likely require significant investments in new infrastructure by governments and providers, and while new federal funding for health information technology may accelerate development, the challenges of integrating information across multiple providers will continue to be daunting.

ADMINISTRATIVE DUPLICATION

In general, all plans describe having to work with two major funders (the state for Medicaid and CMS for Medicare) as a significant administrative burden. In care

management, for instance, both the Medicare Special Needs Plan regulations (by which the four plans we interviewed are regulated) and Medicaid state contracts have distinct and separate requirements regarding needs assessment, care planning, and monitoring. The plans must assure each funder that its separate requirements are met, while offering a unified, integrated product to members.

DISCUSSION

This study examined the care management practices employed by four health plans that focus on providing both Medicare and Medicaid services to dual eligibles. While all four plans acknowledged that there was room for improvement in how they coordinated medical and long-term supportive services for their members, they also strongly believed that they have made considerable strides in coordinating the care of their members across providers, in improving patient outcomes, in reducing wasteful and preventable medical events, and in using available resources in a more cost-effective manner.

While there were clear differences in the care management practices adopted by the four plans, there were more similarities than differences. The following are common features of care management practices across the four plans:

- A team approach to care management
- An emphasis on person-centered approaches
- Regularly scheduled home visits to members by care managers
- Extensive use of advanced nurse practitioners and other strategies for extending and enhancing primary care
- A focus on effective care transitions, particularly hospital discharges
- Heavy use of behavioral specialists
- Culturally sensitive care management approaches
- Flexible benefit packages, beyond contractually mandated Medicare and Medicaid services
- Frequent monitoring of members with chronic illnesses
- Emphasis on patient education and patient self-management programs
- Care management structures for dealing with particularly complex cases
- Centralized information systems for sharing information across providers

These care management practices reflect a belief that increased investments in primary care and preventive services will maintain members at the highest level of functional independence possible, delay functional decline, and avoid negative health care outcomes such as hospital readmissions and nursing home placements. All four plans stated that their performance on measures such as hospital admissions, hospital days, and nursing home stays were superior to comparable measures, for comparable populations, in the

Medicare and Medicaid fee-for-service systems. As noted earlier, we did not validate this claim, as collecting and analyzing these kinds of outcome measures was beyond the scope of this study.

The care management practices observed in this study have many similarities to new care management models that have emerged for Medicare patients with multiple chronic illnesses, around which a common vision is emerging.[26] These include Chad Boult's Guided Care Model,[27] Eric Coleman's Care Transitions Program,[28] and Mary Naylor's Transitional Care Model.[29] These models differ from the ones described in this report in that they target all Medicare beneficiaries, not the dually eligible population, and place less emphasis on long-term care services and related social support needs (e.g., housing, poverty, lack of family support).

The commonalities of the four plans observed in this study went beyond the care management tools and structures they utilized—there were also clear commonalities in philosophy and purpose. Whether for-profit or not-for-profit, these plans had a common sense of mission. Their care management philosophies embed a willingness to meet members "on their own ground," such as conducting visits in the member's home, making efforts to speak to members in their primary language, or providing assistance with everyday life activities beyond the member's health care needs. There was a common respect for people who are poor, and a recognition that people who are old and poor often feel disenfranchised by the health care system. Since the plans were responsible for providing the full continuum of Medicare- and Medicaid-covered benefits to their members, an attitude of "this is not our problem" was not present. This was particularly apparent in the plans' interactions with members who had complex care needs, such as persons with severe behavioral and substance abuse issues.

Recognizing the limitations of observational studies, we offer two recommendations regarding the further development of integrated care models for dual eligibles. The first is that rigorous comparisons of outcomes of persons served through integrated care models versus those served through multiple, uncoordinated programs should be conducted. The four plans visited in this study all claimed that their internal analyses show significant improvements in Medicare and Medicaid utilization patterns, including increased use of primary and preventive care services, reduced readmission rates post hospital discharge, reduced psychiatric admissions, and reduced use of nursing homes for persons with severe functional limitations. They also claim significant improvements in quality, both on health care status measures and quality of life measures, for their members. These programs and others like them should be evaluated through a rigorous analysis of cost and quality outcomes, adjusting for differences in case mix across comparison populations.

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[26] David Reuben, "Better Care for Older People with Chronic Illness," *JAMA* 298, no. 22 (December 12, 2007): 2673–74.

[27] Chad Boult et al., *Guided Care: A New Nurse-Physician Partnership in Chronic Care* (New York: Springer Publishing Company, February 2009).

[28] Eric Coleman and Mark Williams, "Executing High-Quality Care Transitions: A Call To Do It Right," *Journal of Hospital Medicine* 2, no. 5 (Sept/Oct. 2007): 287–90.

[29] Mary Naylor, "The Transitional Care Model for Older Adults." Presentation to the National Health Policy Forum, April 3, 2009.

The second recommendation is for the Centers for Medicare & Medicaid Services to create more opportunities for states to work with the federal Medicare program to expand integrated care models, and to streamline the process. Only about 120,000 of the 8.1 million dual eligibles are currently enrolled in some kind of integrated plan, including PACE plans. Moreover, the plans that currently exist generally took as many as five years to develop because the programs involved had to coordinate their efforts with both state and federal contracting authorities. Under the Patient Protection and Affordable Care Act, Congress established the Federal Coordinated Health Care Office to integrate Medicare and Medicaid benefits more effectively for dual eligibles. Expeditious development of new structures for Medicare-Medicaid integration will be highly beneficial to the more than 8 million dual eligibles.