Health & Medicine Policy Research Group – July 2011
Response to the Coordinated Care Program Key Policy Issues

Health & Medicine Policy Research Group is a 30-year old health policy and advocacy organization that researches health systems policies in order to develop proposals and advocate for reform. Health & Medicine has focused on long-term care reform since 2001, with the development of its Center for Long-Term Care Reform. One of the Center's priorities for system reform since 2001 has been care coordination as it applies to both the aging and disability communities. The National Coalition on Care Coordination (N3C) guides our research on care coordination, and uses a broad definition of care coordination that we support: "… A person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which a care coordinator manages and monitors an individual's needs, goals, and preferences based on a comprehensive plan."

Relevant to this request by IDHFS, over the past several months Health & Medicine has met with providers and advocates from the disability field to explore alternative care coordination approaches to a traditional Medicaid managed care system. These meetings led us to the Disability Practice Institute (DPI), an organization dedicated to researching best practices and lessons learned from disability care providers across the country. Their focus is on cost effective systems delivery reform through better coordination of systems and care. DPI coordinates models in Boston (Dr. Bob Master and the Commonwealth Care Alliance); Wisconsin (Community Living Alliance); and New York City (Independent Care Systems). Health & Medicine spoke with acting Executive Director of DPI, Mr. Chris Duffy who provided information about the progress of taking disability care models to a larger, state-wide, scale. DPI is currently working with the Centers for Medicare and Medicaid Services, CMS, and the Federal Coordinated Health Care Office to achieve program expansion.

Additionally, Health & Medicine has researched specific care coordination models for the disabled and for the elderly, both at a state-level (Medicaid Managed Care) and at a local level. Lessons learned from these models, as well as their barriers to success, are included with our recommendations.

1.) How Comprehensive must Coordinated Care Be?

a.) Coordinated care should cover the entire range of services available to a client via Medicaid, including covered and non-covered medical and social support services.

- A 5 state analysis of Medicaid Managed Care Organization Care Coordination approaches by Mathematica (Rosenbach & Young, 2000) differentiates care coordination from case management. Case management typically coordinates internal services covered by Medicaid. Alternatively, care coordination coordinates social and medical services provided by Medicaid and other providers. For care coordination to be truly effective for the Medicaid system then, coordination must include non-Medicaid covered services. Further, care coordination must address a patient's psychosocial environment including housing needs, social supports, and economic needs.
- To offer such diverse services, care coordination models must incorporate other providers into traditional physician and hospital networks. Additional providers include:
    - Other healthcare providers: physical, occupational, speech, hearing and language therapists, and community health workers;
    - Durable-medical equipment providers;
    - Home health agencies;
    - Community-based social service providers: mental health and substance abuse, transportation, housing, and respite care.
- Problem solving through advocacy is the goal of an effective care coordination program. This is a paradigm shift from eligibility determination and utilization review to a patient/client centered model. It is recommended that stake holders (HFS, MCO's, care coordination organizations, providers and patient representatives) meet frequently to resolve policy questions, facilitate shared decision-making and problem solving and foster patient advocacy.
- Care Coordinators should also be involved with transitions in care, especially the transition from the hospital. This is particularly important for Medicare and Medicaid dual eligible as Medicare hospital readmissions are extremely costly to both patients and payers (Berenson & Howell, 2009).

b.) All Medicaid providers should be required to participate in care coordination but levels of participation may differ. See Attachment A for examples of care coordination models. Please note these are based in a Medicaid managed care context, but are applicable to a state Medicaid network more broadly. The care coordination models are very flexible.

- Although all Medicaid providers should participate, care coordination models differ depending on population served. Care coordination models are not "one-size fits all" (Berenson & Howell, 2009, Palsbo & Mastal, 2006).
    - For example, the Independent Care System (ICS) in New York City realized that its members were suffering due to a lack of appropriate and reliable wheelchairs. ICS developed a specific service focused on wheelchair

purchase and repair (Surpin, 2007). Therapists and certified equipment suppliers now meet with members to help select the right chair. Repair technicians also make home visits to repair chairs as necessary.

d.) Care coordination should be targeted to high-risk beneficiaries. Each enrollee should be screened to determine if they will benefit from care coordination. Not all Medicaid beneficiaries will benefit from intensive care coordination.

- According to a recent study of 15 Medicare care coordination programs, researchers found that care coordination programs often do not save money, particularly when they are not targeted (Peikes, Schore, & Brown, 2009). The study concluded that care coordination would result in savings when it was targeted to higher risk consumers.
- Consumers with complex needs who interface the most with the healthcare system will reap the most benefit from coordinated services (C. Duffy, personal communication, June 28, 2011).
    - Using assessments to stratify the Medicaid population into higher and lower risk consumers is one way to accomplish this. (C. Duffy, personal communication, June 28, 2011)
- For example in North Carolina, the ACCESS II of Western North Carolina uses a stratification approach in its care coordination model. Consumers labeled high-risk are assigned a nurse case manager and receive a full range of care coordination services: links to community resources, ongoing assessments and education. Low-risk consumers, however, are simply monitored through an online database. Short-term interventions are provided to these consumers as needed. (Community Care, 2009).
- Another way to target high-risk beneficiaries is to identify individuals with chronic conditions at risk of hospitalization, as was demonstrated as a successful method of targeting beneficiaries through the Medicare Coordinated Care Demonstration (MCCD) that was initiated in 2002 (Brown, 2009).
- In Washington State, in order to promote long-term care reform, **all** long-term care home and community based care recipients are assigned a care coordinator who provides an assessment, service planning and authorization of services. (Berenson & Howell, 2009).
    - Of note, in this model, care coordinators are also located in hospitals and nursing homes to assist with transitions in care.

5.) What Structural Characteristics should be required for New Models of Coordinated Care?

- Designing a care coordination model requires identifying program location, program structure, and target population. It is imperative that diverse stakeholders convene to design a care coordination model. (Rosenbach & Young, 2000). Stakeholders with differing expertise can share information about existing resources, provider structures, and information-sharing techniques. This stage of model development is an essential to lasting success.
    - For example, Oregon formed an inter-agency workgroup to discuss ways to adapt their Medicaid health plans to special needs populations in developing a Medicaid care coordination model. This took place over an 18-month period, prior to model implementation. (Rosenbach & Young, 2000)
    - In contrast, Washington State did not convene a stakeholder group to comprehensively address model development and began implementation without interagency and other stakeholder communication. Washington's Care Coordination project ultimately failed within 8 months of implementation. (Rosenbach & Young, 2000)
- Goals and objectives of the care coordination model should be explicitly discussed and outlined. Goals and objectives must be specific enough to provide guidance while still retaining some flexibility.
    - For example, Washington State set unrealistic assessment structures within their statute by requiring that all SSI beneficiaries be assessed within 30 days of enrollment and again at 6 months. This was not feasible, but due to the regulations, the state was held accountable to this structure. (Rosenbach & Young, 2000)
- As the care coordination model is developed, an essential component of the model is payment for the care coordination service. If the care coordination service is part of a capitated payment, stakeholders must identify a specified portion of reimbursement for care coordination.
    - For example, in Washington State, care coordination services were not distingused and instead were based on historic fee-for-service data. This did not leave any cushion for increase service demand as a result of the care coordination model (consumers are able to benefit from services they previously were unable to, resulting in higher utilization of services). It is necessary to set aside funding for the care coordination services. (Rosenbach & Young, 2000)
- After care coordination model development, it is essential for key staff members administrating and implementing the model to regularly meet in order to address barriers and problem solve, clarify care coordination policies, discuss State expectations, and discuss best practices. (Rosenbach & Young, 2000).
    - For example, it may make sense to tailor meetings to specific providers. Physicians, for example, may be seeing an increase in mental health

patients and will benefit from discussing with other physicians how to best serve this population.

Medicaid private managed care organizations have not typically included the most complex and expensive Medicaid beneficiaries: the elderly and disabled. However, many states have used a managed care approach to coordinating **long-term care** services. N3C notes three successful managed care, capitated risk models for delivering long-term care services to the elderly and disabled through Medicaid:

- An organization only arranges care for Medicaid long-term care services
    - Example: Wisconsin's Family Care Program
- An organization covers both Medicaid long-term care and primary and acute services
    - Example: the Wisconsin Partnership Program
- An organization is responsible for Medicare services and Medicaid acute and long-term care services
    - Example: the Program of All-Inclusive Care for the Elderly, PACE.

As you will see in Attachment A, and our comments for this section, we recommend that administration of the care coordination model be centrally located.

- There are several models recognized to organize a care coordination approach. We recommend a centralized team model approach that includes leadership from a nurse **and** social work team.
    - Professional qualifications of the various care coordination team members depends on the model of care coordination chosen.
- A centralized team model approach allows all care coordination activities to be managed in a central location—allowing for oversight and accountability throughout the process.
- Care coordination staff must have experience working with individuals with multiple chronic conditions so both medical and social care can be coordinated.
    - Assessment of beneficiaries is integral to the care coordination model's success as the assessment determines the client's plan of care
    - Assessment tools must be flexible, easy to update and easy to share across settings; assessment is not a one-time task, but on-going. Assessment is at the root of the care plan and is thus extremely important (Health & Medicine Policy Research Group, 2009)
    - Assessment tools should be developed through a public-private partnership: federal and state-level policymakers, providers, Medicaid beneficiaries and other stakeholders. (Rosenbach & Young, 2000)
- We recommend that the state evaluate a potential hybrid model: a centralized team model with a regionalized and/or provider-based model. Regionalized and provider-based models allows for community-specific, population specific tailored care coordination.
- A hybrid centralized model with a provider-based model would allow the state to

have provider-based Medical Homes for Medicaid recipients.

- Provider-based care coordination also allows for closer integration of care coordination with care; the care coordinator is a part of the interdisciplinary team of the Medical Home(Rosenbach & Young, 2000).
    - Provider-based care coordination will also allow the care coordinator the opportunity to build a relationship with their clients.
    - Telephonic coordination is important but not sufficient to achieve effective care coordination; in-person relationship building is essential (Brown, 2009; C. Duffy, personal communication, June 28, 2011).
- An example of a hybrid model is North Carolina's Medicaid program: Community Care of North Carolina (CCNC). CCNC has focused largely on providing care to mothers and children. (Berenson & Howell, 2009)
    - CCNC operates as an enhanced medical home model of care that integrated community-based supports and is centered around local non-profit networks.
        - These networks include: physicians, hospitals, social service agencies, and county health departments.
        - The Medical Home provides acute and preventive care, manages chronic conditions, coordinates specialty care and offers on-call assistance 24 hours a day, 7 days a week.
    - Each network utilizes a virtual team to provide chronic care coordination.
    - Physicians take greater responsibility in their medical home practices for the clinical component of care coordination and provide referrals to local agencies for clinical and social support services.
        - Almost all primary care providers agreed to join CCNC networks as they formed, providing care to almost 1 million Medicaid beneficiaries, or 67% of the Medicaid population.
    - Care coordinators are integral members of these clinical, medical and social provider networks and work with physicians to identify and manage high-risk, high-cost patients.
    - CCNC is built around data monitoring and reporting for continuous quality improvement (Berenson & Howell, 2009).

- Another example of a hybrid model is Vermont's Blueprint for Health—a statewide program that brought together the state Medicaid program, insurance companies, and a non-profit HMO (Berenson & Howell, 2009). Blueprint aims to support 5-key components:
    - Financial reform: an enhanced payment to providers participating as Patient-Centered Medical Homes, as well as fee-for-service payment.
    - Community Care Teams (CCTs): interdisciplinary teams of nurses, social workers, behavioral care providers, and other health care professionals. CCT services are provided to all PCMHs to assist with prevention, health maintenance, and care coordination for those with chronic conditions.

- Community activation and prevention: through inclusion of a public health prevention expert on CCT
- Health Information Technology
- Multidimensional evaluation (including NCQA PCMH scores and measures) (Berenson & Howell, 2009)

In response to question 5.) e.) Should special arrangements be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?

- Yes, special arrangements should be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients. According to N3C, the target population for care coordination should be Medicare beneficiaries with multiple chronic conditions, and specifically frail older adults with cognitive limitations (Berenson & Howell, 2009).
- Illinois' Medicaid beneficiaries who are also dual eligible Medicare beneficiaries should be a targeted population, and accommodations to serve this population should be made. Across the country it is estimated that 7.5 million people qualify for both Medicare and Medicaid; this equates to roughly 18% of the Medicaid population and accounts for approximately 42% of Medicaid spending (Berenson & Howell, 2009).
    - Several projects have shown that for care coordination to be effective for the dual eligible population, Medicaid and Medicare funding must be integrated. The benefits of each program, alone, do not cover the continuum of care needed to comprehensively address a beneficiary's health (Berenson & Howell, 2009; C. Duffy, personal communication, June 28, 2011).

7.) How should consumer rights and continuity of care be protected?

- Care coordination should be patient centered. Patients will serve as an active member of the health care team and should be given the opportunity to advocate for their own needs. Patient education is essential to accomplishing this goal. For example, one of AXIS Healthcare in Minnesota's priorities is patient education, in addition to its care coordination service (Palsbo & Mastal, 2006).
- Consumers should be part of all stages of model development and implementation. Consumer input is essential in order to develop and deliver client-centered services, and also to ensure acceptance of the model by consumers. (Rosenbach & Young, 2000)
  - For example, Colorado served a population of special needs children with disabilities, and in the model development phase included parent advocates in the model design phase. Parent advocates were able to train staff on the special needs, resources and barriers associated with this unique population. (Rosenbach & Young, 2000)
- Case coordinators must also work closely with consumers to determine a unique plan of care for each patient. Building relationships between the case manager and the consumer will help develop trust and understanding of the consumer's specific needs (Palsbo & Masel, 2006).
- As compared with for-profit health care providers, research shows the not-for-profit health care providers typically have higher or equal-level health care service quality, access to care, cost and efficiency of care, and higher client satisfaction (Rosenau & Linder, 2003, Tu, & Reschovsky, 2002). We recommend that HFS contract only with not-for-profit entities for care coordination.

8.) What is your organization's preliminary anticipation of how it might participate in coordinated care?

Health & Medicine Policy Research Group's Participation in Coordinated Care

Care coordination remains an evolving model. Best practices are continuing to emerge as programs develop and evaluation results are released. Health & Medicine Policy Research Group (HMPRG) is committed to examining alternatives to traditional Medicaid managed care. We are available to research in more detail the best practices of model listed here, and others that emerge and may be adapted for Illinois. We are also available to serve on state appointed committees charged with planning for the development of care coordination in Illinois.

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EXHIBIT 8

CENTRALIZED TEAM MODEL OF CARE COORDINATION

The care coordinator serves as the central point of contact for all Medicaid beneficiaries and screens members before assigning them to a nurse/social worker case management team. The team coordinates beneficiaries' medical and psychosocial service needs.

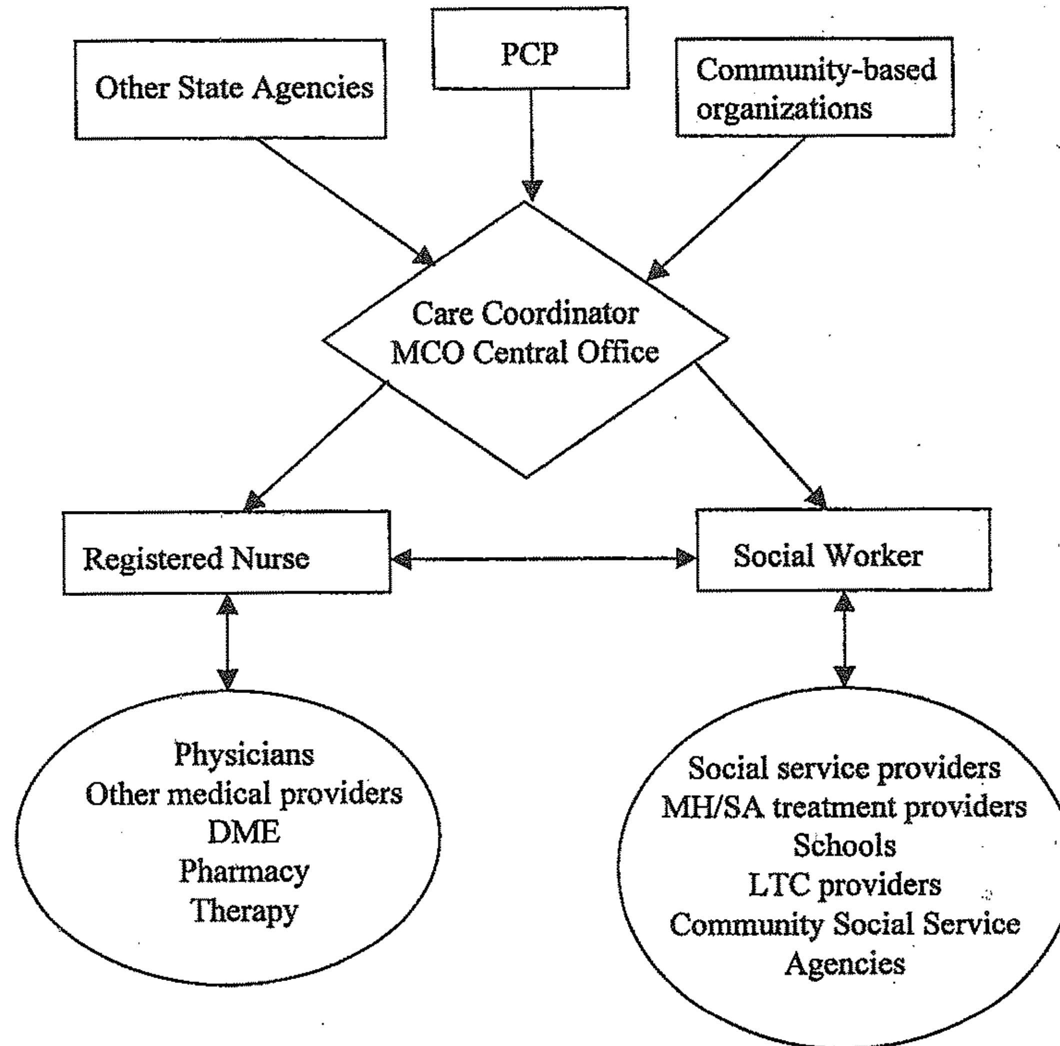

EXHIBIT 9

REGIONALIZED MODEL OF CARE COORDINATION

The care coordinator screens beneficiaries who are referred from inside and outside the MCO. The care coordinator then assigns a nurse case manager who is based in the geographic region. The nurse case managers coordinate care across various providers in that region.

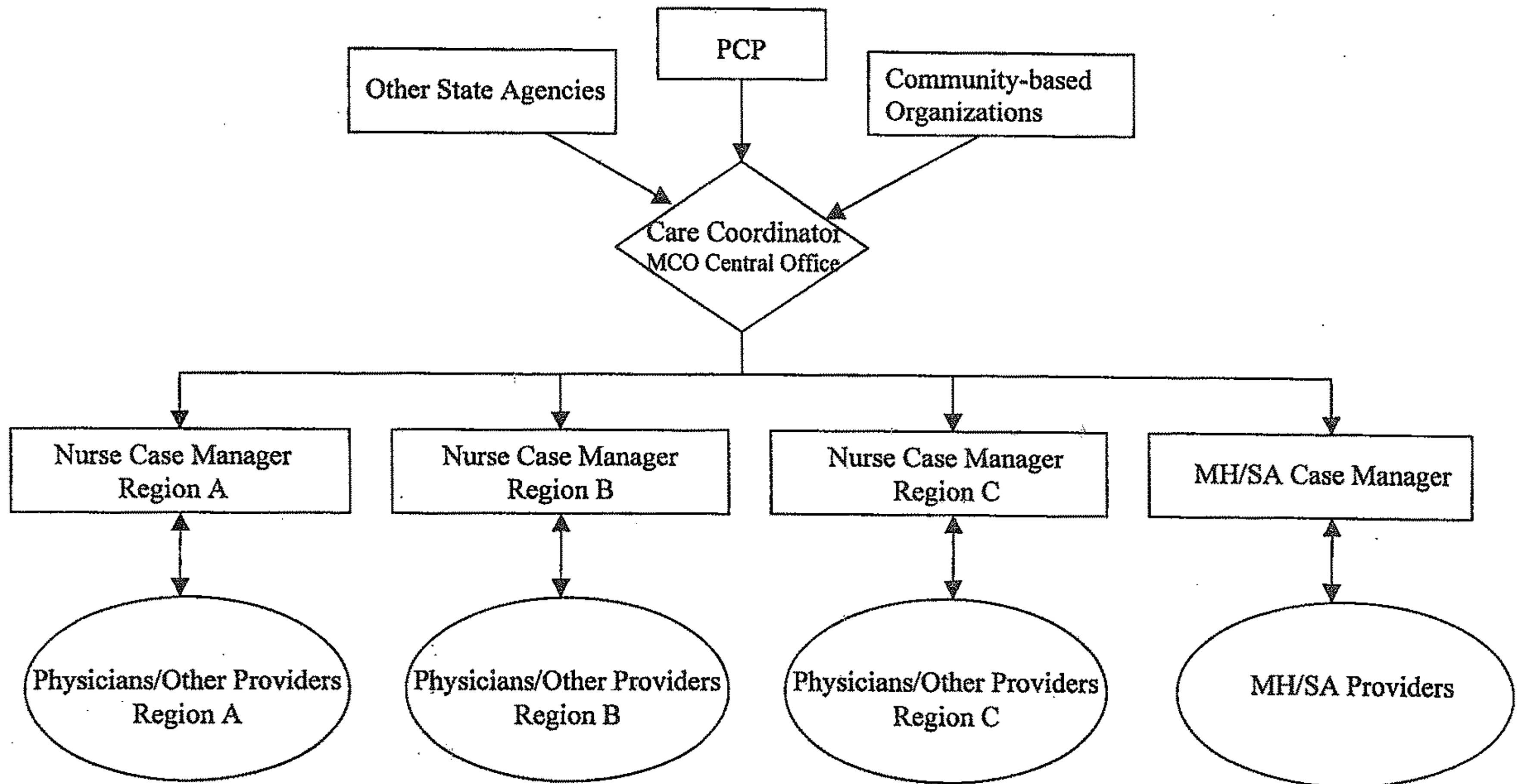

EXHIBIT 10

PROVIDER-BASED MODEL OF CARE COORDINATION

The MCO delegates identification, assessment, care planning, care coordination, and monitoring of members to provider groups. The physician identifies and assesses beneficiaries eligible for care coordination. The nurse case manager, who is employed by the medical group, monitors beneficiaries' progress and facilitates access to medical and social services. The care coordinator at the health plan may provide referral or administrative support as needed.