UnitedHealthcare Senior Care Options

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> LTSS integration is the integration of medical, behavioral health and LTSS benefits in a single capitated program. This case study is part of a larger research project that hypothesizes that LTSS integration has the potential to improve outcomes and lower overall costs of care for people with substantial functional limitations and complex care needs. This body of research is intended to inform business decisions by health plans and other at-risk organizations considering LTSS integration, and to contribute to policy discussions on financing LTSS.
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> Ten programs that are experienced and successful in integrating medical care and LTSS were selected for this study. The programs vary in structure, population served, and geography in order to reflect the diversity of successful approaches to LTSS integration. Each case report provides an in-depth description of program characteristics and operations, as well as a discussion of key integration strategies and outcomes.

Background Information

The Senior Care Options (SCO) program is a program in Massachusetts that integrates Medicare and Medicaid benefits for the elderly dual eligible population in the state. SCO is a comprehensive program that covers all Medicaid and Medicare-covered benefits, including medical, behavioral, and LTSS. Those age 65 and older who are eligible for Medicaid may enroll in the program. Enrollment is voluntary, but individuals must choose to receive both Medicare and Medicaid coverage from the same SCO plan. Non-dual eligible individuals (i.e., Medicaid-only beneficiaries) receive the same benefits as dual eligibles; the state pays SCO contractors a higher capitation rate for these members to compensate for the lack of Medicare reimbursement. Members and providers experience SCO as a single set of services and benefits that covers everything under Medicare and Medicaid; the integration is seamless to the members. The SCO program was a precursor to the development of both the Duals Demonstrations and the FIDE-SNP.[1]

UnitedHealthcare (UHC) has been a SCO contractor since 2004. UHC operates the largest SCO plan in the state, covering about 39 percent of individuals in the program.[2] The SCO plan is the only UHC product in Massachusetts that integrates LTSS. The insurer also operates Medicare Advantage and Commercial

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[1] Please refer to Appendix B for more information on the SCO program in Massachusetts.
[2] As of June 2015, http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf p 9

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plans in the state. UHC's SCO plan is regulated by CMS as a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), and receives two separate capitated payment streams—one from the state and one from CMS. Massachusetts is part of the Duals Demonstration with OneCare, an integrated program for dual eligible individuals between the ages of 21 and 64. UHC is not participating in OneCare at this point.

UHC's SCO plan covers approximately 15,600 individuals throughout Massachusetts. All members are age 65 or older and eligible for Medicaid, and the majority (88 percent) are dual eligible. 89 percent of members live in the community, 11 percent in institutions. 65 percent of members do not speak English; the most common non-English languages are Spanish (28 percent of members) and Chinese (13 percent).

UHC SCO has a very broad network of medical providers, including many choices for primary care providers (PCPs), hospitals, pharmacies, specialists, and other providers. The plan subcontracts with Aging Service Access Points (ASAPs)—Massachusetts' Area Agencies on Aging—for almost all HCBS, and works with only a small number of HCBS vendors directly. In turn, the plan helps the ASAPs with more complex administrative processes, like billing and claims.

Senior Care Options in Massachusetts	
Program Name	Senior Care Options (SCO)
Year Established	2004
Covered Populations	Medicaid beneficiaries age 65 and older
Population Carve-Outs	Individuals with ESRD, residents of ICF/MR facilities, and inpatients in a chronic or rehabilitation hospital
Enrollment Approach	Voluntary, but participants must enroll in the same plan for Medicaid and Medicare coverage
Eligible Population	91,876[3]
Statewide Enrollment	38,672[4]
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	None
Dual Eligible Population	92% of members[5]

Care Management and Provider Organization

UHC SCO has a comprehensive care management model that addresses the needs of members whether they are residents of long-term care nursing facilities or live at home in the community. The goal of the model is to help members live in the least restrictive setting, supported by the appropriate level of LTSS. The model is focused on frequent member interaction and coordination with each member's PCP and extended care team, including family members and other informal supports.

Residents of Long-Term Care Nursing Facilities

For members who are residents of nursing facilities, the primary goal of UHC SCO is to promote and support a high quality of life by focusing on treating in place to avoid unnecessary hospitalizations and other transfers. About 1,700 members of the plan live in long-term care nursing facilities.

The UHC SCO care management model leverages primary care to improve outcomes for nursing home residents enrolled in the plan. Plan-employed nurse practitioners (NPs) and physician assistants (PAs)

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[3] As of June 2015, http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf p 10
[4] As of June 2015, http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf p 10
[5] As of January 2014, http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf p 8

work closely with each member's PCP and facility nursing staff, and act as leaders of the health care team by serving as collaborator, clinician, coordinator, advocate, and coach. NPs/PAs visit patients as often as needed to help avoid trips to the hospital.

NPs/PAs are assigned a member panel at between two to four different facilities. The consistent assignment of one NP/PA to members at a few facilities enables them to establish long-term relationships with facility nursing staff, interdisciplinary team members, and management. The NP/PA serves as an advocate for members with facility staff, and provides oversees member care through frequent on-site visits. This regular presence and proactive communication between plan and facility staff facilitates collaboration and increases the degree to which facilities align with UHC's integration goals. Facilities appreciate the support of UHC staff and work together to improve the quality of care provided to UHC SCO members.

NPs/PAs conduct a comprehensive (medical, functional, and behavioral), in-person assessment of the member within five business days of joining the plan. The member is reassessed every 60 days or more frequently if there is an acute event or status change. In between assessments, NPs/PAs are in the facilities and provide ongoing follow-up and oversight of the member.

The NP/PA generates an individualized care plan as part of the comprehensive assessment process, and upon completion shares the plan with the PCP and extended interdisciplinary care team to get their agreement. The NP/PA acts as the gatekeeper and coordinator for the member as the care plan is implemented. Under the oversight of the NP/PA, facility staff carry out the elements of the care plan. The NP/PA coordinates and runs family meetings to establish goals of care and individual preferences, and leads advance care planning conversations. The NP/PA also acts as a communication hub for the family, facility staff, and the PCP.

The NP/PA communicates regularly with the member's PCP via face-to-face meetings and telephonically, but has the training to provide independent clinical judgment as well. For example, the NP/PA can write orders for medications and therapies.

In the event a member is hospitalized, the NP continues to coordinate care. The NP calls the hospital and talks to the emergency room doctor before the member arrives, and ensures that the member's chart is transferred. Throughout the hospitalization, the NP continues to monitor the member, communicate with the hospital regarding diagnosis, treatment, and patient care preferences, and keeps the family informed. Upon the member's return to the nursing facility, the NP meets them and manages the transition process.

Community-Dwelling Individuals

The overwhelming majority of UHC SCO members (89 percent) live in the community. For these individuals, the plan's goal is to support the member safely in the community as long as possible (that is, to delay institutionalization). The plan has a great deal of flexibility in using the capitated payment for services that will support the member at home.

The core team for a member in the community is the member, their care manager, and their PCP, and depends on the member's level of complexity. Less complex members with minimal LTSS needs are managed telephonically by plan staff trained to provide care coordination services. Members with low to moderate LTSS needs are managed by Geriatric Social Service Coordinators (GSSCs)—specialized staff

based out of ASAPs. Members with moderate LTSS needs coupled with Alzheimer's disease or chronic mental illness are managed by a GSSC with support from an RN. Finally, members with an institutional level of need who live in the community are managed by an RN with support from a GSSC. The care manager is responsible for coordinating all of a member's care: medical, LTSS, behavioral, and any other supports that may be necessary. As part of this coordination, the care manager collaborates regularly with the PCP around changes in member condition and plan of care. Care managers provide PCPs with necessary information about the members' home and psycho-social context—information that often impacts member medical care and progress.

There are multiple assessments beginning with the member's first call to the plan. During the sales process, individuals who are already receiving LTSS are triaged for immediate in-home assessment to avoid any disruption in services. Within the first thirty days of enrollment, an HRA is conducted by phone for every member, which helps to determine the member's level of complexity and appropriate care management staffing. Following the initial HRA screening, a comprehensive, in-home assessment is done for every member. Assessments include evaluation of clinical, functional, and nutritional status, in addition to physical well-being. These assessments also include screenings for mental health conditions, tobacco, alcohol and drug use, and the need for LTSS, including the availability of informal support. Depending on the level of LTSS required by a member, reassessments occur either telephonically or face-to-face at least every three to six months. In practice, the complexity of the enrolled population means that most members are reassessed more frequently due to changes in status or acute events that trigger reassessment.

During a home visit, the care manager develops a comprehensive, individualized care plan built around the member's disease states, with a treatment plan for each condition. The care manager coordinates implementation of all elements of the care plan, and follows up with the member on an ongoing basis to ensure that services are being delivered. Member assessments, care plan, and other information are documented in a centralized, electronic record that is available to all members of the care team.

Transitions

If a community-dwelling member is hospitalized, a nurse on UHC's inpatient care management (ICM) team follows the member and coordinates with the admitting facility, member, assigned care manager and family. Prior to discharge, the ICM nurse conducts a readmission risk assessment with the member. Members who are identified as high risk receive a more intensive level of transition management following discharge. The ICM nurse works with the member's care manager and the facility's discharge staff on discharge planning. Within two business days of discharge, the care manager contacts the member by phone to ensure needed services are in place. Within seven days of discharge, the care manager conducts a post-hospital assessment to determine whether changes are necessary to the care plan, and updates the plan as necessary.

Similarly, if the member has a short stay in a skilled nursing facility, the care manager will follow them throughout their stay, ensure that discharge is safe, and work closely with the member, family, PCP and interdisciplinary care team to ensure a successful transition back to the community.

Plan Incentives and Financial Results

For dual eligible members, UHC SCO receives capitated payments from both Medicare and the state. For Medicaid-only beneficiaries, the plan receives a larger capitated payment from the state. The plan is at

risk for all Medicare and Medicaid-covered services, including medical, behavioral, and LTSS. The plan does not share risk with medical or LTSS providers. Instead, providers are reimbursed on a fee-for-service basis. The plan does have shared savings/quality programs in place for some nursing homes and is beginning to incorporate other alternative payment models in primary care and other settings that tie to quality outcomes.

The SCO program incentivizes plans to keep members in lower-cost community settings rather than in institutions. Plans receive community-level rates for the first 90 days a member resides in an institution, and receives institutional-level rates for the first 90 days after a member is repatriated from an institution to the community.

UHC is the largest SCO participant and has grown rapidly, with enrollment tripling in the last three years. Although the plan did not share financial data, they did report that the program operates at a profit and entered into a new five-year contract with the State effective January 2016.

Utilization Management Strategy

UHC SCO's utilization management strategy is best viewed in light of the overarching goals of program: (1) help community-dwelling members live in the least restrictive setting, supported by the appropriate level of LTSS, and (2) support quality of life for members living in long-term care facilities by avoiding unnecessary hospitalization and procedures. The plan's primary tools for managing utilization are the care management staff and the comprehensive and flexible set of services available to support the member.

Care managers use a two-fold approach to utilization management. First, care managers work to understand the service needs of their members, whether in the community or in nursing facilities. Standardized clinical assessments along with clinical experience help care managers develop service plans that take into account not only current needs but also future needs that may arise due to aging in place or worsening of existing conditions. Services that do not add additional value to accomplish the goals of each member's care plan are slowly reduced or eliminated with the consent of the member and PCP. Changes to the service package—whether increases and decreases—are implemented gradually. When increasing services, the care manager starts with the least expensive option (e.g., one hour of homemaking weekly), and then evaluates the impact and further escalates if necessary.

For community-dwelling members, HCBS is explicitly viewed as a tool for preventing exacerbations and high-cost events, like hospitalizations. The plan focuses on the most complex members to manage these outcomes. A Significant Episodes of Cluster Activity (SECA) report is used to identify the 1 to2 percent of population that drives overall plan costs. The plan actively tracks and monitors these high-risk members over time. Care managers follow these members very closely and check on them regularly for any changes or deterioration. Particularly challenging cases are brought to interdisciplinary team meetings including medical directors, behavioral health specialists, and pharmacists to problem solve and share best practices. In addition to these reports, the plan uses data from initial and subsequent assessments to identify high-risk members and anticipate ER and hospital admissions. By comparing changes in member assessments over time, the plan is able to identify new HCBS needs and provide services that could prevent unnecessary ER or hospital admissions. A third tool the plan uses is Interdisciplinary Care Review (IDCR), which is a case conference where the plan medical director and other members of the interdisciplinary care team discuss enrollees who are readmitted to the hospital within 30 days. Finally,

the plan averts some hospitalizations via a 24/7 hotline staffed by an on-call team of NPs that members can call for assistance before calling 911 or going to the emergency room.[6] UHC uses NPs on staff to answer the hotline.

When members are hospitalized, a centralized UHC inpatient utilization management team works with the hospitals, checking in on a daily basis to monitor the services being used and assist in discharge planning. After discharge, RNs provide transition management home visits to members identified as being at high risk of readmission based on the Coleman model.[7] For lower risk members, transition management is telephonic.

Quality Metrics and Performance Management

UHC SCO's quality measurement activities are very medically focused—75 percent of the measures they track are clinical indicators, while 25 percent assess quality of life, social supports, and member satisfaction. Compliance drives the plan's quality program, with a focus on HEDIS, Medicare Star Ratings, and other measures required for D-SNPs. The plan also administers a survey to measure functional health and well-being from the patient's point of view.

UHC conducts chart audits on all care managers monthly to measure adherence to the care model. These audits include timely initial member assessments, timely ongoing member assessments, health risk assessments generating appropriate care plans, communication with interdisciplinary care team, and other elements. The plan's clinical management team also conducts regular field-based visits with the staff to monitor adherence to corporate guidelines.

UCH SCO does not use person-centeredness as an organizing principle for their care model. Although care plans are individualized and oriented to individual needs, they are also organized around the member's disease states. Member goals and preferences are reflected in the care plan, but are constrained by what is realistic for the individual to achieve.

Key Integration Strategies and Outcomes

UHC SCO's integration strategy is grounded in their ability to offer a comprehensive suite of services. The plan presents the benefits to the member as a single, complete package, and coordinates all care so that the member experience is seamless. A single care manager is responsible for coordinating the entire package of services for each member, serving as a single point of contact for that member's medical, LTSS, and behavioral needs. The care model is truly needs-based and customized for each member, with care management staff carefully titrating services to effectively support the individual in the community. Coordinating an effective package of supports may mean increasing or decreasing services—the emphasis is on filling members' unmet needs. UHC SCO also hires linguistically and culturally competent

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[6] This hotline is a requirement of the plan's contract with the state, but has also proven to be a useful tool for preventing hospitalizations.

[7] The Care Transitions Program (http://www.caretransitions.org/) was developed by Dr. Eric Coleman to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move from hospital to home, the Care Transitions intervention is composed of: 1) a patient-centered Personal Health Record that contains all essential care elements, 2) a structured Discharge Preparation Checklist, 3) a session with a Transitions Coach in the hospital prior to discharge, and 4) follow-up visits and phone calls from the Transitions Coach in SNF or in home.

staff. Although this may seem like a minor point, it has actually proven critical to serving their diverse membership.

UHC SCO further attributes their success to several distinguishing attributes. Primary is the close relationship with ASAPs, who are experts on the LTSS provider network and play a key role in connecting members with appropriate resources. The plan also points to effective management of care management staff as an important contributor to successful integration. Finally, the SCO care model leverages UHC's years of experience of caring for residents of long-term care facilities.

The plan focuses on results that reflect their primary goals: helping members live in the least restrictive setting, supported by the appropriate level of LTSS services, and supporting a high quality of life for members in nursing facilities by focusing on treating in place. A state evaluation of the SCO program shows that the program has succeeded in keeping members in the community and decreasing the utilization of SNFs.[8] UHC SCO also points to its low disenrollment rate (less than 2 percent) and strong membership growth as indicators of how well their plan is doing.

The plan was able to point to many anecdotal successes of managing members cost-effectively, but does not have robust quantitative data on program outcomes. There are several reasons that it is difficult to quantitatively demonstrate impact. One is the lack of adequate quality measures for LTSS, especially HCBS. Second, by the time individuals enroll in SCO, they are often in deteriorating health and increasing needs for care. Therefore, a time-series analysis would not be expected to show improving health and cost after enrolling in time. Finally, it is difficult to identify an appropriate comparison group against which to benchmark the results of the program. There are significant differences between the population enrolled in SCO and the fee-for-service Medicare population, which makes it challenging to compare data on outcomes between the two groups.

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[8] Jen Associates (2013) "Massachusetts Senior Care Option 2005-2010 Impact on Enrollees: Nursing Home Entry Utilization." Available at: http://www.mass.gov/eohhs/docs/masshealth/sco/sco-evaluation-nf-entry-rate-2004-through-2010-enrollment-cohorts.doc

Long-Term Quality Alliance

Long-Term Quality Alliance (LTQA) is a community of organizations aimed at improving outcomes and quality of life for persons and their families who are managing functional limitations due to chronic health conditions. It draws member organizations from the full range of health care and social services delivery systems involved in provision, administration, innovation, policymaking, and advocacy for quality long-term services and supports (LTSS).

Organizations come together in the Alliance to share knowledge and experience needed to advance development and continuous improvement of high-quality systems of integrated, person- and family-centered LTSS. The Alliance serves as a convener of disparate private-sector and governmental organizations, with an eye to identifying and resolving the most significant challenges and advancing the replication of successful models that demonstrate the potential for more widespread adoption of person-centered LTSS integration.

Acknowledgements

Contact

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*Advancing high-quality, person- and family-centered,
integrated long-term services and supports*

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