Building a Community of Coordinated Care

Dual eligibles are known to be disproportionately vulnerable and costly when compared to the general population of Medicare or AHCCCS (Medicaid) beneficiaries (Jacobson, Neuman, & Damico, 2012). To control these costs and improve the outcomes, CMS has looked to capitated managed care plans to integrate acute and long-term services and supports (LTSS). Capitated Medicare Advantage Special Needs Plans focusing on the duals are required, among other things, to have a cooperative arrangement with the state AHCCCS (Medicaid) program to serve the dual eligibles (Grabowski, 2009). The complexities in these “dual eligible special needs plans” (D-SNPs) have CMS open to “managed fee-for-service” (MFFS), which involves strategies that coordinated care across provider sectors within the existing payment structure (Verdier, Au, & Libersky, 2012). The MFFS approach tends to be more acceptable in some areas because the risk of payment changes for providers compared to traditional Medicare is removed while there is still an effort to use care management strategies to reduce the fragmentation that leads to poor care outcomes. In practice both capitated and fee-for-service managed care models need to coordinate care if they are to be effective.

In an effort to coordinate care and better serve members, Care1st Health Plan Arizona, an AHCCCS (Medicaid) plan and ONECare by Care1st Health Plan Arizona, a Medicare Advantage Special Needs Plan for members with AHCCCS (Medicaid) and Medicare Parts A and B, teamed up with the Area Agency on Aging (AAA) and the Pima Council on Aging (PCOA) in Maricopa and Pima Counties to connect their members to much-needed supportive services and additional in-person case management to promote the use of preventive and primary care services, lower costs and encourage members aging well in-home. These non-profit organizations have a long and reputable history of offering programs and services that can enhance the quality of life for seniors and adults with disabilities. AAA and PCOA both strive to provide the strong advocacy and support that these members need most.

Integrated Care Management Program

Through this partnership with AAA and PCOA, Care1st and ONECare have implemented an Integrated Care Management Program. AAA and PCOA perform a comprehensive assessment called the “Arizona Standardized Client Assessment Plan” (ASCAP) in the comfort of members’ homes to identify key services and programs that can benefit these members. The Integrated Care
Management Program works to identify problems, goals, interventions and outcomes. Utilizing the ASCAP form, members are thoroughly assessed both physically and psychosocially in order to recognize medical, behavioral health and socioeconomic issues that create challenges for members when attempting to adhere to treatment plans.

During this assessment process, solutions are also identified. For example, AAA and PCOA may link members to home delivered meals, volunteer respite organizations, chronic health improvement programs, community resources and more. These agencies also help members fully understand their Medicare and AHCCCS (Medicaid) benefits and how to apply for government programs such as SNAP or ALTCS, when needed. Such education has been shown to improve self-sufficiency and health outcomes.

Care Transition Program

Care1st and ONECare have also partnered with AAA and PCOA to assist with the enrollment of members into a Care Transition Program. This Care Transition Program aims to safely and cost-effectively transition members in hospitals, skilled nursing facilities or other acute inpatient facilities back to their homes. Transitioning a patient home is associated with a 9%-20% increased risk of early re-admission or a visit to the emergency room. As a result, members in these types of facilities who are identified as being at high risk for hospital re-admission or post-discharge complications due to psychosocial issues leading to non-adherence with their treatment plans are ideal candidates for the Care Transition Program.

Once a Care1st or ONECare member is enrolled in the Care Transition Program, the program begins with the AAA and PCOA’s care transition teams visiting the member while he or she is still in the facility to assess the discharge plan and identify any barriers to a smooth and safe care transition. These potential barriers include an unstable living environment, lack of caregiver support, transportation and financial issues that could lead to poor nutrition or inability to obtain medicines or other needed medical supplies.

After discharge, the AAA or PCOA representative also visits the member’s home to assess the member’s status while in the home environment and to perform a full social service assessment to ensure the member is connected to all available social and financial resources. When the social service team identifies any issues, these are directly communicated to the Care1st and ONECare teams. Then all parties, in a collaborative effort, work together with the member and his or her caregivers to help resolve any barriers to care that may exist. In addition, the AAA or PCOA teams
participate in the plans’ Interdisciplinary Care Team meetings to discuss the member’s needs and any actions taken. Then a comprehensive care plan is created based on these needs.

Walking through the facility-to-home transition process with high risk members is a wise investment. Care Transition Programs have been shown to reduce hospitalization by 8%-33% for high risk patients. ³ By utilizing a multifaceted Care Transition Program, Care1st and ONECare continue to ensure better health outcomes for members while reducing re-admission costs for the plans.

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1. Mark R. Meiners PhD, Pamela M. Mokler MS, Mary Lynn Kasunic MS, CPM, Scott Hawthornthwaite BA, Susan Foster MSW, ACSW, LCSW, David Scheer MA & Anna Maria Maldonado BA (2014) Insights From a Pilot Program to Integrate Medical and Social Services, Home Health Care Services Quarterly, 33:3, 121-136, DOI: http://dx.doi.org/10.1080/01621424.2014.929067


3. Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients, June 2012, http://content.healthaffairs.org/content/31/6/1156.short