Insights From a Pilot Program to Integrate Medical and Social Services

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This study examines lessons learned from the design, implementation, and early results of an integrated managed care pilot program linking member benefits of a Medicare-Medicaid health care plan with community services and supports. The health plan’s average monthly costs for members receiving an assessment and services declined by an economically meaningful, statistically significant amount in the postintervention period relative to the preintervention period compared with those who did not accept an assessment or services. The results along with the lesson learned from the pilot are viewed by the parties as supportive of further program development.

KEYWORDS care coordination, dual eligibles, managed fee-for-service, Medicare and Medicaid managed care
INTRODUCTION

Integration of medical and social services has long been one of the strategies that held promise for containing health care costs for our aging population. Substitution and complementary benefits of community-based services and supports that help people avoid or minimize acute care use have been a major goal in public and private program development (Polivka & Zayac, 2008). Two prominent models emerged in the 1980s to explore this potential. The Social HMO’s vision was to build an array of community-based services into Medicare HMOs that could better help eligible disabled seniors avoid needing hospitals and nursing homes (Leutz, Nonnenkamp, Dickinson, & Brody, 2005). On Lok sought to achieve the same goal but was much more prescriptive, targeting those age 55 and older who were eligible for both Medicare and Medicaid and nursing home placement (Eng, Pedulla, Eleazer, McCann, & Fox, 1997). Today, only the On Lok model survives. Recast as the nationwide Program of All-Inclusive Care for the Elderly (PACE) initiative, it is available as a special health plan option within Medicare (Li, Phillips, & Weber, 2009). But the interest in using managed care to integrate medical and social services beyond the PACE model remains active and has become a key aspect of the Center for Medicare and Medicaid Services (CMS) health reform efforts to care for those eligible for both Medicare and Medicaid (aka dual eligibles, duals, or Medicare-Medicaid eligible; Clemans-Cope & Waidmann, 2011).

Dual eligibles are known to be disproportionately vulnerable and costly when compared to the general population of Medicare or 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 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 this article we provide an assessment of processes, procedures, and problems addressed in the development and implementation of an Arizona-based test of a hybrid of these two managed care models that involved coordination of two different organizational cultures in caring serving the
same members; one focused on acute care and the other on community-based services and supports. To provide insights on the potential of this type of collaboration we provide an analysis of the costs experienced by the initial pilot study health plan members in the 6-month period before their referral to community services compared to the 6 months following that referral.

PILOT PROGRAM BACKGROUND

Care1st Health Plan Arizona (Care1st) and the Area Agency on Aging, Region One (AAA), both headquartered in Phoenix, Arizona, launched a collaborative partnership, the Integrated Care Management Pilot (ICMP), in September 2010. The purpose of the ICMP is to integrate the medical and social care management functions for two distinct Care1st member groups; those eligible for only Medicaid acute care benefits (Medicaid-only) and those who are dually eligible for both Medicare and Medicaid acute care benefits (duals). The key components of the model are summarized in Figure 1.

![FIGURE 1 Integrated Care Management Pilot (ICMP).](image-url)
It is important to note that neither the duals nor Medicaid-only members in the ICMP receive Medicaid LTSS from Care1st as part of the pilot program. In Arizona when Medicaid-supported LTSS are needed, the beneficiary must disenroll from the Medicaid acute care health program (known as AHCCCS), and join ALTCS, the Arizona Medicaid managed care program that covers long-term care in nursing homes and with home- and community-based services (HCBS). As such the ICMP is more similar to the Social HMO effort to add limited HCBS benefits to Medicare than to the more comprehensive approach of PACE which integrates and expands on what Medicare provides in the way of acute care benefits and Medicaid provides for long-term care.

In the ICMP the Care1st duals plan provides traditional Medicare acute and subacute benefits with Medicaid providing supplemental gap filling payment for those benefits but not long-term care. Care1st does provide some additional benefits not offered by Medicare. When the Pilot was launched, these included dental, up to $1,250 per year; vision, up to $350 per year; hearing, up to $1,000 per year; transportation, up to 10 one-way visits; and over-the-counter allowances, up to $65 each quarter. The benefit details change each year.

The model of care goals emphasize among other things improved access to medical, mental/behavioral health, and social services. Each member is assigned to an interdisciplinary care team (ICT) to provide these services. Also emphasized is the improvement of care coordination, improvements in transitional care across settings and providers, and access to preventive health services. Taken together these reinforce the desire to team with the AAA to achieve its stated outcomes goals. The AAA agreed to providing the following services, “as requested,” for the target ICMP populations:

- comprehensive in-home assessments using the Arizona Standardized Client Assessment Plan (ASCAP) assessment tool to comply with the various regulatory requirements governing the parties;
- assistance with the development of, and regular updates to, Individualized Care Plans (ICP), as required by CMS and the State of Arizona, as well as assistance with member goal setting, development of member self-care skills, and care planning for chronic illnesses and conditions;
- linkages to the wide array of services provided by the AAA and its’ contracted agencies and organizations to assist members with activities of daily living (ADL), instrumental activities of daily living (IADL), and health-related tasks, including, but not limited to, home-delivered meals, attendant services and supports, personal care, etc.;
- ongoing monitoring of frail and at-risk ICMP members, which includes visits in the home by AAA case managers and AmeriCorps volunteers on a regular basis;
- provides ongoing reporting and communication as agreed upon by the parties, including joint meetings with Care1st on a regular basis to ensure program success; and additional assistance as agreed upon by the parties.
The intervention is designed to be low cost. Care1st pays the AAA an hourly rate for social case management services. The rate was based on an estimate of what it would cost the health plan to employ case managers to perform the same service. Care1st does not pay for any of the AAA’s HCBS programs (e.g., home-delivered meals, home aides).

ICMP LOGIC MODEL

Care1st and the AAA serve mutual clients who need, or are at risk of needing, an extensive array of medical and social services. These patients are eligible for either Medicare or Medicaid, with many eligible for both; typically these clients have a high degree of chronic illness and disability that requires significant coordination and management. Both organizations serve seniors and people with disabilities. As such their clients cover a broad spectrum of age groups.

Care1st’s expertise is in the medical management of its members but recognizes the potential value of community-based LTSS that reinforce and augment the acute care-oriented processes they are paid to manage. Working with the AAA under a vendor relationship to supply community outreach, assessment, and services for their members, Care1st seeks to help its members to better focus on their medical conditions (by supporting and meeting their social service needs) and keep their medical conditions better controlled. The expectation is that this will decrease utilization of high-cost hospital services and emergency department (ED) visits.

The AAA is a private nonprofit organization that advocates, plans, coordinates, develops, and delivers services for adults aged 60 years and older, persons of any age with HIV/AIDS, adults aged 18 years and older with disabilities and LTSS needs, and family caregivers. As such, its mission embraces the broad view of aging rather than focusing only on those who are old. The AAA is seeking to grow its ability to facilitate community social supports that complement medical services so that it can be a provider of those services for health plans and hospitals. The AAA is driven by the desire to provide meaningful services to a larger segment of the Maricopa County community.

The ICMP intervention targets clients for a comprehensive assessment that drives a care plan, which looks to suggest home-based LTSS that can help the client better use their health plan services. The logic model hypothesis is that well-targeted interventions that support the clients in their own homes and community settings can help these clients be better prepared to engage with their providers as an active and empowered member of their own care team resulting in lower per member per month (PMPM) costs.
MEMBERS TARGETED FOR ASSESSMENT AND SERVICES

The ICMP covers approximately 1,600 community dwelling members. There is a significant burden of the most prevalent medical conditions like diabetes and its complications (28.7%); hypertension and hyperlipidemia (55.3% of population), respiratory conditions like asthma and COPD (12.9% of population), and heart disease (9.1% of population). Approximately 40% of the population suffers from behavioral health and substance abuse conditions. Just over half (54.9%) of the membership are less than 65 years old. In addition to high levels of comorbidity and cooccurrence of physical and behavioral health conditions, frequently the members face challenging social and economic situations such as lack of emotional and social support and residential instability, which frequently impairs their ability to adhere to treatment plans and to maximally benefit from them.

There is no one basis for referrals in the ICMP. Referrals during the study period happen on a case-by-case basis. Both duals and Medicaid-only members are identified as having potential social services needs through the following: concurrent review rounds, hospital discharge planners, case management, ICT referrals, and provider member and caregiver referrals. Things that could trigger a referral include a recent hospitalization, fall, multiple medications, multiple chronic conditions, noncompliance with medications, not showing up for PCP appointments, or a member/family request. Although Care1st refers some Medicaid-only members to the ICMP, the large majority of those identified for referral to the AAA to date are duals.

Once a beneficiary is identified and referred to the AAA, a case manager is sent to the home to perform an assessment utilizing the ASCAP, which looks at financial need, ADLs, orientation, behaviors, environmental problems/barriers, medications, medical conditions, nursing services and treatment, hospitalization/ER use, risk for falls, assistive devices, and nutritional status. The assessment is used to develop or update individualized care plans. The assessment also identifies members that may qualify for additional services through the AAA, including but not limited to: transportation, personal care, counseling, legal assistance, home making/chore assistance, adult day health care, home delivered meals, benefits assistance program, and a family caregiver support program.

ICMP EVALUATION CHALLENGES

The evaluation reported on here was commissioned by St. Luke’s HealthCare Foundation to document the design and implementation of ICMP. Of significance is the care management capability of Care1st, which represents a challenge for evaluating the added value of the ICMP. But access to understanding the patient in their own home is an important new feature worthy
of being tested. There are also challenges in identifying an appropriate comparison group as the ICMP was not formally designed to be evaluated.

The health care needs of the Care1st members requires a multifaceted member centric health plan approach to care based on physical and mental health integration and intensive coordination and case management interventions. According to their assessed needs, all members are eligible to get “significant, appropriate, and timely” support to improve their health-related quality of life. Members need to consent to case management, though everyone is assigned to a Care Coordinator. All of this makes it difficult to distinguish exactly what intervention among the various available allowed the members to achieve optimal health. The best approach is to have a matched control group similar in all measurable ways except that they do not receive referral to the ICMP. In this initial evaluation effort we were only able to analyze the prereferral and postreferral costs per member per month for a cohort of members referred to the ICMP during its 1st year of operation. No patient specific determinants (e.g., age, sex, diagnoses, risk score, referral source/reason) were available for this initial assessment of ICMP outcomes.

**EVIDENCE IN SUPPORT OF REPLICATION**

To provide an initial sense of the results of the ICMP, a number of prereferral and postreferral cost comparisons were conducted on Care1st members who were identified as having been referred to the AAA during 2011. To allow for a 6-month prereferral/postreferral observation period we focused on members who were first referred before July 14, 2011. The sample included 94 cases examined in total and in selected groups to allow for a comparison of the results under different specifications. Of the total referred for an assessment, 21 declined an assessment and services, 52 received an assessment but no services, and 21 received an assessment and services. Two different periods (3- and 6-month prereferral/postreferral) were examined to assess the effect of time around the point of the referral on the cost results. The initial cost comparisons were done using the average per member per month (PMPM) cost for the select subgroups.

The analysis also broke the cases into groups where the member “terminated” in the follow-up period. That is, in some cases, the member was no longer with Care1st at some point in the postreferral period. This could happen for a number of reasons, including moving out of state, choosing another health plan, death, or enrollment in ALTCS. It is not obvious how a “terminated” member would affect the results but for at least two reasons the result would likely reflect higher costs. When patients die they tend to have high costs in the months before death, and when patients are transferred from AHCCCS to ALTCS to receive Medicaid LTSS it means their health status has deteriorated to the point of being nursing home certifiable.
In Table 1, PMPM cost averages for the 3- and 6-month prerereferral/postreferral periods are shown for the 21 Care1st members who received both an assessment and services. Those who received the services recommended in the assessment experienced dramatically lower costs after the referral. The reduction was 59% ($3,291) in the 3-month time frame and 47% ($2,055) in the 6-month time frame. The results were even more pronounced for those who had not termed. For those still in the plan, the reduction in PMPM was 76% ($6,123) in the 3-month time frame and 69% ($3,441) in the 6-month time frame. Those who termed had much lower reductions ranging from 16–17% ($488–$634).

In Table 2, PMPM cost averages for the 3- and 6-month prerereferral/postreferral periods are shown for the 52 Care1st members who received an ASCAP assessment but no services. The PMPM reduction for those who received the assessment but no services was 24%, which resulted in a $970 lower cost in the 3-month follow-up period compared to the 3-month period prior to the referral. For the 6-month time frame there was no reduction indicating that whatever reductions may have been achieved in the shorter 3-month period was fleeting or an anomaly in the data. It is the termed members that influenced these results most dramatically. In the 3-month period they had shown a 33% PMPM reduction ($1,632) in the

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Average PMPM Cost for Members With Assessment and Services by 3-Month and 6-Month Prereferral and Postreferral Periods</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>3 Months</td>
</tr>
<tr>
<td>Members receiving service</td>
<td>Members</td>
</tr>
<tr>
<td>Currently a member</td>
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</tr>
<tr>
<td>Termed members</td>
<td>11</td>
</tr>
<tr>
<td>Total all members</td>
<td>21</td>
</tr>
<tr>
<td>Total PMPM reduction</td>
<td></td>
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<tr>
<td>PMPM reduction percentage</td>
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<tr>
<th>TABLE 2</th>
<th>Average PMPM Cost for Members With Assessment Only by 3-Month and 6-Month Prereferral and Postreferral Periods</th>
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<tbody>
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</tr>
<tr>
<td>Members receiving service</td>
<td>Members</td>
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<td>Termed members</td>
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<tr>
<td>Overall PMPM reduction</td>
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<tr>
<td>PMPM reduction percentage</td>
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</table>
TABLE 3 Average PMPM Cost for Members Opting to Receive No Services by 3-Month and 6-Month Prereferral and Postreferral Periods

<table>
<thead>
<tr>
<th>Members opted not to receive services</th>
<th>3 Months</th>
<th>6 Months</th>
<th>3 Months</th>
<th>6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Members</td>
<td>PMPM Pre</td>
<td>PMPM Post</td>
<td>Members</td>
</tr>
<tr>
<td>Currently a member</td>
<td>12</td>
<td>$4,222</td>
<td>$1,311</td>
<td>12</td>
</tr>
<tr>
<td>Term</td>
<td>9</td>
<td>$5,301</td>
<td>$7,925</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>$4,672</td>
<td>$3,744</td>
<td>21</td>
</tr>
<tr>
<td>Overall PMPM reduction</td>
<td></td>
<td>$928</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMPM reduction percentage</td>
<td></td>
<td>20%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

postperiod but in the 6-month time frame those members showed a 16% higher PMPM cost ($614) in the postperiod. This suggests that those who are termed tended to be high need members with volatile claims experience. If an assessment without services is to have an effect, it appears that it is most likely to be helpful in the short run.

Table 3 shows PMPM cost average during the 3- and 6-month prerereferral/postreferral periods for the 21 Care1st members who received a referral for an assessment but declined it, thereby also refusing services. This group also had reduced PMPM in both the 3-month ($927) and 6-month ($246) follow-up periods indicating that there indeed was likely to be some regression to the mean taking place with these comparisons. The decline in the 3-month period was 20%, so on a percentage basis the decline in PMPM costs was much less than for those accepting an AAA referral for an assessment and services but similar to those receiving only an assessment.

Figure 2 summarizes the average PMPM cost from the 3- and 6-month prerereferral/postreferral period comparisons for the different levels of intervention. In nearly every comparison, even when no assessment or services were provided, costs declined in the postperiod suggesting that regression to the mean may have influenced the observed pattern. In fact, one member who received an assessment only, recorded very large costs in the prereferral period but not in the postreferral period which would be consistent with regression to the mean.

No statistical adjustment can completely overcome what is essentially a shortcoming of the lack of a formal evaluation design along with recruitment and retention policies used in this pilot program. To examine the data more closely and bolster the robustness of our results we dropped all 12 months of cost data observed for the outlier member and then estimated the following regression equation using fixed effects methods to rule out changes in membership composition and differential attrition as possible explanations for any estimated changes in monthly cost (Allison, 2005):
\[ \text{COST}_{it} = \beta_0 + \beta_1 \text{POST}_t + \beta_2 \text{POST}_t \text{ASSESSMENT\_ONLY}_i + \beta_3 \text{POST}_t \text{ASSESSMENT\_SERVICES}_i + \beta_4 t + \gamma_i, \]

where,

- \( \text{COST}_{it} \) is member \( i \)'s cost in current dollars in month \( t \);
- \( \text{POST}_t \) is a postreferral indicator variable coded as 1 if month \( t \) fell into the 6-month postreferral period and 0 otherwise;
- \( \text{ASSESSMENT\_ONLY}_i \) and \( \text{ASSESSMENT\_SERVICES}_i \) are indicator variables coded as 1 if member \( i \) received an assessment only or an assessment and services, respectively, and 0 otherwise;
- \( t \) is a count variable indicating the month of the study period during which the cost was reported; it ranges from 1 to 21 and accounts for time-related factors such as seasonality, cost inflation, aging of the members, and experience gained as the study progressed;
- \( \gamma_i \) is a set of indicator variables coded as 1 if the cost was recorded for member \( i \) and 0 otherwise to control for “member fixed effects.”

The final analysis sample included 93 members whose cost was observed for 10.6 months on average (992 member-months/93 members). The regression-adjusted cost of a typical member 6 months before exposure to the program was $1,122 and grew by $180.3 each month throughout the 12-month sampling period. Among members who received no assessment, exposure to the program was associated with a drop in monthly cost by $693. Among members who received an assessment, the drop was $418. Among members who received HCBS, the drop was $2,795.1. This drop was statistically significant at the 5% level.
INSIGHTS AND CHALLENGES FOR REPLICATION

The early experience of the ICMP implementation provided useful insights on what it takes for Medicare and Medicaid health plans serving duals to effectively partner with traditional safety net providers to improve the health and health care of their mutual constituents. The data suggest that after the referral, those members receiving both an assessment and services had reduced PMPM costs allowing those targeted members to average significantly lower monthly costs than they did before the referral. The level of savings suggested by this analysis is of practical significance to the health plan and has encouraged further work on refining its efforts with the AAA. Access to an assessment done in the home environment along with buy-in from members to participate in care plan development and follow through is recognized as important for members who have significant chronic illnesses.

Still there were areas in need of attention that fall within the scope of cultural change challenges. In the early implementation period there were delays in response from the AAA to requests for feedback and information regarding referrals. Care1st needs real-time feedback as much as possible or it will not be useful and they then have to look to other parts of their operation to care for their members. Following the identification of these problems, the AAA reports that most of the Care1st referrals have been completed within five working days of the referral.

Plans and expectations have needed to be revisited in a number of key areas of implementation based on actual experience. By the end of 2011, a total of 148 cases had been counted as being referred to the AAA for an assessment and the number is reported to have grown at a slower pace in 2012. The AAA wants the referrals to grow so the program can support hiring a person at the AAA dedicated to the ICMP effort.

This process evaluation also served to highlight other challenges with the referral process. Care1st members identified for AAA assessment may not be interested in what the AAA has to offer. They may not understand what might be available through the AAA. About half of them are younger disabled rather than older Americans. Not being old per se, they might not see themselves as eligible. They also may be wary of having someone come into their home for the assessment and services. In order to troubleshoot these challenges the AAA has worked with Care1st to develop a script and brochure to do a better job of informing and selling the value of letting the AAA help with social services and supports.

Another issue is that those Care1st clients who meet the functional and programmatic eligibility for services such as home delivered meals are supported just as any client referred to the agency would be. They do not have special priority to receive services. The AAA mission covers many more clients than just the Care1st members. There are always limits to what resources are available and those have become more acute during the past
few years as Arizona along with most other States has experienced the need for cutbacks in funding. During the study period there was a small area of the county that had a short waiting list for meals. Also, some Care1st clients referred do not meet the required functional impairment need levels under which the AAA operates. This prompted discussion regarding the possible payment by Care1st for services when members otherwise would not be eligible.

This discussion highlights an opportunity for further development in the ICMP model. If the health plan is not aware of the lack of resources or is aware and does not step up to fill the gap or if the member is not eligible for AAA services identified in the care plan, the assessment-based care plan may not be implemented in part or in whole. This would essentially eliminate at least some of the value of doing the assessment. At the same time, the AAA cannot push the health plan’s members ahead of other clients with similar or perhaps greater needs. It should be noted, however, that the assessment has greater value than just authorizing federal and state services. It prompts an awareness of needs that allows the AAA to target more private pay and informal services that could help the client stabilize their health conditions.

With the likely interest in replicating the ICMP in other locations, more work is needed to do a formal evaluation of the effectiveness of the ICMP. There are still outstanding questions as to what data are available to help determine if there is a natural control group that could serve to examine pretreatment and posttreatment utilization and cost-estimate comparisons in more detail.

RECOMMENDATIONS

The following recommendations are all consistent with the basic idea that Care1st should have the incentive to help their members avoid the kind of deterioration that leads to needing higher levels of care. This is particularly true in Arizona, where such deterioration can force members to disenroll from Care1st dual plan, which is an AHCCCS Medicaid acute care plan, to enroll in an ALTCS Medicaid long-term care plan. This can confuse efforts at the margin on whether and how to help members who might be at risk of such a change and is not in the best interests of the member.

Targeting the right intervention to the right need at the right time is a long-standing challenge made more difficult in the ICMP by the fact that the members range from being at risk of needing significant services to actually needing those services. Along this continuum there is potential value in various levels of preventive interventions. With an accurate predictive
model telling you in advance who was going to need more care you could
target specific interventions to avoid some or all of the higher level care
needs. But predictive modeling remains a work in progress.

Care1st, for example, seeks to coordinate transitions of care by identi-
fying beneficiaries with upcoming planned transitions through a daily prior
authorization report that identifies planned upcoming transitions and then
provides outreach to beneficiaries to ensure they are educated and pre-
pared for their transition. Care1st also wants to identify beneficiaries with
unplanned transitions through the daily hospital and skilled nursing facility
census and ensure appropriate discharge planning. This is important with
or without AAA involvement as there are significant financial incentives to
avoid unnecessary hospitalizations. Where and when to call on the AAA,
given their unique community presence requires experimentation along with
patience and perseverance. Targeting members with specific interventions is
important and needs to have clearly defined expectations; the role of com-
community providers in this effort needs more research (Golden, Tewary, Dang,
& Roos, 2010).

Care1st should consider expanding its commitment to having all of its
members as possible candidates for the ICMP. Describing the ICMP as a
member benefit could be examined if it would help to get more people to
accept the referral and allow the AAA to do the assessment. People eligible
for referral to the AAA under the ICMP are at risk of needing the in-home
services and supports offered by the AAA by nature of their Medicare and
Medicaid eligibility. If they do not want an in-home assessment, they are
likely to refuse it but if they are open to it a relationship of trust might
be established that could lead to earlier intervention if needed. This could
serve to set the stage for better communication with members in advance
of any high-level need. There seems to be the opportunity for this type of
thinking as part of the member marketing and enrollment process, which
provides the first opportunity to meet the members in and around their own
living communities. It would also serve to give the AAA more business,
which might enable them to hire a dedicated staff member to work with
on the ICMP. In addition, it might help simplify the referral processes and
procedures because they would become commonly followed, thereby giving
everyone more experience with what is expected.

Care1st should also consider paying for services identified in the ASCAP-
driven care plan. Perhaps a budget amount per client as with some of the
other add-on services would assure that needed services were available on
a timely basis. To determine this amount Care1st and the AAA should work
together to estimate the cost of AAA services typically recommended and
delivered in the care plan. Unfortunately this suggestion is more complicated
than it should be as noted in the next section.
MEDICARE AND MEDICAID BARRIERS

Care1st cannot pay for HCBS that are not previously approved by Medicare and/or AHCCCS (depending on the membership). Any service has to be available to all members in the specific product, and submitted and approved by CMS and/or the State prior to launching the product. The benefits that managed health plans are allowed to pay for must be included in its product bid and approved by CMS and/or the State. Fortunately, the Duals Demonstrations, supported by CMS in some states, are beginning to provide some flexibility with regard to HCBS for dually eligible beneficiaries. Efforts to go beyond the blended Medicare and Medicaid capitated payment model by embracing managed fee-for-service could help open up the development of virtual teams of providers offering community services and supports that can complement the health plan benefit package.

But the problem is more fundamental. If services and supports are not recognized as medically necessary they cannot be part of the bid process under current Medicare rules.

In the ICMP, Care1st subsidized the intervention from its administrative profit line; an approach that makes sense only if the intervention works on some dimension that contributes to profits. For this to happen, home environment assessment and service strategies need to be targeted and tailored carefully to achieve cost-effectiveness. As noted earlier, this is a difficult challenge when the members have diverse medical needs and tend to experience unexpected transitions in those needs when community services and supports are not available.

SUMMARY AND CONCLUSIONS

The ICMP is testing a community-based strategy to expand services beyond the normal Medicare and Medicaid primary and acute benefit package offered by Care1st health plan to its dual eligible and Medicaid-only members. Care1st targeted selected high-risk members for an in-home assessment and care plan provided by the local AAA along with linkages to community services and supports. The collaboration challenged two different cultures in caring to better serve their mutual clients and allowed for process improvements from the early experience.

Lessons learned from the design, implementation, and early results of this pilot effort are supportive of further development and replication. The health plan’s average monthly costs for members receiving an assessment and services declined by an economically meaningful, statistically significant amount in the postintervention period relative to the preintervention period compared to those who did not accept an assessment or services.
This process evaluation has served to highlight several areas in need of attention in preparation for further replication and evaluation of the ICMP model. More extensive targeting of the assessment and care plan along with payment for care plan services are suggested as a ways to make the collaboration more effective. However, Medicare and Medicaid rules on what is allowed in the benefit package are identified as a barrier to this type program and may need more attention from CMS if this approach is to be widely replicated.

Both partners demonstrated their commitment to achieving success with the ICMP and there is receptivity to making adjustments to accommodate further experimentation with this model. The interest in continuing and growing the partnership between Care1st and the AAA is reinforced by this study. Referrals in the ICMP are now running at approximately 20 cases a month. Care1st also recently replicated the model with the Pima Council on Aging, the designated AAA in Pima County.

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