Medicare Special Needs Plans: Lessons from Dual-Eligible Demonstrations for CMS, States, Health Plans, and Providers

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Evaluation on Medicare Modernization Act Changes on Dual Eligible Beneficiaries in Demonstration and Other Managed Care and Fee-For-Service Settings

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Executive Summary

Background

This study reviews the experiences of eleven contracting programs that pool Medicare and Medicaid funding to create integrated systems of care for beneficiaries eligible for both programs (dual eligible beneficiaries). Sponsored by the Centers for Medicare and Medicaid Services (CMS) in partnership three states (Massachusetts. Minnesota, and Wisconsin), these demonstration contractors operate under a Medicare payment waiver and a range of Medicaid waiver authorities.

Section 231 of the 2003 Medicare Modernization Act (MMA) created the opportunity for Medicare Advantage health plans to develop Special Needs Plans (SNPs) that focus enrollment and services on Medicare beneficiaries who reside in nursing facilities, who are dual eligible beneficiaries, or who have severe and disabling chronic conditions. The MMA allowed changes in enrollment targeting, but it did not direct CMS to specify requirements for other "special" things that SNPs might do or provide (e.g., benefits, care management, coordination with Medicaid). This flexibility has the potential to stimulate health plans, providers, and states to innovate and demonstrate models to inform future policy for SNPs.

These 11 demonstration contractors all achieved MA SNP approval beginning in 2006, with Medicare waiver provisions continuing through 2007. The demonstration experience is valuable to other SNPs, states, and CMS as they think about how the SNP provisions can best serve special needs populations. The components of the models tested in the demonstration include case-mix adjusted payment, long-term care benefits for both community and institutional settings, and methods to coordinate clinical care

across acute care and chronic care settings. Information on enrollees, utilization, finance, service delivery, and marketing should be valuable to health plans. Information on the three approaches to integrated models, including targeting, benefits, and payment approaches should be of special interest to states. The contractors' experience as MA SNPs should help CMS shape regulations for the Medicare bidding processes, appropriate clinical care (including pharmacy coverage), ensuring comprehensive services, and marketing practices.

The integrated systems encompass Medicare acute care services, as well as Medicaid-covered prescription drugs, institutional and community-based long-term care (called "community care" herein), and a range of ancillary services. Most programs enroll only those over 65, but some serve adults with disabilities. Beneficiaries enrolled include nursing home residents, as well as those with and without disabilities but living in the community. Capitated payments from Medicare and Medicaid are pooled to pay for these standard services, as well as for care coordination and occasional extensions of coverage. This report highlights five areas of these programs' experience:

- Enrollee characteristics and utilization.
- Medicare and Medicaid payment.
- Contracting for and managing community care services.
- Coordinating acute care and community care.
- Marketing to people with special needs.

The 11 integrated SNPs and three states that are reviewed in this report represent the most comprehensive approach to integrating Medicare and Medicaid, with the possible exception of the Program for All-inclusive Care for the Elderly (PACE)

program. Since the large majority of the approximately 275 SNPs approved for 2006 will serve dual eligible beneficiaries, an assessment of these plans' approaches to integrating Medicare-Medicaid services for special needs populations is particularly timely. A second report under this evaluation contract will assess the strategies the plans used to maintain integrated finances, marketing, and prescription drug coverage with MMA changes.

Major Findings

Three models for states to partner with integrated SNPs have been developed. The programs in Minnesota and Wisconsin have been operating for 10 years, while the Massachusetts program began in 2004. The programs share some features but they are also distinct (Table A).

- Minnesota Senior Health Options (MSHO) and Disability Health Options (MnDHO). MSHO is open to all dual eligible beneficiaries in participating counties as a more integrated alternative to mandated enrollment in a Medicaid-only managed care organization. Three large, non-profit health plans contract with a variety of care systems for services, and service integration is through a care manager. The state handles all enrollment, grievances, and review of marketing material for both Medicare and Medicaid. One of the health plans also offers MnDHO program for adult disabled beneficiaries.
- Wisconsin Partnership Program (WPP). The WPP is open only to dual eligible community residents who meet nursing home pre-admission screening criteria (nursing home certified - NHC) and reside in the participating counties. Four small, non-profit, specialized health plans contract with individual providers for

services. Integration is through teams, including a nurse practitioner who works closely with physicians. Two of the plans enroll only elders, one enrolls only adult disabled, and one enrolls both.

- Massachusetts Senior Care Organization (SCO). SCOs are open to all dual eligible elders who reside in areas where SCOs are located. Three health plans developed to offer SCOs (two for profit and one not) contract with a variety of providers (including community health centers) for services. Integration is through nurse/social worker teams, the latter contracted from the state home care system.

Table A: State Models

	Minnesota Senior Health Options	Minnesota Disability Health Options	Wisconsin Partnership Plan	Massachusetts Senior Care Organization
Contracting health plans	Large non-profits	Large non-profit	Small, specialized non-profits	Small and large for-profits and non-profit
Target market	- Community residents (NHC and non-NHC) - Nursing home residents	Community residents (NHC only)	Community residents (NHC only)	Community residents (NHC and non-NHC)
Age groups served	65+	Under 65	Under and over 65	65+
Care coordination model	Nurse or social worker care coordinator	Nurse-social worker team	Multi-disciplinary team	Nurse-social worker team

Enrollees have high rates of disability, high risk scores, and high utilization. The integrated SNPs focused on enrolling the most disabled sectors of the population. Among the MSHO plans, nearly half of enrollees reside in nursing homes, another fifth to quarter are NHC, and only about a third are non-NHC (Table B). Among WPP sites,

there are few if any non-NHC enrollees, while about 90% or more are NHC and the rest residing in nursing homes. Among SCO plans, there almost no nursing home resident enrollees, while the proportion of NHC enrollees ranges from 22% to 49%, and non-NHC enrollees are from 51% to 77%. Finally, not surprisingly, the plans serving under-65 disabled enrolled the NHC and institutional populations almost exclusively.

Table B: Enrollee characteristics - 2005

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

* Demonstration utilization data are annualized from the first six months of calendar year 2005.

** Includes MnDHO, as well as two WPP plans.

The frailty of enrollees was reflected in high rates of utilization of acute hospitals and prescription drugs (Table B), which for most plans were several times higher than the 1.5 hospital days/member and 22 prescriptions/member in standard Medicare Advantage

plans in 2004[1]. The WPP and under-65 disabled plans had particularly high utilization, given their enrollment of NHC and institutional members exclusively. Finally, the disability levels of memberships are reflected in high utilization rates for personal care attendants.

Medicare and Medicaid capitations are adjusted for frailty. Since inception, Medicare has paid these plans modified demographic rate cells that pay a higher rate for beneficiaries meeting NHC criteria. This formula is being phased out, and, as in other Medicare Advantage plans, the CMS-HCC (Hierarchical Condition Category) methodology is being phased in. However, these and other frail elderly plans receive a frailty adjustment to HCCs to compensate for HCCs' underpayment for community-resident beneficiaries with disabilities.[2] To determine the frailty adjustment, the proportions of community-living enrollees aged 55 and over in the plan with difficulties performing activities of daily living (ADLs) such as bathing and dressing are calculated based on a survey conducted in the prior year[3]; the proportions are multiplied by the adjustors (Table C); and the products are summed. This is the plan's overall frailty score, and it is added to (or subtracted from) the plan's overall HCC score for enrollees age 55 and over.

Table C - CMS-HCC frailty adjustors

# of ADLs	Adjustor
0	- 0.143

[1] Sanofi Aventis (2005). Managed Care Digest. Bridgewater, NJ.
[2] Kautter, J. and G. C. Pope (2005). "CMS frailty adjustment model." Health Care Financ Rev **26**(2): 1-19.
[3] Galina Khatutsky, et al. (2006). The 2004 PACE Health Survey for the Minnesota and Wisconsin Demonstration Programs: Methodology and Results. Final Report to CMS. Contract No. 500-00-0024, T.O. No. 11. Baltimore, MD.

1-2	+0.172
3-4	+0.340
5-6	+1.094

The data in Table B show that all plans had disproportionately high HCC scores and frailty adjustors, ranging from 143% to 236% of the average Medicare community population (1.00). The table also shows that the frailty adjustor added a substantial amount to payment for all these plans. According to the adjustors, community beneficiaries in the MSHO plans averaged roughly 1 to 2 ADL difficulties, while the enrollees in the other plans averaged closer to 3 to 4, and even more in the under-65 disabled plans.

In all three states, Medicaid paid a capitation that included the costs of Medicare copays and deductibles, prescription drugs, ancillary services, community care waiver benefits, personal care attendant benefits, and all or some risk for custodial nursing facilities.

Except for Massachusetts, which has a risk sharing arrangement with contractors during start-up, sites are at full risk for costs. The combination of risk-adjusted Medicare and Medicaid payments was covering their high costs, and all plans reported that they were financially viable.

Contract for and Manage Home-based and Community-based Care: What makes these dual eligible plans comprehensive is their responsibility to deliver Medicaid community care services, as well as at least some long-term nursing home care. Community care services include:

- Waiver program services (e.g., personal care, homemakers, adult day services, adaptive equipment, home modifications, care coordination), which are generally managed by care coordinators, and
- Personal care attendant (PCA) program services, which may consist of PCAs managed by consumers themselves, with administrative supports from the program in training, payroll, etc.

To be consistent with state policies, many of the structures for operating these two state programs were essentially reproduced within the dual eligible plans. Plans targeted services covered in waivers to beneficiaries who were NHC, but plans were also able to extend eligibility to additional beneficiaries and add services that were not explicitly covered under waivers. Two approaches were identified for contracting for and managing community care services: in-house or self-management and sub-contracted management (to the agencies operating the waiver program in the fee-for-service system). Minnesota and Massachusetts plans used both models, while the Wisconsin sites all managed waiver services in-house.

Most of the integrated SNPs reported that compared to managing waiver benefits, contracting for and managing the Medicaid PCA benefit posed special challenges, including identification of staff qualified to conduct the eligibility assessment, contracts with PCA management agencies and fiscal intermediaries for training and paying PCAs, employment of family members as PCAs, and excessive expectations of new enrollees previously receiving generous PCA hours under the standard fee-for-service program.

In a sense the integrated SNPs had to integrate the two competing models of community care (care coordinators for waiver services and consumer-directed PCAs),

and plans seemed more comfortable with the former than the latter. The exception to this experience was the Wisconsin plans that hired and managed their own PCAs as staff members.

Mutually enhance acute care and community care through integration: The demonstration plans not only delivered Medicaid community care services, they also assessed enrollees' needs in their homes, developed community care plans, and coordinated the delivery of these services with Medicare acute care services. Three general models for connecting community care with acute care were demonstrated (Table A):

- The single coordinator (MSHO). Either a nurse or social worker managed community care and also coordinated with physicians and others in the acute care system as needed and available.
- The nurse/social worker team (SCO and MnDHO). The team social worker managed community care and the team nurse coordinated with medical care. Physicians were the formal heads of teams, but they participated mostly at a distance through the nurse.
- The multidisciplinary or interdisciplinary team (WPP). The team included a nurse, social worker, therapists, and nurse practitioner. The nurse practitioner worked closely with physicians.

There was variation in how closely community care coordinators and teams in each of these models were actually connected to physicians, and in how extensively they could use community care staff to support medical care plans. Factors that appeared to aid closer collaboration between community and acute care included:

- the interest of individual physicians.
- having a critical mass of the plan's patients in a practice.
- co-location of a care manager in the practice.
- presence of a physician "champion" in a practice.
- use of nurse practitioners (WPP) or nurses (MnDHO) to accompany patients on visits.

The WPP and MnDHO programs appeared to have the only models that consistently and closely integrated community care and medical care, but both required very low caseloads for these coordinating staff. The degree of integration in these situations was impressive, e.g., in WPP sites the nurse practitioner often took the lead in prescribing medications based on close knowledge of home situations. Some of the plans actually packaged medications to suit individuals, delivered them to the home, and had support in place to ensure that they were taken as ordered and to monitor symptoms.

All sites and states also cited special efforts to help teams function and to spur coordination. These included joint training and quality initiatives in Minnesota, work on teamwork in Wisconsin, standardized risk screening and care plans in two Massachusetts plans, and clinical leadership from the medical director in the third Massachusetts plan. Among the sites serving under-65 disabled beneficiaries, the two Wisconsin sites, as well as the MnDHO site, had proactive efforts to ensure that key sectors of the medical care system were working closely with the team.

In addition to developing a care coordination approach for community care, plans in all three states enhanced the coordination and delivery of primary and preventive care in nursing facilities. The plans tended to follow the model developed by EverCare™,

which teams physicians with nurse practitioners who visit patients regularly to try to reduce hospital admissions.[4]

Define and reach target market segments: The integrated SNPs served relatively narrow market segments, using niche marketing strategies.

- Wisconsin sites mostly relied on referrals and word of mouth from providers, families, and beneficiaries themselves.
- Massachusetts sites welcomed referrals but they relied more on signing up medical groups that served large numbers of dual eligible beneficiaries, e.g., community health centers.
- Minnesota sites all also looked for referrals and for medical group links, but they had the added advantage of being able to market to members of their own Medicaid HMOs. All (except the MnDHO contractor) were approved by CMS to passively enroll dual eligible beneficiaries already enrolled in their Medicaid HMOs into their new companion SNPs in 2006 to assure continuity of pharmacy coverage with the implementation of Medicare Part D.

Because many dual eligible beneficiaries who could benefit from the plans' integrated service approach were in Medicaid community care waiver programs, these programs were seen by some as a logical source of referrals. However, few integrated SNPs relied on this source for many members, in part since there was often a perception of competition between the SNPs and the waiver programs. As of March 2006, the total enrollments in the demonstration sites by state were approximately 35,000 in Minnesota

[4] Kane, R. L. and S. Huck (2000). "The implementation of the EverCare demonstration project." J Am Geriatr Soc 48(2): 218-23.

(which allowed MSHO to go nearly statewide for the first time), 2,000 in Wisconsin, and 4,500 in Massachusetts.

Discussion

In summary, the three states and their demonstration sites share some features, which could serve as a foundation of an integrated SNP model for dual eligible beneficiaries:

- Voluntary enrollment by both dual-eligible and Medicaid-only beneficiaries.
- Finance through risk-adjusted capitations from both Medicare (for eligibles) and Medicaid.
- Assumption of financial risk by health plans.
- Inclusion in the capitation of Medicaid funds to cover community care services, e.g., personal care, that support independence and avoid inappropriate institutionalization.
- Inclusion in the capitation of all or some responsibility for long-term nursing facility care.
- Full coverage of prescription drugs through the Medicaid capitation (now shifted to Medicare but with wrap-around Medicaid pharmacy) .
- Special efforts at coordination of medical and social care services.

The three states show that within this framework, there can also be variation in how to structure a comprehensive, integrated approach to a dual eligible SNP.

This synopsis of the operations of the integrated SNP demonstration plans also illustrates the complexity of their development and operations, as well as the challenges of paying and regulating them. Only these three states and eleven health plans developed

them under waivers, and it may take time for comprehensive, integrated plans to emerge under new SNP authority.

The main challenge for health plans will be contracting for and taking risk for the full range of acute and long-term care services and developing care coordination models that span acute and long-term care. The main challenges for states are first to choose among the targeting and benefit models, and then to develop payment approaches and work out relationships among waiver service, PCA, and aging network organizations. To make integrated SNPs an attractive choice under Medicare Advantage, CMS will need to transition the supports that have been provided under demonstration authority into the SNP program for dual eligible beneficiaries. These include integrated approaches to financing, benefits, service delivery, marketing, and other areas of regulation. In February 2007, CMS announced that it will phase out the frailty adjustment to payment for these demonstration health plans between 2008 and 2010, after which they will be paid 100% with standard HCC factors[5].

[5] CMS. February 16, 2007. Advance Notice of methodological changes for calendar year 2008 for Medicare Advantage (MA) capitation rates.

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Lessons from Dual-Eligible Demonstrations

for CMS, States, Health Plans, and Providers

I. Background

A. MMA, SNPs, and the Dual Eligible Demonstrations

Section §231 of the 2003 Medicare Modernization Act (Marshall, Long et al.) created the opportunity for a new type of Medicare Advantage health plan focused on enrollment and services to "special needs beneficiaries," i.e., beneficiaries who reside in nursing facilities, who were dually eligible for both Medicare and Medicaid, or who had severe and disabling chronic conditions. The intent is that such "special needs plans" (SNPs) will address the high costs and care challenges of growing numbers of beneficiaries with chronic illnesses and disabilities.

The SNP provision allows health plans to target special needs beneficiaries, but it does not call for the Centers for Medicare and Medicaid Services (CMS) to specify requirements for other "special" things that SNPs might do or provide. This flexibility has the potential to stimulate health plans, providers, and states to innovate and demonstrate models to inform future policy for SNPs. Since the large majority of the 275 SNPs approved for 2006 will serve dual eligible beneficiaries, models are particularly needed for the dual-eligible SNP option.

Many of these new dual-eligible SNPs stem from current Medicaid HMOs that passively enrolled dual-eligible beneficiaries into a companion SNP.[6] CMS allowed this

[6] Beneficiaries were told that they could get their Part D benefits in the new SNP, and unless they responded that they did not want to join, they were "passively" enrolled.

to try to minimize the problems that occur when care systems are fragmented. Because the initial implementation of SNPs occurred during a period when there were other important changes taking place in Medicare and Medicaid, it is likely that these new plans have initially taken a minimal approach to coordinating Medicare and Medicaid finances, benefits, and services, i.e., they will continue to just manage Medicaid ancillary services as a Medicare wrap-around, and they have not included long-term care in their Medicaid capitations (Peters 2005). In the future, however, they could develop more comprehensive models that add some responsibility for Medicaid-covered long-term care services and that seek more coordination across acute and long-term care lines.

B. The Integrated Demonstration Programs

This report synthesizes approaches and lessons from 11 demonstration health plans contracting with CMS and three states that can be seen as prototypes of this more comprehensive and coordinated approach that SNPs might take to integrating Medicare and Medicaid (GAO 2000). One demonstration model was pioneered by the State of Minnesota in 1997 in the Twin Cities area as the Minnesota Senior Health Options (MSHO), followed in 1999 by the Wisconsin Partnership Program (WPP). All these plans had substantial support from foundations, particularly the Robert Wood Johnson Foundation, which supported replications of the MSHO, WPP, and SCO models through the Medicare Medicaid Integration Program, Building Health Care Systems Program, and the Center for Health Care Strategies. The Massachusetts Senior Care Organization (SCO) initiative, which began operations in 2004, was the only other state to implement the fully integrated Medicare/Medicaid model. In 2001, Minnesota added a Disability Health Options (MnDHO) plan for under-65 disabled beneficiaries, which operates as a

subcontractor to one of the MSHO plans. Two of the WPP plans also serve physically disabled adults age 18-64. All of the 11 plans became MA SNPs for 2006.

Evaluations of the Minnesota and Wisconsin demonstrations showed decreased utilization in a number of services compared to comparisons, indicating that the integrated models had some success in substituting community services and care coordination for institutional services (Kane and Homyak 2003; Kane and Homyak 2004). Although results were not significant for all comparisons, demonstration plans for elders outperformed fee-for-service in hospital days (WI), hospital length of stay (MN & WI), preventable hospital admissions (WI), and preventable emergency department services (WI & MN). In no areas was fee-for-service performance superior. Results for under-65 plans in WI were mixed.

The three states and their demonstration sites share some features, which could serve as a foundation of an integrated SNP model for dual eligible beneficiaries:

- Voluntary enrollment by both dual-eligible and Medicaid-only beneficiaries, which requires plans to reach eligible beneficiaries and convince them to join.
- Finance through risk-adjusted capitations from both Medicare (for eligibles) and Medicaid, and assumption of financial risk by health plans.
- Inclusion in the capitation of Medicaid waiver and personal care attendant (PCA) funds to cover community care services that support independence and avoid inappropriate institutionalization, e.g., personal care, homemaking, transportation, personal emergency response systems, home-delivered meals, adaptive equipment, home modifications, incontinence supplies, and respite care.

- Inclusion in the capitation of all (WI and MA) or some (Smith and Smith) responsibility for long-term nursing facility care.
- Full coverage of prescription drugs through the Medicaid capitation (now shifted to Medicare but with wrap-around Medicaid pharmacy) .
- Special efforts at care coordination of medical and social care services using capitation funding to cover staff, information systems, teams, and benefits not covered in standard Medicare and Medicaid programs.

The three states show that within this framework, there can also be variation in how to structure a comprehensive, integrated approach to a dual eligible SNP.

1. Minnesota. During 2005 Minnesota required 41,000 of the state's 51,000 Medicaid-eligible seniors to enroll in a Prepaid Medical Assistance Plan (PMAP), which by state law were operated by non-profit health plans. Three of the nine HMOs that offered PMAP (UCare, Medica, and Metropolitan) also offered MSHO, and one (UCare) also offered MnDHO for under-65 adults with physical disabilities. Since 2001, MSHO has been available in 7 Twin Cities metro counties and 3 rural counties. The much smaller MnDHO program has been available only in the Twin Cities counties (See Figure 1 for additional characteristics of the plans). The MSHO and MnDHO plans handle enrollment, claims, reporting, and finances; and they contract with "care systems" (e.g., clinic groups, hospitals and affiliated physicians), as well as other providers to deliver the MSHO services. Coordination of medical and social care in MSHO is performed by nurse and social worker care coordinators. Coordination in MnDHO is handled by a subcontract from UCare to AXIS Healthcare, which identifies disability-competent providers, with which UCare has or develops contracts. AXIS then manages care with a

team consisting of a nurse, social worker, and member representative. Both community residents (frail and non-frail elders) and nursing home residents can be enrolled in

Figure 1: Integrated Special Needs Plans			
A. Service areas, plan types, and enrollees served	Service area	Profit Status	Enrollees served
Minnesota			
UCare	Twin cities area	Non-profit	65+
Metropolitan Health Plan (MHP)	Hennepin Co (Minneapolis)	Non-profit	65+
Medica	Twin cites area	Non-profit	65+
UCare & AXIS Healthcare	Twin cites area	Non-profit	Adult disabled
Wisconsin			
Eldercare of Wisconsin (ECW)	Dane Co. (Madison)	Non-profit	55+
Community Care for the Elderly (CCE)	Milwaukee & Racine	Non-profit	65+
Community Health Partnership (CHP)	3 rural counties near Eau Claire	Non-profit	65+ & Adult disabled
Community Living Alliance (CLA)	Dane Co. (Madison)	Non-profit	Adult disabled
Massachusetts			
Commonwealth Care Alliance (CCA)	Metro Boston, Springfield	Non-profit	65+
Senior Whole Health (SWH)	Metro Boston	For-profit	65+
Evercare SCO (ESCO)	Metro Boston, Fall River	For-profit	65+

MSHO. The MnDHO plan focuses on under-65 disabled beneficiaries.

2. Wisconsin. The WPP was conceived as a "PACE without walls," i.e., the plans enroll only the frail elderly and/or physically disabled and coordinate all services through a multidisciplinary or interdisciplinary team, but without the PACE requirements to come to the day center for care or to use the PACE physician (Mui 2001). The WPP teams typically include a nurse practitioner, one or two registered nurses, one or two social workers, and a part-time service coordinator. Each team manages from 30 to 120 members, with the typical range of 50 to 75. In addition to being housed in one location, teams generally meet weekly to review their panels of patients. Most WPP services were

delivered in the home, and a nurse practitioner from the team coordinates with each enrollee's current physician by accompanying patients on most primary care visits. WPP sponsors were small, community-based non-profits that were not managed care organizations before the program. Two of the sites serve only frail elders (ElderCare of WI and Community Care for the Elderly), one serves physically disabled adults age 18-64 (Community Living Alliance), and one serves both populations (Community Health Partnership).

3. Massachusetts. During 2005, the state contracted with three SCOs, which were something of a cross between Wisconsin and Minnesota in their approaches to contracting for medical care and clinical care coordination. Like Wisconsin, all were small, new managed care entities: Senior Whole Health is a free standing for-profit, Commonwealth Care Alliance is a free-standing non-profit, and Evercare SCO is a subsidiary of for-profit United Health Care. Like WPP sites, they also use teams to coordinate care, rather than the single care coordinator, as MSHO does. However, the SCO teams were smaller than the WPP teams, consisting of a nurse and a social worker, and a nurse practitioner for selected members. The social worker is called a Geriatric Support Services Coordinator (GSSC), and the SCOs were required to contract for the GSSC's services from the Area Agencies on Aging (called Aging Services Access Points) that run the state-funded home care and Medicaid waiver programs. The SCO teams coordinate with physicians through face-to-face contact, the telephone, and information systems. All SCOs serve only elders – both the frail and non-frail, and they can enroll nursing home residents directly. The state has a risk sharing arrangement with plans in the start-up years.

Given this overview of the general and state-specific approaches to integrated SNPS, we turn to five issues in more depth: (1) beneficiary characteristics, utilization, and service costs, (2) Medicare an Medicaid payment; (3) contracting for and managing community care services; (4) coordination between acute care and community care, and (5) marketing and enrollment.

II. Dual-eligible characteristics, utilization, and service costs

The goal of the integrated comprehensive SNPs for dual-eligible beneficiaries is to coordinate acute and long-term care services to improve both medical and long-term care outcomes for high-risk populations. Taking on this challenge requires understanding the needs of dual-eligible beneficiaries, the full range of services they use in both programs, and the costs and utilization patterns that health plans can expect.

This section reports data obtained from the demonstration sites on their case mix, utilization, and expenditures for several acute and long-term care services for January through June of 2005. The long-term care services may be unfamiliar to traditional acute care health plans that may be interested in starting integrated SNPs, while the acute care services may be unfamiliar to potential community care sponsors. For comparison purposes, we have also obtained data on some items from standard Medicare Advantage programs.

We report the data by state but not by names of health plans because we do not think the data support cross-plan comparisons of why there are differences. We have little reliable case mix data, and we relied on the sites' definitions of how they categorize and count utilization and costs. It is not possible or appropriate to draw conclusions

from these data about the relative effectiveness or efficiency of individual sites. The data were reported by the sites based on their own reporting systems and definitions, and there are differences in what is included or excluded. Moreover, there are differences in practices with related services that may mean that the data provide less than the full picture of a site. For example, some geographic areas and plans may rely more on home health aides while other plans rely more on personal care assistants (PCAs). Some areas may have extended types of both of these services under the community waivers, and all of these are used in combination or may substitute for each other.

Table 1 shows the case mix, number, and age of enrollees in each of the plans. With the exception of the MSHO plans, all were quite small in 2005 (less than 500 enrollees) and had high rates of eligibility for community waiver services (i.e., they are nursing home certifiable or NHC). Minnesota plans also served large numbers of nursing home residents. Average age of enrollees for the plans serving elders was at or near 80, while the plans for the disabled were around 50. Among elders, data not included in the tables show that enrollees residing in nursing homes were generally six to eight years older than community residents.

Table 2 shows rates of emergency department visits per 1,000 members per year, hospital admissions/1,000, hospital days/1,000, and hospital costs per member per month, annualized based on data from the first 6 months of 2005. To the extent that data are available, it can be seen that NHC enrollees generally had higher utilization in all of these hospital categories than non-NHC beneficiaries or even nursing home residents. Since they do not serve non-NHC community enrollees, the Wisconsin plans had higher rates of utilization, compared to MSHO and SCO plans. The under-65 plans were consistently at

the high end of all categories. By way of comparison, conventional Medicare Advantage plans reported hospital utilization of 1,500 days/1,000 in 2004. Similar patterns hold for hospital costs per member per month: highest costs generally in WPP and under-65 plans.

Table 1 - Enrollees by Rate Cell and Age	NHC community enrollees	Non-NHC community enrollees	Institutional enrollees	Total enrollees	Average age
MSHO Plans - 65+					
A	687	786	1,138	2,611	80
B	na	na	na	na	na
C	552	1,006	1,390	2,948	80
WPP Plans - 65+					
D	436	na	22	458	79
E	na	na	m	400	76
F	423	na	63	486	79
SCO Plans - 65+					
H	167	173	1	341	76
I	135	465	6	606	75
J	75	575	89	739	76
Under 65 Disabled Plans					
K	232	7	26	265	47
L	195	na	17	212	52
M	301	na	4	305	49
na: data not available from the health plan					

Table 3 shows annual utilization rates and monthly expenditures for outpatient physician visits and pharmacy. Due to differences in categorization and counting methods, physician visits and costs were typically difficult to compare across plans, and these data illustrate the challenges. An additional problem is that some of these plans use nurse practitioners to provide primary care in the home and in nursing facilities, and

some plans may have counted these while others did not. The pharmacy data in Table 3 show the very high rates of prescription drug use in these dual eligible programs. To the extent that there are data, the figures show higher use by NHCs than non-NHC community enrollees, but the rates of NHCs compared to nursing home residents are not consistent. The WPP and under-65 plans were particularly high - with annualized rates between 109 to 190 scripts per person per year and costs above $397 PMPM in five of the six plans.

Table 4 shows annual utilization rates and monthly expenditures for Medicare-covered skilled nursing facility care and non-Medicare, custodial nursing facility care. Again, several of the plans had difficulties breaking out utilization and costs in these categories, in distinguishing between Medicare-type and other type nursing facilities, or even reporting in this area at all. Large differences between NHC and non-NHC community enrollees are apparent again, but in this service area, nursing home residents are not surprisingly by far the highest users of nursing facilities. The risk for high costs in this area is apparent in the figures for Plans A, D, K. Plan D in Wisconsin is fully responsible for the costs of the 22 enrollees in the institutional category who used an average of 342 days of custodial care each per year. This site may be losing significantly on the long-term care portion of the capitation, since the state pays only 95% of a formula weighted heavily to community care costs.

Table 5 shows utilization rates and monthly expenditures for personal care attendants. The proportions of members with PCAs are also reported. The data show that in most plans, about half or more of the enrollees who were NHC had PCAs. Much

Table 2: Hospital Utilization & Costs	NHC	Non-NHC community	Institutional	Total		NHC	Non-NHC community	Institutional	Total
	Emergency Dept Visits/1000					*Hospital Days/1000/yr*			
MSHO Plans - 65+									
A	1,314	860	651	883		2,835	1,247	1,267	1,662
B	na	na	na	na		na	na	na	na
C	536	331	121	268		4,935	1,242	1,784	2,213
WPP Plans - 65+									
D	372	na	182	363		2,817	na	4,000	2,873
E	na	na	na	1,708		na	na	na	4,639
F	na	na	na	1,458		na	na	na	5,148
SCO Plans - 65+									
H	500	238	na	368		4,441	342	na	2,390
I	1,871	873	1,548	1,141		14,008	2,628	17,032	5,780
J (1)	7,628	7,628	216	933		5,970	595	359	1,214
Under 65 Disabled Plans									
K	2,408	3,243	3,022	2,486		4,749	na	4,978	4,649
L	na	na	na	1,648		na	na	na	6,001
M	1,469	m	500	1,456		6,827	na	6,500	6,822
MSHO Plans - 65+	*Hospital Admissions/1000/yr*					*Hospital costs $PMPM*			
A	607	281	294	370		$ 404	$ 216	$ 210	$ 261
B	na	na	na	na		na	na	na	na
C	836	276	270	380		$ 564	$ 177	$ 183	$ 254
WPP Plans - 65+									
D	578	na	455	572		$ 331	na	$ 439	$ 336
E	na	na	na	887		na	na	na	$ 599
F	na	na	na	1,098		na	na	na	$ 542
SCO Plans - 65+									
H	559	149	na	353		$ 612	$ 71	na	$ 341
I	1,414	461	1,161	717		$ 1,204	$ 275	$ 391	$ 516
J	1,688	152	180	339		na	na	na	$ 270
Under 65 Disabled Plans									
K	793	na	1,067	798		$ 669	na	$ 709	$ 655
L	na	na	na	1,056		na	na	na	$ 544
M	1,046	na	1,000	1,045		$ 828	na	$ 467	$ 824

na: data not available from the health plan

(1) Plan J figures for NHC and Non-NHC enrollees pooled.

Table 3: Physicians and Prescriptions	NHC	Non-NHC community	Institutional	Total		NHC	Non-NHC community	Institutional	Total
	Outpatient Physician Visits/1000					***Prescriptions/1000/yr***			
MSHO Plans - 65+									
A	7,466	5,960	304	3,836		73,317	48,046	116,464	84,864
B	na	na	na	na		na	na	na	na
C	24,795	16,435	12,892	16,309		84,329	49,817	108,878	85,212
WPP Plans - 65+									
D	4,537	na	13,818	4,983		180,002	na	116,211	176,784
E	na	na	na	3,280		na	na	na	109,029
F	na	na	na	na		na	na	na	125,392
SCO Plans - 65+									
H	2,279	4,307	1,500	3,279		na	na	na	86,544
I	16,129	9,259	8,903	11,024		51,741	34,447	66,581	39,392
J(1)	35,844	35,844	47,102	36,972		54,148	54,148	98,443	58,588
Under 65 Disabled Plans									
K	5,693	2,919	3,733	5,439		105,489	56,432	154,133	108,782
L	na	na	na	na		na	na	na	152,104
M	6,062	na	5,500	6,054		190,579	na	160,500	190,173
	Physician $PMPM					***Pharmacy $PMPM***			
MSHO Plans - 65+									
A	$ 52	$ 41	$ 3	$ 27		$ 273	$ 176	$ 345	$ 276
B	na	na	na	na		na	na	na	na
C	$ 99	$ 56	$ 67	$ 70		$ 331	$ 198	$ 321	$ 283
WPP Plans - 65+									
D	$ 27	na	$ 11	$ 26		$ 434	na	$ 392	$ 432
E	na	na	na	$ 94		na	na	na	$ 397
F	na	na	na	na		na	na	na	$ 340
SCO Plans - 65+									
H	$ 3	$ 4	$ -	$ 3		$ 391	$ 215	$ 62	$ 302
I	$ 102	$ 77	$ 58	$ 83		$ 465	$ 264	$ 493	$ 319
J (1)	$ 70	$ 70	$ 65	$ 68		$ 197	$ 197	$ 327	$ 210
Under 65 Disabled Plans									
K	$ 42	$ 25	$ 32	$ 41		$ 649	$ 306	$ 1,061	$ 678
L	na	na	na	na		na	na	na	$ 558
M	$ 22	na	$ 25	$ 22		$ 786	na	$ 488	$ 782

na: data not available from the health plan. (1) Plan J figures for NHC and Non-NHC enrollees pooled.

Table4: Nursing facilities	NHC	Non-NHC community	Institutional	Total	NHC	Non-NHC community	Institutional	Total
	Medicare SNF Days/1000				***Other Facility Days/1000/yr***			
MSHO Plans - 65+								
A	3,366	749	5,782	3,651	2,835	1,247	1,267	1,662
B	na	na	na	na	na	na	na	na
C (1)	6,470	611	5,421	4,077	na	na	na	na
WPP Plans - 65+								
D	4,776	na	13,818	5,232	5,197	na	342,183	21,384
E	na	na	na	3,240	na	na	na	37,232
F	na	na	na	na	na	na	na	na
SCO Plans - 65+								
H (2)	1,588	na	262,500	2,081	0.01	na	na	0.01
I	798	210	11,613	535	-	-	24,000	926
J	13,960	134	12,072	2,982	na	na	na	na
Under 65 Disabled Plans								
K	2,181	na	31,022	4,823	340	na	14,400	1,647
L	na	na	na	na	na	na	na	na
M	273	na	na	270	2,270	na	307,500	6,384
	Medicare SNF $PMPM				***Other Facility $PMPM***			
MSHO Plans - 65+								
A	$ 98	$ 24	$ 163	$ 105	$ 404	$ 216	$ 210	$ 261
B	na	na	na	na	na	na	na	na
C (1)	$ 179	$ 12	$ 149	$ 111	na (1)	na	na	na
WPP Plans - 65+								
D	$ 138	na	$ 401	$ 151	$ 76	na	$ 3,963	$ 272
E	na	na	na	$ 34	na	na	na	$ 156
F	na	na	na	na	na	na	na	na
SCO Plans - 65+								
H	$ 56	$ 0.05	$ 4,593	$ 51	$ 5	$ 1	$ 28	$ 3
I	$ 28	$ 5	$ 13	$ 11	$ -	$ -	$ 7,001	$ 106
J	$ 357	$ 3	$ 309	$ 76	na	na	na	na
Under 65 Disabled Plans								
K	$ 793	na	$ 1,067	$ 798	$ 7	na	$ 271	$ 32
L	na	na	na	na	na	na	na	na
M	$ 8	na	na	$ 8	$ 25	na	$ 3,285	$ 69

(1) Experience tracked for SNF/ECF - not separated between Medicare SNF and Other nursing facility
(2) Medicare SNF utilization and costs based on one enrollee.

smaller proportions of non-NHC community residents receive PCA services, often through the PCA portion of the Medicaid benefit, which generally has less stringent eligibility. Nursing home residents do not receive PCA services from plans, with the exception of one of the under-65 plans that sends its own PCAs into facilities to supplement services. In two of the plans, nearly all members had PCAs. The hours of service or visits per member also vary considerably, and some of this variation is likely due to differences in counting methods. Spending on PCAs in some plans is similar to (A, H, and M) or substantially more than (K) they spend on hospital services.

Table 6 shows utilization and costs for transportation services. These figures include coverage for a variety of types of assisted transport (e.g., taxis, chair cars) to primary care visits, adult day services, and other medical care. The data show that transportation benefits were used by NHC, non-NHC, and institutional beneficiaries alike; but patterns of transporting nursing home residents, versus providing rides for those who live at home apparently vary. Most plans appear to provide enrollees at least two round-trips a month. In some plans, high rates of transportation reflect trips to adult day services. Transportation is also an expensive service for some plans, although the lack of consistency in the data between high utilization rates and high costs again reflects the differences in reporting practices.

The integrated SNPs in the demonstration were shaped by their states' approaches to the initiative, by the health care systems in their communities, and by the contracting organizations' goals. Minnesota began MSHO and MnDHO in the Twin Cities, which was characterized by large and sophisticated health care systems and (by law) non-profit HMOs. Wisconsin sought to replicate the PACE program, but without the PACE

Table 5: Personal Care Attendants	NHC	Non-NHC community	Institutional	Total
% of Members with PCA				
MSHO Plans - 65+				
A	47%	17%	0%	17%
B	na	na	na	na
C	na	na	na	na
WPP Plans - 65+				
D	52%	0%	0%	50%
E	na	na	na	94%
F	na	na	na	38%
SCO Plans - 65+				
H	47%	5%	0%	26%
I	23%	1%	0%	6%
J (1)	8%	8%	0%	7%
Under 65 Disabled Plans				
K	60%	14%	24%	55%
L	na	na	na	44%
M	86%	na	0%	85%
PCA visits/hours/1000				
MSHO Plans - 65+				
A	646,260	144,046	503	208,806
B	na	na	na	na
C	698,915	195,288	6,034	199,462
WPP Plans - 65+				
D	93,872	na	na	89,362
E	na	na	na	80,081
F	na	na	na	86,557
SCO Plans - 65+				
H	662,559	40,782	na	351,463
I	324,502	13,124	na	93,172
J (1)	55,921	55,921	na	50,316
Under 65 Disabled Plans				
K	1,313,750	93,081	42,844	1,163,551
L	na	na	na	186,739
M	981,041	na	na	967,813
PCA $PMPM				
MSHO Plans - 65+				
A	$ 818	$ 182	$ 1	$ 264
B	na	na	na	na
C	$ 402	$ 91	$ 4	$ 108
WPP Plans - 65+				
D	$ 264	na	na	$ 250
E	na	na	na	$ 126
F	na	na	na	$ 158
SCO Plans - 65+				
H	$ 658	$ 39	na	$ 349
I	$ 334	$ 14	$ -	$ 96
J (1)	$ 351	$ 351	$ -	$ 316
Under 65 Disabled Plans				
K	$ 1,708	$ 117	$ 55	$ 1,513
L	na	na	na	$ 338
M	$ 822	na	na	$ 811

(1) Plan J figures for NHC and Non-NHC enrollees pooled.

Table 6: Transportation	NHC	Non-NHC community	Institutional	Total
One-way Trips/1000				
MSHO Plans - 65+				
A	28,118	8,325	6,237	12,461
B	na	na	na	na
C	162,159	23,418	39,037	57,593
WPP Plans - 65+				
D	88,904	na	11,091	85,166
E	na	na	na	128,923
F	na	na	na	49,910
SCO Plans - 65+				
H	83,176	25,040	3,000	54,000
I	1,643	380	44,516	1,376
J (1)	na	na	na	na
Under 65 Disabled Plans				
K	83,802	58,378	74,222	82,254
L	na	na	na	74,083
M	26,617	na	36,000	26,744
Transportation $PMPM				
MSHO Plans - 65+				
A	$ 53	$ 17	$ 15	$ 25
B	na	na	na	na
C	$ 69	$ 15	$ 32	$ 34
WPP Plans - 65+				
D	$ 218	na	$ 26	$ 209
E	na	na	na	$ 156
F	na	na	na	$ 27
SCO Plans - 65+				
H	$ 44	$ 13	$ 5	$ 28
I	$ 37	$ 11	$ 841	$ 30
J	na	na	na	na
Under 65 Disabled Plans				
K	$ 232	$ 170	$ 196	$ 227
L	na	na	na	$ 44
M	$ 153	na	$ 101	$ 152

requirement to attend adult day center or to switch to the PACE physician. Massachusetts had no size or profit-status requirements, but they wanted plans that would serve all Medicaid-only and dual-eligible elders, go statewide, and be willing to work with the aging network. Most plans were still very small and their memberships were characterized by high rates of disability and medical complexity. Utilization and costs of key services - hospitals, physicians, prescription drugs, nursing facilities, and personal care - were also very high (Tables 1-6). Plan characteristics are summarized in Figure 1 above.

III. Payment Approaches

For integrated SNPs to be financially feasible, states and CMS need payment approaches that are sensitive to expected costs for covered Medicare and Medicaid services, as well as other services and management expenses (particularly care coordination) that are not normally reimbursed by either payer. This section describes the case-mix-adjusted payment approaches that have been used by Medicare and Medicaid. A common core of payment schemes for both payers has been the concept of "nursing home certifiable" (NHC), which refers to beneficiaries who reside in the community, but who meet pre-admission screening requirements for nursing facility care. Medicare has used the NHC payment category in demonstrations for more than 20 years in Social HMOs (Leutz, Kistner et al. 1990) and PACE (Associates 1997), and it was carried over into these three dual-eligible demonstrations. Medicaid community waiver services were generally targeted at NHC beneficiaries, and Medicaid agencies also used the NHC concept to adjust payment in a wide range of demonstrations. While the NHC

approach is being phased out in Medicare in favor of a "frailty" adjustor (see below), NHC is likely to remain a factor in Medicaid payment.

A. Medicare payments

The Medicare financing approach has been uniform across the 11 plans. Under Section 402 waivers, Medicare has paid plans with a variant of the NHC-adjusted demographic formula used in Social HMO and PACE programs (Temkin-Greener, Meiners et al. 2001). Plans receive the regular demographic rate cells for non-NHC and institutionalized members, but they receive PACE adjustors, i.e., 2.39 times the county rate cells for both Parts A&B, for members who were NHC. Per mandate of the 1997 Balanced Budget Act, between 2004 and 2008, the demographic payment approach is being phased out, and the Hierarchical Condition Category (HCC) risk adjustment approach is being phased in (Kautter and Pope 2005). However, under waivers (again similar to PACE and Social HMOs), CMS adds frailty adjustors to the HCCs. To determine the frailty adjustment, the proportions of community-living enrollees aged 55 and over in the plan with difficulties performing activities of daily living (ADLs) such as bathing and dressing are calculated based on a survey conducted in the prior year (Khatutsky, Walsh et al. 2006); the proportions are multiplied by the adjustors (Table 7); and the products are summed. This is the plan's overall frailty score, and it is added to

Table 7 - CMS-HCC frailty adjustors

# of ADLs	Adjustor
0	- 0.143
1-2	+0.172
3-4	+0.340
5-6	+1.094

(or subtracted from) the plan's overall HCC score for enrollees age 55 and over.

On February 16, 2007, CMS issued an Advance Notice that the frailty adjustors in Table 7 would be phased out between 2008 and 2010 for these demonstration health plans. In 2008, payment will be weighted at 75% with the frailty formula and 25% with regular HCCs. Weights move to 50/50 in 2009, 25/75 in 2010, and 100% regular HCCs in 2011. Newly calculated frailty factors were announced in the Advance Notice, but they will be available only to PACE in 2008. Even if the new factors were offered to the state dual-eligible plans, they provide much lower additions to payment for frail beneficiaries than the old factors. The frailty adjustor and the NHC-AAPCC have not been available to other new SNPs.

Table 8 shows that all of the dual eligible plans had HCC scores consistent with high-cost, complex enrollments (an HCC score of 1.0 is the average Medicare beneficiary). The frailty adjustors add significantly to reimbursement for all plans, reflecting the high proportions of NHC beneficiaries with accompanying ADL difficulties (e.g., Plan M's .46 frailty adjustor indicates a population with difficulty on average in more than 4 of 6 ADLs). The three Massachusetts plans all used a frailty factor of 0.30,

Table 8 - Medicare risk adjustors	**HCC Score**	**Frailty factor**	**Total Adjustor**
MSHO Plans - 65+			
A	1.43	0.15	1.58
B	-	-	-
C	1.56	0.21	1.77
WPP Plans - 65+			
D	1.91	0.39	2.30
E	2.36	0.44	2.80
F	2.28	0.45	2.73
SCO Plans - 65+			
H	2.05	0.30	2.35
I	na	0.30	na
J	1.51	0.30	1.81
Under 65 Disabled Plans			
K	1.53	0.70	2.24
L	2.28	0.45	2.73
M	2.28	0.46	2.73

which was the default for start-up plans with no prior experience. The right-hand column of the table showing total risk adjustments indicates that most of the demonstration sites received at least double the average Medicare spending in their locality.

B. Medicaid payments

In contrast to Medicare rates, where most costs are in acute care, Medicaid rates are dominated by long-term care. The one similarity across the three states is that all states had a rate cell for beneficiaries who were NHC, which incorporates the state's average spending for community waiver services for NHC beneficiaries, the estimated costs of supplementary services for NHC beneficiaries, and a component to cover the plans' risk for nursing home care. The nursing home risk provides the plans with incentives to keep beneficiaries living in the community. The NHC cell is the only rate cell in Wisconsin, but the other states also had Medicaid rate cells for community non-NHC beneficiaries and for institutional residents.

1. Minnesota. The state puts plans at risk for the first 180 days of nursing home costs for enrollees who initially reside in the community (Figure 2). A component to cover the estimated risk for the 180 days is included in both the NHC and the community "well" rate cells. The state pays directly for nursing home costs after 180 days, as well as for enrollees who join MSHO directly from nursing homes. Funds for all of the basic care Medicaid benefits, including PCA, home health aide, private duty nurse, and skilled nurse visits benefit flow through the non-institutional Minnesota Senior Care rate to PMAP, MSHO, and MnDHO plans; and these components of the rates are the same for both NHC and non-NHC community residents.

2. Wisconsin. The capitation rate for WPP sites is based on the fact that among all elders age 65 and over in Wisconsin who were NHC, 80% reside in the community and 20% reside in nursing homes. The state calculates the per capita costs for each group (nursing home and community NHC) for long-term care, medical services, and ancillary services. They use the costs of waiver participants for the community long-term care cost profile (although they know that not all NHC beneficiaries were in waiver programs). Then the state pays the WPP plans a weighted average of the two groups' costs, less 5%, i.e.: (0.2 X NH resident costs + 0.8 X waiver participant costs) X 0.95. There is also an annual retrospective case mix adjustment to the Partnership rates. If the rates change based on actual plan experience, the state pays or collects the difference. Therefore, the state believes that this reduces the financial incentive to "cherry pick" or practice

Figure 2: Payment approaches

	Minnesota MSHO/MDHO	**Wisconsin WPP**	**Massachusetts SCO**
Medicare capitation			
NHC-AAPC Frailty-adjusted CMS-HCC	- Phasing out - Phasing in (55 & older only)	- Phasing out - Phasing in (55 & older only)	- Phasing out - Phasing in
Medicaid capitation			
HCB waiver services	- Yes	- Yes	- Yes
Personal care services	- Yes	- Yes	- Yes
Custodial NH services	- 180 days risk	- Unlimited risk	- full risk, but offset by transition to 3-tier nursing home rates

selective enrollment.

3. Massachusetts. Massachusetts put plans at risk for the first 90 days of nursing home costs, after which they paid plans at a case-mix adjusted rate (there were three tiers) to cover nursing home costs directly. Enrollees who entered a nursing home from one of

the community "well" rate cells were paid using the NHC rate cells for three months, after which they were paid through the institutional cells. If a plan moved a nursing home resident into the community, the nursing home rates continued for three months. This rate structure put plans at risk for nursing home costs (since plans had to pay nursing home per diems within the rate structure) and also created incentives to move nursing home residents back to the community. In addition, Massachusetts had a risk-sharing arrangement with sites that limits overall profits and losses on Medicaid reimbursement and services within pre-defined risk corridors.

C. Discussion

In summary, the long-term care components were the most sensitive part of the Medicaid capitation for integrated comprehensive SNPs, since the components for nursing home care and for community care added considerably to the rates. Rate components for custodial nursing home care differed by state: The Wisconsin rate structure was the same regardless of residence; Minnesota limited nursing home risk to six months of exposure for those entering from the community and no responsibility for those enrolled in the nursing home; and Massachusetts put contractors at full risk for nursing home costs but limited that risk by building in transition to higher rate cells (first to NHC rates and then to three-class institutional rates) for those staying three months or longer. These structures reflected tradeoffs for states between (1) wanting to give incentives to keep enrollees in the community (by building long-term nursing home risk into basic capitations), and (2) wanting to avoid paying too much for enrollees with relatively low risk of institutionalization (by making rate adjustments or risk limits that were closer to the actual costs of nursing home care).

All states based rates for community care waiver services on beneficiaries who were NHC and actually participated in waiver programs, rather than also including beneficiaries who were NHC and did not participate. Rates for PCA benefits were perhaps the most sensitive, since the rates were included in the ancillary and other medical components of rates, which were paid for all enrollees, whether they were NHC or not. Each of these rate calculations was based on assumptions that the case mix of enrollees within each of the rate cells would approximate the case mix of the population used to calculate rates. Obviously significant discrepancies of enrollee case mix from assumptions would lead to over- or under-payment. States had various ways to track and adjust for these possibilities (e.g., rebasing rates periodically in Minnesota, retrospective adjustments in Wisconsin), but it was beyond the scope of this evaluation to assess their accuracy.

The key policies supporting the plans were disability-adjusted capitations from both Medicare and Medicaid. Medicare's long-standing use of special demonstration rate cells (i.e., 2.39) for beneficiaries meeting NHC criteria was being phased out, and a frailty-adjustment was added to the HCC methodology. All plans had HCC scores much higher than the Medicare average, and the frailty factor was used with all of the dual eligible plans. In all three states, Medicaid paid a capitation that included funds for community waiver benefits, personal care attendant benefits, and some or all risk for custodial nursing facilities. Although it was beyond the scope of this report to assess financial viability of the plans, they all reported that they were viable. The combination of risk-adjusted Medicare and Medicaid payments were covering their high costs.

IV. Contracting for and Managing Community Care

A comprehensive approach to dual eligible SNPs requires that health plans enter the world of policy, programming, and systems for community care services. A long-standing goal of both federal and state policies for these services is to maintain independence in the community for dual eligibles, and in turn to reduce spending on long-term nursing facility care. Most states now pursue these ends through Medicaid waiver programs and/or personal care attendant (PCA) programs. The integrated SNPs were capitated to deliver services covered in both of these programs as part of their comprehensive benefit packages.

This section analyzes how states contract for these services with the integrated plans, and how the plans in turn contract for and manage these services. States' contracts lend to the reproduction of certain waiver and PCA program features within the plans, and these programs' continued existence guides and restrains what the plans can and cannot do regarding service eligibility and how benefits were managed. We first review issues and then illustrate them with examples from the states and plans. The issue of coordinating these services with medical care will be covered in Section V.

A. General Issues in Community Care Contracting

Following long-standing state and federal policies in a wide range of community care programs, all three states and the 11 contractors targeted community care services and care coordination at a minimum to NHC beneficiaries, to beneficiaries who met eligibility criteria for PCA benefits, and to beneficiaries who met targeting criteria for skilled home health. Some contractors were more expansive in making community care available to their enrollees, but they could not be more restrictive.

We will see presently that the criteria for being NHC differed across the three states, as did the assumptions and data behind payment rates (as was described in Section III). Contracts called for plans quickly to identify and serve enrollees who were NHC, and to develop care plans from their wide range of community care services. NHC eligibility was assessed (and periodically reassessed) in the home by plans' care managers. Beyond contract requirements, there was a financial incentive to find, assess, and serve NHC enrollees, since enrollees needed to be assessed in order to bring the higher NHC rates from Medicaid and Medicare. One innovation of the Massachusetts and Minnesota models was that non-NHC members also received an assessment, a care plan, and care coordination, although at a different intensity and variety of community care services than NHC beneficiaries.

The PCA and home health benefits were also paths to receive community care services. The PCA and home health rate components paid by these three states were separate from the community care waiver component paid for NHC-eligible enrollees, as were eligibility criteria, assessments, benefits, and (in some cases) providers. In Medicare, the criteria for eligibility for home health and hospice services, as well as the payment components in the capitation, were also carried over into the demonstration plans. The specific approaches used by contractors to pay for, monitoring delivery of, or to coordinate the delivery of Medicare home health and hospice benefits and Medicaid home health benefits are not addressed in this report.

To deliver the services covered by Medicaid waiver and PCA benefits, health plans contracted with organizations for services not usually covered by managed care organizations. The eleven dual eligible plans had to decide whether to use the existing

waiver program and PCA program networks, and even the terms of existing state contracts, or to develop and manage their own services. The former path had the advantage of using existing infrastructure, but there was the disadvantage of its being difficult to tailor services to the demands of the plans' more closely coordinated systems of care.

Plans also had to establish relationships with local agencies that ran the Medicaid waiver programs for the states. The terms of these relationships were more or less determined by states, but most sites could choose whether or not to purchase case management and/or services through them, and all hoped for referrals from them. The following descriptions illustrate how these issues played out in each state. The arrangements by state are summarized in Figure 3.

B. Minnesota

1. Waiver services

Assessment, eligibility, and care planning. In Minnesota the care coordinator performed the initial and annual in-home assessment to determine NHC status and prepare a care plan. To determine NHC, the coordinator weighed the evidence, and near the end of the assessment form, checked a "yes" or "no" box as to whether "this person require(s) the level of care provided by a facility." A "yes" resulted in a care plan and NHC classification if the member agreed to the plan. A "no" also led to a care plan, but likely with much less contact unless there were medical issues, or the beneficiary might qualify for the PCA benefit (see below). Re-assessments are scheduled as needed. One site reported that few eligible enrollees refused services, but many more refused to be assessed.

State staff pointed out that this assessment sequence reversed what takes place outside MSHO in the fee-for-service world. There the policy was to use state plan services (i.e., PCA) first, and then refer to the waiver program if a person's needs could not be met with a PCA, or if a person was not eligible. Within MSHO, plans seemed to

Figure 3: Community care service contracting & management

	Minnesota MSHO/MDHO	Wisconsin WPP	Massachusetts SCO
HCB waiver services			
Targeting	- NHCs	- NHCs - Beneficiaries who lose NHC status are disenrolled	- NHCs
Care management & service contracting	- 2 plans self-managed - 1 plan contracted with county waiver program - All added some services beyond waiver package	- All plans self-managed - 3 plans produced their own HCB services, e.g., personal care attendants and adult day - All added services beyond waiver package	- 1 plan self-managed - 2 plans contracted with waiver programs - All plans got team social worker through contract with waiver programs

prefer to assess NHC (and waiver service) eligibility first, and then to turn to the PCA benefit for non-NHCs. Perhaps this may be due to the need to assess NHC eligibility anyway for payment purposes, the ability to cover PCAs as well as other services through the waiver, and the need to use outside assessors to determine PCA eligibility.

Community care providers. Plans bought community waiver services for the most part from the same providers as county waiver programs, often using the terms of county contracts, including counties' standard elderly waiver rates. One site said they used the county contract structure rather than the health plan's standard provider contracts because using the health plan's standard 30-page contract with small community providers would not be appropriate. Working through the same providers with standard county waiver contracts made it difficult for plans to get a higher level of performance from these providers than waiver programs received, e.g., no help from the in-home aide in

supporting medical care. To address this problem, one plan developed a special contract for most home care and PCA services, which allowed it to expect assistance from the in-home aide in supporting medical care.

Community care benefits. Plans reported the ability to use money from the pooled capitation to purchase non-traditional services, e.g., grab bars that are installed properly and quickly; a microwave oven for someone who can't cook; pocket amplifiers from Radio Shack for people who were hard of hearing but not qualified for hearing aids; or a bed or mattress for someone with a bad back because of a bad mattress. Minnesota sites occasionally offered extra community care benefits for members who were not NHC.

Relationship with county waiver programs. The sites described different models for handling the financial, contracting, and referral relationships with counties. One site - the county health plan - simply contracted back to the county for all care coordination and purchase of community services. This protected the county from losing business and brought them into the medical care coordination process. The other two sites hired their own care coordinators (or used contracted health systems' care coordinators), and (with the county exception) purchased services directly from vendors. Thus counties were left out, and the potential for loss of participants and revenues existed. Since MSHO grew slowly (after ten years it was serving only about 6,500 of 41,000 dual eligible seniors who were required to enroll in PMAP in 2005), and was limited to 10 Twin Cities area and rural counties, the situation has been manageable. The impact of moving MSHO statewide in 2006 is discussed in Section VI on marketing. In 2005, all of the plans contracted with counties for some aspect of the expansion.

2. PCA benefits

In Minnesota, most utilization of PCA services was through the Medicaid state plan, but some PCA services were provided through waivers. Both funding sources had to be included in MSHO and MNDHO plans, and all PCA services for those eligible for the waiver from both sources were run and managed through the same mechanism that ran the waiver services. To assess beneficiaries for PCA eligibility, the Minnesota health plans had to contract with public health nurses (from the Visiting Nurse Association, the county health department, or independent) who were qualified to administer the required assessment of ADL, behavioral, and cognitive issues, and then the health plans were responsible for the care planning and managing the care. Plans were frustrated with their management of the PCA benefit and services. One issue was control: The outside assessors recommend services to MSHO care coordinators, who could approve or not. Another frustration was allowing family members to be PCAs, which sites said increased costs substantially.

Summary of Minnesota community care contracting. The structures of waiver and PCA programs & criteria were replicated within the prepaid program or at times contracted for outside the program. There was some flexibility in creating new benefits (e.g., a special mattress) from pooled funds as deemed beneficial, but plans mostly bought what was already available through standard contracts and rates. Moving care coordination for waiver services into managed care created competition with counties for beneficiaries and funds, unless the MCO used the county care coordinators.

C. Wisconsin

1. Waiver services

Assessment, eligibility, and care planning. Since being NHC was a requirement for membership in WPP, all beneficiaries went through the same assessment and care planning process. Wisconsin assessors were trained to use the online functional eligibility screen developed by the state, which had an automated scoring system that determined whether a person was in the frail elder or physically disabled target group. Eligibility was based on both ADLs and Instrumental ADLs (IADLs), which were meal preparation, managing medications and treatments, money management, and using the telephone. In addition, "the screen has questions about cognition, behavior, diagnoses, medically-oriented tasks, transportation, and employment; as well as indicators for mental health problems, substance abuse problems, and other conditions that put a person at risk of institutionalization" (http://dhfs.wisconsin.gov). The social worker on the team was responsible for assessing the need for and coordinating the delivery of community care services. Among other things, the assessments focused on the personal care needs of the member, including whether they needed a PCA, meals on wheels, equipment at home, etc. The team reviews care plans at least every six months.

The requirement that all enrollees meet NHC eligibility criteria was reported be a problem when functional status improved. In this case, beneficiaries either had to go back to Medicaid fee-for-service (if they were income-eligible) or to the waiver. But on the waiver there was a waiting list, and they would not qualify anyway since they were not NHC. So if they did not have Medicaid eligibility except through the waiver, they could lose not only their community care services, but also their Medicaid coverage.

Community care providers. One of the WPP sites generally contracted with existing providers to deliver community care services, while the other three often delivered community care services with their own staff, including PCAs, and variously adult day centers, skilled nursing, and rehab. Staff reported that PCAs in these sites could do more medically related services because there was close professional oversight. One site that served both elders and under-65 disabled had 130 PCAs on staff to care for its nearly 700 members, including some who were more highly skilled Certified Nurse Assistants. Another site that served only under-65 disabled had a pool of 700 approved PCAs from which its 300 enrollees could choose. About 25% to 30% of members at one site used its day center, where staff had the opportunity to provide clinical services as well (they had a dental office, a memory loss center, blood pressure check, etc.).

Community care benefits. The pooled revenues from the capitation allowed plans to pay for the extensive team care management described in Section I, as well as a wide range of community care services. Respondents pointed to advantages of their service package as compared to the fee-for-service world, particularly with respect to physical and restorative therapy. One of the sites serving under-65 disabled set up a Resource Allocation Committee to establish guidelines around community services. Its seven members met weekly and vote anonymously to review requests and/or establish guidelines. They had guidelines and data on cost-effectiveness for air conditioners, complimentary therapies (acupuncture and massage), health classes, warm water therapy, dance therapy classes, carpet cleaning, blood pressure cuffs, light therapy, lotions, medication alarms, one-time moving fee, and support shoes for diabetics.

Relationship with existing community care programs. Wisconsin's integrated SNPs had particularly complex relationships with existing community care programs. First, depending on the county, there were one or two such programs in WI: the Community Options Program (the community care waiver program), which is run by county human services departments, and the Family Care program, which is accessed through county Resource Centers and managed by capitated, county-run Care Management Organizations. In some counties, PACE was also an option. Fully eligible Medicaid beneficiaries had a choice to enroll in WPP or the other options, and WPP programs worked with these other local organizations to seek referrals of eligibles. Each program has a different type and level of care management, a different benefit package, and a different approach to including family members as caregivers. The county Medicaid office certifies Medicaid eligibility, which is a prerequisite for enrollment in a dual eligible program. WPP programs reported that they tried to maintain good relationships with county offices to minimize the degree to which WPP members rolled on and off Medicaid.

2. PCA benefits

The WPP sites did not report frustration managing the PCA care as a separate benefit, as was found in Minnesota and Massachusetts. This may reflect the fact that they did not need to use outside staff to conduct assessments and care planning, and to the fact that WPP sites did not need to provide PCA services to enrollees who were not NHC.

3. Summary of Wisconsin community care contracting

Since Wisconsin Partnership sites only enrolled NHC beneficiaries, they did not have the issue of assessing and care planning for non-NHC beneficiaries, including the

issue of managing a separate PCA benefit with separate eligibility. Personal care benefit funds were included in the WPP capitation, but the funds to support the service were pooled and managed with other long-term care benefit funds rather than managed separately. The team care management approach, as well as the capability of team members to deliver services directly, provided the team with greater control over community care service delivery than the MSHO model. Moreover, the three sites that directly employed, trained, and managed their own PCAs had even more capability to enlist community care in the broader clinical enterprise. Competition with county community care programs for beneficiaries and funds was reported, but it did not appear to be as intense as in Minnesota. Perhaps this is because there was no immediate prospect of mass conversions of beneficiaries to WPP, either in the counties currently served or in new counties.

C. Massachusetts

1. Waiver services

Assessment, eligibility, and care planning. The initial assessment process included (1) triage to see if the new member might be NHC, (2) completion of the Minimum Data Set/Home Care (MDS/HC) by the team's nurse, and (3) entry of the data (to date by hand) into the state's secure internal web site. Then there were re-certifications every six months for some categories. The state SCO contract described NHC eligibility as follows: "If an Enrollee is a community resident, is limited in two or more activities of daily living (ADLs), and has a skilled nursing need three or more times per week, as recorded through the MDS/HC form and approved by DMA, the Enrollee will be classified NHC."

Once the assessment was completed, two of the sites obtained leadership in developing and implementing the plan for community care services from the Geriatric Social Services Coordinator (GSSC). The GSSC worked for Aging Services Access Points (ASAPs), which are the state-chartered non-profit Area Agency on Aging that managed the state home care program and the Medicaid waiver program. The SCO contract requires that sites contract with ASAPs for the services of the GSSC, since they were familiar with the community provider system. The third site to date based its teams in community health centers, many of which already had home visiting nurses, who assumed that role in the SCO team. The GSSC still functioned as an expert in the local service system, but s/he was less involved with home visiting if the health center had this experience.

Community care providers. The SCO sites differed in the extent to which they used the ASAPs to access community care. Two sites relied heavily on ASAPs to arrange and provide community care. They paid the ASAP the cost of services plus an administrative fee. The third site, in contrast, contracted directly with in-home and community-based providers.

Community care benefits. SCOs were responsible for all waiver-covered and PCA benefits, plus regular Medicaid benefits.

Relationship with ASAPs. All sites described close and mutually beneficial relationships with ASAPs. Besides the contributions of GSSCs, ASAPs also had other sources of revenue for community care services, which were available to SCO members. SCO staff believed that they also helped bring ASAPs "to the table" with the medical community, which is something ASAPs did not normally have as a social model. The

two sites that contracted with ASAPs for community care contended that SCOs were a new source of revenue rather than competition to ASAPs, since the new people that the SCO found were new revenue to the ASAP through the SCO contract. No revenue was lost, and a waiver slot opened up.

2. PCA benefit

Two of the three sites mentioned challenges related to differences in philosophy, practices, and policies between the PCA program and aging network programs operated by ASAPs. The PCA providers were reported to be less prepared to work with the medical care system, to often use family members as paid providers, and to have less awareness of some aging services, e.g., adult day care. Also, unlike relationships with ASAPs, which were stipulated by the SCO contract, the SCOs' were still in the process of developing contracts with local PCA program managers and providers. Although SCOs performed assessments and authorized hours for PCA services, they then had to work with the Personal Care Management Agencies (which found and trained PCAs), and Fiscal Intermediaries (which paid PCAs), and enrollees themselves (who hired and fired PCAs). Finally, Massachusetts plans also reported occasional frustration with finding out only after enrollment that beneficiaries were receiving PCA benefits, and then having to straighten out payment arrangements and hours of care.

3. Summary of Massachusetts community care contracting

The SCO sites had been operating for barely a year at the time of the site visits, and the ways they contracted for and managed community care services was still evolving. The arrangements differed by plan and by geography (i.e., by ASAP and by enrollment level), but some things were common. The connections and expertise of

ASAPs in organizing community care was brought to the SCOs in the person of the GSSC, and the SCO teams were taking advantage of this in care planning and implementation. The GSSCs were planning care in a context that was much stronger in medical information and leverage than the standard ASAP care coordinator. Two of the sites bought what might be called the "full package" of community care services and coordination from the ASAP (similar to MHP in MN), while the third took only the minimum (the GSSC). Two sites expanded the role of the GSSC into a broader population than NHC beneficiaries. This was not so unusual in Massachusetts, since the other part of the state home care program that the ASAPs managed (actually the larger part) was targeted at elders who did not need to meet NHC eligibility criteria. Management of the Medicaid PCA benefit echoed MN in the types of problems identified.

D. Discussion

The structures of the two state community care services programs (community care waivers and PCA) were in many respects transported into all of these comprehensive dual eligible plans, but management of the former appeared to be smoother than the latter. All plans followed state community care waiver policies of targeting waiver-covered services to beneficiaries who were NHC, and some expanded eligibility and services beyond what community care waiver programs covered. In Wisconsin beneficiaries needed to leave the program if they lost NHC eligibility.

Two models for managing and contracting for community care waiver services were used: in-house/self-management, and sub-contracted management (to the waiver program). Minnesota and Massachusetts plans split on choosing these models, while the

Wisconsin sites all managed and contracted in-house for community care services. Another difference was that only the Wisconsin sites chose to employ, train, and manage their own PCAs.

Finally, the Medicaid PCA benefit was perplexing to manage for all plans except those in Wisconsin. Although Minnesota plans in some cases exercised their option of performing the required PCA assessment and care planning themselves, others chose to contract with county health department nurses, leading to some loss of control. Plans in both Massachusetts and Minnesota reported that PCAs who were family members presented different management challenges.

V. Delivery of integrated acute and long-term care

The analysis in Section IV traced how the integrated SNPs managed and delivered Medicaid waiver and PCA services. This section reviews how the plans integrated those services with medical care. The central objective of this comprehensive SNP model is that integration will enhance the efficacy, quality, and efficiency of care in both sectors, i.e., that having links with community care and care management will enhance medical care, and that having links with medical care will enhance community care.

The plans' common approach was to create a care coordination mechanism that was available to all members at all times, and that sought to involve all care sectors in creating and implementing a common care plan. This type of care coordination function is not a service or benefit that is covered by either Medicare or Medicaid, but it could be financed from the pooled capitation available to these programs.

The “glue” or the driver for care coordination ranged from an individual (the MSHO care coordinator), to a small team (SCO), to a multi-disciplinary team (WPP).

Physicians seldom attended team meetings in any of the states, but all models used flexible ways to try to involve physicians when they needed their input or cooperation. The coordinators' key resources were a commitment to coordination, their presence in the home and the knowledge of the member they gained there, and the resulting capacity to foster compliance. The plans sometimes used community care coordinators to extend what traditional health plans did in a wide range of interventions for prevention, quality improvement, end-of-life care, medication management, and more. The plans also trained actual and virtual members of the care coordination enterprise, and they monitored performance and try to improve it. A few examples from the programs illustrate their capabilities in these areas.

A. Minnesota

1. MSHO plans (for elders)

The care coordinator. Care coordinators were either nurses or social workers, and they were the key community-based contact with members. Some care coordinators worked for health plans (the three MSHO contractors), and some worked for the care systems with which the plans contracted for services. The only required care coordination contacts in the MSHO contract were the initial and annual assessments, which were administered to all community members; but care coordinators did much more, including preparing community care plans and authorizing all community care services (as discussed in Section IV), and coordinating with medical care (as discussed here). The theme that stood out in talking to site staff about coordination with medical care was flexibility, i.e., being ready to look for and use what worked, according to the terms on which the medical care system was ready to work collaborate. Our findings are

also consistent with a detailed field comparison of MSHO, waiver, and HMO coordination (Malone, Morishita et al. 2004).

Care coordinators and physicians. According to one of the plans, the medical care/care coordinator connection was made "any way that works." Every clinic was different. In some practices, the medical director would even make a home visit. In others the nurse practitioner was a consultant and home visit resource. Factors that tended to foster collaboration included:

- a "physician champion" based in a clinic
- many MSHO patients in a clinic
- access to the medical record
- basing the MSHO coordinator in a clinic

When physicians were not available, coordinators tried to work through a nurse, or to coordinate around a discharge, or to follow a regimen of care. At one of the plans, the care management and clinical coordination staff had monthly meetings with physicians, but with others, they faxed the care plan and problem list. When a new clinic came on, the care management supervisor went out with the care coordinator and asked how they wanted to work. The care management supervisor at one plan organized rounding (topics included ethics, prescribing, assessment forms) and regular care coordinator training (topics included how to talk to the physician, multicultural issues).

Cross-plan collaboration. The lynchpin of the MSHO care coordination model has been collaboration among the three contractors to develop a set of shared features for care coordination, including the assessment process, training, and care planning. This

way medical care providers who were serving patients through more than one MSHO contractor, or care coordinators who worked for more than one MSHO, all saw the same requirements and expectations for what care coordinators did.

Quality improvement programs. Cross-site collaboration was evident in the three sites' development, implementation, and evaluation of a common set of Performance Improvement Projects (PIPs), which were initiated under CMS's annual Quality Improvement System for Managed Care (QISMC). The PIPs covered heart failure, diabetes, medication management, and hospice and palliative care. In all these initiatives, the model was to train care coordinators about patient issues in the area, to give them information about the problems and care status of the patients in their caseload, and to give them the responsibility to help their patients get the care/tests that were recommended.

The issues that arose in these initiatives illustrate the promise and the limits of how care coordinators could take on a role in support of medical care. One issue was training - how expert could the care coordinator be expected to be in a clinical area? For example, in the diabetes initiative, coordinators needed some clinical information, but they could never be expected to be as expert as a diabetes nurse manager. Another issue was time. Care coordinators were in a position to be helpful to the clinical enterprise, but they had their own job to do, so they couldn't be asked to take on something that was too time-consuming.

The Optimal Medication Management (OMM) PIP illustrated both of these points. For the initial and annual in-home assessments, care coordinators were given lists of all prescribed medications on the member's health record and asked to check it against

what the member was actually taking, including over-the-counters, vitamins, supplements, and herbals. Discrepancies from the record (including non-compliance and additions) were noted on the list, and the corrected list was sent to a consulting pharmacist, who prepared a report on potential problems. The protocol called for the care coordinator to accompany the patient with the lists to his/her next PCP visit and to discuss what to do.

The three sites pooled their OMM data through the Quality Improvement Organization. The results in 2004 for 532 members reviewed were: (1) members took an average of 7.8 medications; (2) 38% had at least one medication issue; (3) issues were identified for 503 medications (12%); 530 interventions/changes were recommended, but only 53 (10%) were resolved; (5) 22 resolutions (42%) were to stop or change therapy (MSHO QAPI News 3/05). In terms of process, sites said that a benefit was that OMM "was a chance to get the coordinator clinically focused, not just coordination focused." OMM also brought real information to the medical system. One medical director reported: 'A physician can have a great plan in the office and even (if lucky) get the patient to understand it. But carrying out the plan is another thing. The care coordinator listens, facilitates, identifies barriers and tries to overcome them.' However, care coordinators were put in the middle as the bearer of critical news that they had not created (the pharmacist's report). Also, the brown bags and follow up took a great deal of the care coordinators' time. The sites were looking into whether OMM could be better targeted.

Based on OMM and the other PIPs, the MSHO sites looked at other supports to care coordinators and what they became involved in, e.g., prevention activities such as

supporting eye exams, dental appointments, and flu shots. MSHO care coordinators were found to be more effective than waiver case managers in helping both NHC and non-NHC members connect with the medical care system (Malone et al 2004). But they did this largely by their own presence and by bringing in medical system resources. They did not make special use of contracted paraprofessional workers to support medical care plans in the home.

2. MnDHO plan (for under-65 disabled)

The MnDHO care management organization (AXIS) was much more aggressive and systematic than the MSHO plans in coordinating community care services with medical care. AXIS reported that its major responsibility under the sub-contract with the UCare HMO was to identify and work with providers who embraced the mission of keeping severely disabled individuals as healthy and independent as possible. If contracts with these providers were not already in place with UCare, the plan added them. The most common conditions of beneficiaries served by AXIS included spinal chord injury, multiple sclerosis, and cerebral palsy. In contrast to the single care coordinator in MSHO, the MnDHO care team consisted of a nurse, a social worker, and a member services rep. There were 70 patients to a team, and the team could authorize specific services (including transportation) and make appointments for care. AXIS also handled member services, which meant that members called AXIS not UCare when they had a problem. The calls rolled to the care team.

In June 2005, AXIS worked with only 20 to 30 physicians in a handful of clinics to serve its 265 members. One-third of the members were in two clinics, and many were in community health centers. More members in a clinic meant greater visibility and the

opportunity to create a critical mass behind things like exam rooms that work, longer appointments, and mechanisms for fast response working with the care coordinator.

Many of UCare's AXIS enrollees were subject to urinary tract infections and pressure ulcers. To avoid costly hospitalizations, AXIS developed a quality improvement program to reduce urinary tract infections, including standards for care, help for members to identify the signs of infections, standing orders from PCPs and guidelines for nurses to assess and start to treat. They contracted with a lab that would not discard the samples (which labs routinely did when they saw the contamination from the catheter). The contract made a stat analysis standard, and it included that they faxed the results to the right place. They were thinking about giving stipends to members to train other members in groups.

B. Wisconsin

In contrast to Minnesota, the WPP plans serving elders and the under-65 disabled were not structured differently in terms of teams or their work with physicians. Differences were pronounced, however, in terms of member characteristics, as described at the end of this section.

The team. All members of the large, multi-disciplinary WPP teams worked out of the same office and generally met weekly to review their panel of patients. Each site had processes to keep teams running well and to monitor and improve performance. For example, one site had a team leader (the "go to" person on the team) and a practice leader (responsible for assessing and resolving problems related to team dynamics). Each team at another site had a designated "facilitator," a person responsible for running all care team meetings, ensuring that protocols were followed, reviewing utilization, and pulling

together a care plan. All sites also monitored team performance through review of various metrics across teams, e.g., hospital and drug utilization patterns, hospital admissions, satisfaction surveys, cost information, falls, ER use, nursing home admissions, disenrollment, and appeals. These metrics were used to flag problem teams or staff within a team.

Working with physicians. At all WPP sites, new members typically kept their own physician when they joined, which meant that teams had to establish relationships with them. Compared to MSHO and SCO, the connection of WPP care coordination to primary care physicians (PCPs) was more structured and more intensive. At all WPP sites, the team's nurse practitioner established a direct relationship with each PCP serving the team's members. One site worked with 130 PCPs for its 700 members, another worked with 100 for its 300 members, and another worked with 30 PCPs for its 900 members. At two sites, the nurse practitioner attended every medical visit with the beneficiary (primary care and specialty care visits), while at the third, the nurse practitioner sent notes, made a phone call, or went on the visit, depending on the complexity of the visit. To make the link stronger, sites tried to limit the number of PCPs a nurse practitioner worked with. Another strategy that made collaboration easier for physicians was to have nurse practitioners be PCP-based rather than team-based.

Medications. The power of WPP teams in clinical coordination was evident in medication management. All sites reported that they actively managed medications for all of their members, since all members were NHC, and across sites the average number of medications was 10 to 15 a month. One site reported that after consulting with the PCP, the nurse practitioner wrote almost all medication orders. Two sites packaged and

delivered all medications to their members at home, according to knowledge of the patient's capabilities and living situation. Two sites also used their own PCAs to monitor medications.

Under-65 disabled plans. The enrollees in the under-65 disabled plans in Wisconsin were similar to elders in their multiple and complex medical conditions, but they brought additional needs in the areas of behavioral health, obesity, and concomitants of severe physical disability (e.g., need for wound care). For example, two of the eleven teams at one site specialized in enrollees who had behaviors that might alienate providers, e.g., psychiatric problems (histrionic), drug abuse (in methadone clinic), social chaos (facing eviction), and complex medical issues. These teams had smaller caseloads (25 to 30).

C. Massachusetts

The team. The state contract with SCOs stipulated that clinical care coordination was the responsibility of a "Primary Care Team, consisting of a PCP working in conjunction with a Geriatric Support Services Coordinator, a nurse practitioner, a registered nurse, or physician's assistant, all of whom must have experience in geriatric practice." Sites described the team as being run primarily by the nurse, with the GSSC social worker responsible for community care service plans (as discussed in Section IV). Sites included nurse practitioners for members with more complex medical care issues, particularly nursing home residents. Physicians were brought into the care planning process as needed and available. The SCOs were each obligated to develop and use an electronic Centralized Enrollee Record system that is available at all times, and through which clinicians and care managers could access information about client demographics,

health conditions, and care plans, but not the medical record. Each site developed its own approach to the CER.

Beyond this core, the sites had different approaches to the team. The Commonwealth Care Alliance (CCA) site stationed the nurse leader of the team in participating medical offices and also developed orientation, training, and monitoring activities to bring PCPs and medical offices into an active collaboration with the SCO's clinical leadership. Up to the point of the site visits, CCA had chosen primary care sites with large numbers of dual eligibles, and which had physicians who were willing to work with the team. Of its first seven primary care sites, three had PACE sites and several others were community health centers. Both of these settings were accustomed to teamwork and already employed RN/nurse practitioner team leaders, whom CCA allowed to act as the SCO team member in this capacity. At the one primary care site that did not have a nurse practitioner/RN, CCA was employing and supplying this member of the team to the site. Beyond the placement of the nurse care coordinator at the primary care site, CCA also expected primary care site staff to participate in training about expectations for staff and physicians, in an interdisciplinary assessment committee, in a consumer advisory committee, and in reviews of statistics and comparisons of practice at each site. The GSSC on the CCA team was the leader in knowing about and arranging for community care services.

In contrast, the Senior Whole Health (SWH) site relied more on the Centralized Electronic Record to create something of a virtual team. SWH had broader strategies for signing up physician groups, and this site subsequently did not put as many expectations on physicians' participation. While SWH looked for medical groups with large numbers

of dual-eligible beneficiaries, they also were setting up a network that covered the whole area within the outer beltway around the Boston metro area. Physicians were expected to participate in assessments and care planning, and those with decent size panels had a care management meeting every other week. A specific nurse case manager was assigned to each physician, so there was a continued relationship. The care manager, emergency department staff, the PCP, and others could get into the electronic record to see what was going on with the care plan and the referrals. SWH also worked on making its teams community-based, particularly through the person of a community resources coordinator on the team, who knew the community, spoke the language of non-English speaking enrollees, received the 1-800 call after hours, and also handled member relations. The biggest panel for a single physician was 100 members. This site's teams handled 65-75 members.

The Evercare SCO (ESCO) plan lay somewhere between these models. It based its nurse leaders in medical groups when there were large numbers of enrollees in the office, but it did not contract with groups to use their existing care coordinators as team members. Rather, the RN/nurse practitioner members of the team were always ESCO employees. Different team members played more-or-less prominent roles in care planning and coordination with the medical system, depending on the determined risk level of the enrollee, as determined by a telephone screen: (1) telephone care managers led the team for the community well, (2) nurses led for the community at risk, (3) the GSSW led for the clinically complex, i.e., those who were NHC, and (4) the nurse practitioner led for nursing home residents. A team meeting that included the physician, the nurse, and the GSSC was required (within 90 days of enrollment) only for the

clinically complex. Care teams were assigned to a geographic area, and nurses lived in the geographic areas they served. ESCO reported that community health centers were generally very open to the SCO model. At one community health center, ESCO had 500 members; and ESCO had assigned a bi-lingual nurse and a bi-lingual telephone case manager to this center.

Approaches to clinical care. In the area of clinical care planning and management, SWH and ESCO again contrasted to CCA. Both SWH and ESCO relied heavily on care planning guidelines within the Centralized Enrollee Record system to suggest care plan elements in both medical and community care. The SWH care plans were driven by a pre-set menu in the system tied to members' specific conditions, and the ESCO plans and team leaders were tied to classification of members into one of the four risk levels discussed above. In both of these SCOs, physicians were asked to contribute to the development of plans, and their input was explicitly sought when needed, especially for more high-risk patients.

CCA's approach to clinical care was more individualized, without a distinction between NHC and non-NHC members, and without standard care plans triggered by assessment data. However, there was an extensive quality improvement effort that included structure, process and outcomes components. The structural features were best practice and standardization for physicians and case managers. Outcomes were tracked for some diagnoses. The process monitoring compared sites on utilization measures using bar graph on average and by site. CCA clinical leaders took data to the sites and asked clinicians to be ready to talk about the comparisons. CCA leaders acknowledged the challenges of expanding this model to different types of practices.

D. Summary of acute care connections

Three models for connecting community care with acute care were demonstrated: the single coordinator, the nurse/social worker team, and the multi-disciplinary team that included a nurse practitioner. There was variation in how closely managers and clinicians in each of these models were actually connected to physicians, and in how closely they could use community care staff to support medical care plans, e.g., monitoring medication problems and compliance. The Wisconsin teams' use of nurse practitioners to accompany patients on physician visits was the only way to consistently and closely connect community care and medical care, but it was required intensive staffing.

All sites and states cited special efforts to help teams function and to spur coordination. These included joint training and quality initiatives in Minnesota, work on teamwork in Wisconsin, standardized risk screening and care plans in two Massachusetts plans, and clinical leadership from the medical director in the third Massachusetts plan. All three plans serving under-65 disabled beneficiaries had extensive teamwork and pro-active efforts to ensure that key sectors of the medical care system were working closely with the team. Figure 4 summarizes the ways sites coordinated acute and long-term care.

VI. Marketing and enrollment

The integrated SNPs illustrate a range of approaches to finding and enrolling new members. The first section reviews some common issues that were identified, as well as approaches to addressing them. After that, we provide state and site examples.

A. Common marketing issues and approaches

The product and the market: The integrated SNPs needed to convince beneficiaries that what they offered was better than other combinations of health care and long-term care alternatives. The plans were essentially been selling programs that featured a full range of acute and long-term care benefits, better care coordination, the ability (usually) to keep your own doctor, and expansive formularies of prescription drugs without copays. With this broad benefit package under a single evidence of coverage, they had two kinds of competition that beneficiaries could choose from: conventional medical care systems (Medicare fee-for-service or managed care, Medicaid fee-for-service or managed care), and alternative community care systems (Medicaid waiver or personal care programs).

Figure 4. Integration of acute care and community care

	Minnesota MSHO/MDHO	**Wisconsin WPP**	**Massachusetts SCO**
65 & over plans			
Care management links to physicians	- Nurse or social worker care coordinators work for the HMO or the contracted acute care system. - Links with physicians vary by clinic, health system, and plan based on "what works"	- Multidisciplinary team works for plan. - Team nurse practitioners go to physician visits with patients - Teams pro-actively manage medications. - Two sites package and deliver all medications.	- Nurse and contracted social worker teams. - Links with physicians vary by plan, practice, and level of enrollee need. - Nurse stationed in medical offices that serve many enrollees (2 plans). - Electronic centralized enrollee record.
Special features	- Cross-plan collaboration in training, reporting, and quality initiatives for coordinators.	- Attention to team process and leadership.	- Standardized risk screening and care recommendations (2 plans) - Clinical leadership from medical director in coordination and practice improvement (1 plan).
Under-65 disabled plans			
Care management links to physicians	- Nurse, social worker, member rep teams work for sub-contracted management	- Same as elder care plans	(Not applicable)

Reaching beneficiaries - outreach and referrals: The plans attempted to identify and communicate with dually eligible beneficiaries directly, and they also cultivated referrals from state community care agencies, medical offices, and word of mouth among enrollees, families, and staff.

As in most states, the three states' waiver programs were managed either by local government (counties in MN and WI) or by Area Agencies on Aging (in MA). Few of the plans reported that such programs were a major source of good referrals, and this was not surprising to most informants. In part this may be due to turf issues regarding beneficiaries and funds. As seen in Section III, when a dual eligible who was NHC joined a dual demonstration plan, part of the capitation from the state included funds to cover the services and care management that normally would have flowed to the local waiver program. It was policy in all three states that waiver program did not lose a waiver slot automatically when a beneficiary chose one of the integrated SNPs. The hitch was that there may or may not have been an eligible person on the waiver program's waiting list. If the program could not fill the slot, they lost revenue immediately, and they might lose the waiver slot in the future. Minnesota had a policy that there were no waiting lists for waiver services - either in the county system, or when beneficiaries received their waiver services through MSHO.

All plans saw primary care providers as important sources for referrals for new members. The typical approach was to try to identify medical groups that were believed to have significant numbers of dual-eligible beneficiaries in their panels, to try to sell the groups on the advantages of the supports that the integrated SNP could offer them, and then to ask the group to reach out to patients on their behalf. The most successful

outreach appeared to be to community health centers and to practices serving ethnic minorities and immigrants.

The final way that plans found new members was even more micro: word of mouth among patients, their families, friends, and staff from plans. Word of mouth was particularly cited at the under-65 disability sites. The other micro source was referrals from other parts of the system, e.g., discharge planners, home health agencies, senior centers, and advocacy groups.

Enrollment and assessment: Once beneficiaries applied for enrollment, plans said they moved quickly to identify and assess NHC eligibles so that beneficiaries would receive service entitlements, and the plan would receive payment at the appropriate reimbursement cells. The Medicare NHC rate cell was being phased out, but the higher Medicaid cell for NHC beneficiaries appeared likely to continue. All sites reported that initial and follow-up assessments took substantial time and staff. Some plans said that this could be a bottleneck for enrollment growth.

Selectivity: The individualized nature of the marketing and enrollment process for these plans opened up opportunities for selectivity in enrollment. We saw the potential in all states, particularly regarding enrollment of beneficiaries receiving high levels of Medicaid PCA services prior to joining. Some plans said that they talked to applicants about their policies regarding PCAs before enrollment was formalized, and that beneficiaries who did not want to see their hours reduced were encouraged to withdraw their applications. There was no discussion of this happening in relation to waiver services, but it was certainly possible that the same dynamic could occur. If so, there was potential for favorable selection in terms of severity of disability (or weakness

of informal supports) and concomitant lower service needs in both medical and community care. Sites were more likely to argue that they experienced negative selectivity, primarily because providers and waiver programs referred their most difficult cases, and because many individuals joined a managed care program with strong care management only after they could no longer manage on their own.

B. Minnesota

State as third party administrator. Unique among the three states participating in the demonstration, the MN Department of Human Services acted as the third party administrator for Medicare and Medicaid marketing and enrollment. This includes enrollment processing/reconciliation for both Medicare and Medicaid to insure match through an interface with CMS systems. The state also reviews and approves marketing/member materials in collaboration with the CMS Regional Office.

Internal HMO markets. Minnesota differed from the other two states in that it mandated managed care for about 80% of Medicaid beneficiaries. The mandate to choose from one of nine Prepaid Medical Assistance Plans (PMAP) applied to aged dual-eligible beneficiaries but not under-65 disabled. Three of the PMAP plans also offered MSHO to dual-eligible beneficiaries, while others did not. Throughout the demonstration, the PMAP plans competed against each other for members, but the MSHO plans marketed only to their own PMAP members, i.e., they did not market MSHO to other plans' dual-eligible beneficiaries after they had made a PMAP decision. Having the dual-eligible beneficiaries already in the health plan made the identification of MSHO eligibles very easy, but the plans generally marketed only to dual-eligible

beneficiaries who were associated with providers in their networks who were willing to work with the MSHO care model. Thus providers were an important source of referrals.

Waiver program relationships. The relationships with the county waiver programs in Minnesota were radically altered in 2005, when planning started for the statewide expansion of MSHO in 2006. PMAP plans were already statewide, and MSHO plans were allowed to go where the plan sponsor already had a PMAP. The PMAP plans around the state applied to be MSHO sites, as did several "county-based purchasing plans" through which counties banded together to offer PMAP in areas where HMOs were not allowed to operate. (These were rural areas where CMS did not require choice.) Because the county-based purchasing plans, PMAPs, and MSHOs were Medicaid managed care organizations, they exercised their new option to passively enroll their non-MSHO dual eligible beneficiaries into their MSHOs (which had become dual eligible SNPs in 2005). The effect of all this was that counties could lose most or even all of their waiver participants to new MSHOs when beneficiaries were passively enrolled into the various MSHO plans. It was anticipated that the situations would differ by county, since some of the MSHOs would follow the Metropolitan Health Plan model and subcontract with counties for care coordination and services. Others were expected to use this as an interim measure, since there were substantial start-up issues, perhaps most importantly the need to hire care coordinators. Also, all sites cited the political issues of not wanting to alienate counties.

Relationships with assisted living. The relationships of MSHO and assisted living and foster care illustrated another internal care coordination issue that spilled over into long-term care system finances and marketing. The MSHO care coordinator could

choose to not authorize the whole package of community care services covered by the waiver that assisted living typically delivered. In these cases, the assisted living facility would not get the whole rate that it was used to receiving through the county waiver programs. Given this, two sites reported that not all assisted living facilities were keen to have their residents marketed to and enrolled in MSHO.

MnDHO marketing. Since Medicaid beneficiaries with disabilities were exempt from Minnesota's managed care mandate, the MnDHO contractor had to find eligible beneficiaries within the UCare provider network. Their approach has been to first find physicians and practices that were willing to work within their care model, and then to convince beneficiaries to use these physicians because they would receive better care. The ideal setup was a physician champion, plus 2 or 3 other physicians - 15 per provider and 50 per site. The number one reason beneficiaries do not want to join was having to leave their primary care physician (or their specialists, since many do not have a primary care physician).

C. Wisconsin and Massachusetts

Wisconsin and Massachusetts contrasted to Minnesota in that there was no policy requirement for Medicaid beneficiaries to join managed care. Thus these sites did not have an internal market of dual eligibles familiar with managed care to enroll into their Medicare plans.

Waiver program relationships. Plans in both states had arrangements with local waiver programs to get referrals, but plans seldom found this source sufficient. This was the case even at the two Massachusetts plans that contracted back to the waiver programs

on a cost-plus basis for care management and service arrangement. Generally plans saw the waiver programs as competitors.

Physicians. All plans in these two states tried to build their enrollment by identifying physicians and medical groups with large Medicaid panels who would be willing to work with care teams. Two of the Massachusetts plans were actively seeking relationships with community health centers, which qualified on both counts.

Ethnic outreach. All Massachusetts plans also were actively recruiting in ethnic and immigrant minority communities, which they said were underserved by the home care system.

Under-65 disabled plans. Wisconsin Partnership plans also relied heavily on word of mouth, particularly at the sites serving under-65 disabled beneficiaries, where personal and advocacy networks could be tapped. Additionally, one WPP site had something analogous to the internal HMO market, since it operated a PCA and a community care waiver program alongside WPP. New applicants had choices: The WPP had the most intensive management; there was a wait list for the waiver program; and the PCA program allowed enrollees to hire and mange their own aides.

D. Marketing Conclusions

Medicaid community care waiver programs were cultivated as a source of referrals, but few integrated SNP plans relied on this source for many members. Wisconsin sites were largely reliant on referrals and word of mouth from providers, families, and members themselves. Massachusetts sites welcomed referrals but they relied more on signing up medical groups serving large numbers of dual eligibles in which physicians were willing to work with the plan's care managers. Minnesota sites all

also looked for referrals and for medical group links, but they had the added advantage of internal Medicaid HMO markets. They took the one-time option to passively enroll dual eligibles into their new SNPs in 2006. Sites in all states reported that high users of PCA benefits might be discouraged from joining a dual eligible plan. Sites in Massachusetts and Wisconsin reported that enrollment could be slowed by the need to assess and plan care for new enrollees who were NHC. See Figure 5 for a summary of marketing approaches and issues.

Figure 5. Marketing

	Minnesota MSHO/MDHO	Wisconsin WPP	Massachusetts SCO
The product	- Comprehensive acute and long-term care benefits - Better care coordination - Keep your own doctor (except MnDHO) - Prescriptions without copays	- Same	- Same
Primary sources of members	- Internal HMO market - Word of mouth and sign up medical groups serving the disabled (MnDHO)	- Professional referrals and word of mouth - Internal HCB programs market (one site)	- Sign up medical groups with many duals, e.g., community health centers.
Secondary sources	- Waiver programs - Outreach to immigrants	- Waiver programs - Sign up medical groups with many duals.	- Waiver programs - Outreach to immigrants
Special features	- Passive enrollment from Medicaid HMOs into SNPs (2006 only)		
Special issues	- Assessments can slow enrollment - Selectivity on PCA users	- Same	- Same

V. Discussion and Recommendations

This brief overview of the operations of the integrated SNPs in three states illustrates the complexity of developing and operating them, as well as the challenges of paying and regulating them. Only a handful of states and health plans developed

integrated SNPs under Medicare and Medicaid demonstration waivers, and it will take time for such comprehensive plans to emerge under new SNP authority.

Health plan sponsors face the challenges of reaching and enrolling beneficiaries with high rates of chronic illnesses and disabilities, contracting for and taking risk for the full range of acute and long-term care services, and integrating the delivery of acute care and community care. How new and difficult each of these challenges will be will differ by whether sponsors come from the medical care or community care sector. Among the plans in the three states, there were a variety of specific innovations in the delivery and management of integrated care, including:

- Personal Care Attendant Pool (WPP)
- Collaboration among plans on care coordination training, practices, and reporting (MSHO)
- Web-based Centralized Enrollee Record (SCO)
- Community care coordinators "at the table" with medical care (all)
- "Formula" for integrating delivery: "physician champion," critical mass of patients in a clinic, access to the medical record, clinic-based care coordinator (MSHO, MnDHO, SCO)
- Resource allocation committee to make policy on benefit expansions (WPP)
- Individualized dosing, re-packaging, home delivery, and support for prescriptions (WPP)
- Bi-lingual Community resources coordinator on the team as first line for after hours calls, as well as member relations and marketing (SCO).

So far, states have taken the lead in formulating the specific models for these comprehensive prototypes. They have specified benefits, targeting, care management

models, payment approaches, and relationships with the aging network; and they have limited plans by number and geography. Since states still control Medicaid programs, states will continue to dictate key terms, including whether the Medicaid side of the comprehensive model will be available at all.

Finally, HCFA and CMS have worked for years with states, health plans, and providers to shape these comprehensive, integrated models of care. Foremost has been support for special reimbursement formulas for both Medicare and Medicaid. With the February 2007 CMS announcement frailty-adjusted Medicare payment will be phased out between 2008 and 2010, the plans will have some time to absorb a payment change, and CMS will have more time to consider whether other payment alternatives are available and appropriate. Beyond making a decision about payment policy, CMS will need to work out how to encourage dual eligible SNPs and Medicaid programs to work together to offer comprehensive, integrated benefits. Since states will likely need to be in the lead in including the Medicaid side, it may be that comprehensiveness and integration will remain optional features for dual-eligible SNPs for some time.

Glossary

AAPCC - Adjusted average per capita costs
ASAP - Aging Services Access Points
CMS - Centers for Medicare and Medicaid Services
GSSC - Geriatric Support Services Coordinator
HCC - Hierarchical Condition Categories
MA - Medicare Advantage
MMA - Medicare Modernization Act of 2003
MSHO - Minnesota Senior Health Options
MnDHO - Minnesota Disability Health Options
NHC - Nursing home certifiable
PACE - Program for All-inclusive Care for the Elderly
PIP - Performance Improvement Plan
PCA - Personal Care Attendant
PCP - primary care physician
PMAP - Prepaid Medical Assistance Plan
PMPM - per member per month
RN - registered nurse
SCO - Senior Care Options
SNP - Special Needs Plan
WPP - Wisconsin Partnership Program

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