

Case Management Model Matrix

	Texas Star + Plus	ALTCS	PACE	SCAN SHMO	Minnesota MSHO	Wisconsin Partnership	VNS Choice
Funding Source	Medicare Medicaid	Medicare Medicaid	Medicare Medicaid some private pay sources in some programs	Medicare Medicaid member co-pays member premiums	Medicare Medicaid	Medicare Medicaid member's SOC	Medicaid - capitated Medicare-fee-for- service
Capitation Rate \$/Mo/Member	<u>Medicaid Only</u> SNF - \$3327.78 SNF Waiver - \$3012.60 Community Care - \$597.34 <u>Dual Eligible</u> SNF - \$1819.89 SNF waiver - \$1523.62 Community Care - \$96.13	avg. \$2,117.68 for fiscal yr. 98/99 different for each county and contractor	Medicare- AAPCCx2.38 Medicaid - 85% of SNF bed rate for the area combined rate \$3,000 to \$3,700	100% of the AAPCC rate varies by county, age, sex, and institutional status rate adjusts monthly depending on rate cell	PMAP cap. Medicaid SNF add- on avg. Elderly Waiver pymt. AAPCC(adjusted per capita costs)+ an addl. risk factor many different rate cells	Medicaid avg. \$2,800. Medicare avg. \$1,000.	several rate categories based on member's impairment, age and county of residence rates are negotiated annually with NY DHS 55% to 65% of avg. monthly SNF rate in New York City area and can't exceed 95% of the upper pymt. limit
Federal Waivers	1915b 1915c	1115	1115 222	several - not specifically identified by the program and not available on the Internet	(originally)1115 Medicare 1395b Medicare 402 pending 1915a and 1915c	1115 222 1915b	none were required demonstration program through a contract with NY DHS
Population #	56,179 as of 6/1/00	28,033 as of 7/01/00	current at ON LOK - 860	33,620 as of 8/99	3,420 as of 1/1/00	850 as of 8/24/00	2,400 as of 8/00

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Population Served	all aged and disabled Medicaid recipients in Harris County must participate must be SSI eligible	SNF eligible elderly and physically and developmentally disabled	55 yrs. and over enrolls only very frail "high risk" elderly must be SNF eligible	frail 65 yrs. and over must have Medicare A&B benefits may receive Medicaid must be SNF eligible must reside in service area	65 yrs. and over must receive Medicare A&B benefits must receive Medicaid must receive all acute and LTC services through same contractor must live in 5 county metro service area	available in various areas of state must receive Medicaid can be dual eligible must be SNF eligible must be 55 yrs. or over or physically disabled	65 yrs. and over must reside in 5 boroughs of N.Y. City and Long Island must be SNF eligible and Medicaid eligible must receive Medicare A&B benefits must require LTC services for at least 120 days
Percent Dual Eligibles	about 50%	59%	ON LOK 88%	5%	100%	75%	100%
Enrollment Type	mandatory for all Medicaid recipients voluntary enrollment in same HMO for Medicare	mandatory for all eligible Medicaid recipients	voluntary	voluntary	voluntary	voluntary	voluntary

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Contractor	HMO 3 capitated plans- Access, Amercaid, HMO Blue	5 county based providers 2 private plans 1 state contractor for DD pop. only 1 program operates in each county	non-profit organizations or public entities subject to application approval	health plans many HMOs	health plans (3) community based organizations many subcontractors	community based organizations some are PACE models organizations subcontract with hospitals, clinics, HMOs, etc.	Prepaid Health Plan (PHP) Visiting Nurses Services and VNS Community Care Network non-profit home health agency has many capitated sub-contractors
Scope of Services	day health, personal care, SNF, adaptive aids, adult foster care, assisted living, emergency response sys., DMEs, supplies, minor home modifications, respice, emergency and acute services	acute rehab, mental health, custodial care, RCFEs, adult day care, environmental modifications, adult foster care, respice	all acute services all meds ongoing rehab adult day health center social services personal care at home SNF and hosp. care dental, vision, audiology, podiatry recreation	all Medicare A&B services plus incentives custodial care services can be purchased by member at a reduced rate all custodial services provided to Medicaid members at no cost	all acute and LTC services 180 day SNF coverage assisted living each plan offers special "incentives"	acute and LTC services adaptive aids meds transportation	all acute and LTC services plus "extras" adult day care, personal and skilled home health, prescription and nonprescription meds, home meal delivery, chore service, SNF care, environmental modifications, assisted living

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Incentives for Participation	<p>unlimited prescriptions to dual eligibles that use same HMO for Medicare & Medicaid services</p> <p>some plans offer transportation, dental, eyeglasses, smoke detectors, pest control, housekeeping</p>	<p>one stop shopping</p> <p>all services (acute and LTC) arranged and authorized by 1 contractor with PCP in control of care plan</p> <p>daily rate of RCFE is reimbursed by rate set based on ADL status</p>	<p>all drugs covered</p> <p>continuity of care at home, center and institution</p> <p>team provides services and case management</p> <p>operates senior housing units</p> <p>maintenance for dental and vision</p>	<p>pharmacy, vision, dental, hearing, transportation</p> <p>custodial care services avail. at low cost</p> <p>short term SNF coverage</p> <p>taxi service to dr.'s appts.</p>	<p>includes pymt. for assisted living</p> <p>first 180 days in a SNF paid</p> <p>caregiver training</p> <p>adult foster care</p> <p>home modifications</p> <p>extended DMEs and supplies</p>	<p>strong consumer choice</p> <p>provides preventive, primary and chronic care</p> <p>members can maintain relationship with current dr. and providers</p>	<p>multi-cultural programs</p> <p>dental care, podiatry, prescription and non-prescription meds</p> <p>24/7 on call services</p> <p>emergency response system</p> <p>home safety modifications</p> <p>scheduled transportation</p>
Member Participation	<p>input encouraged and incorporated in care plan</p>	<p>care plan must be approved by member and/or rep.</p> <p>all changes to care plan must be approved by member and/or rep.</p>	<p>strong participation by member in care plan development and changes</p> <p>members are expected to attend the center regularly</p>	<p>member, fam./rep. agree to care plan and agree to pay for services arranged as needed</p>	<p>member and family are part of the ID team that develops and makes changes to the care plan</p>	<p>members receive health education</p> <p>member and/or rep. are part of ID team that develops and changes care plan</p>	<p>member participation encouraged</p> <p>member is offered choices about what services will be provided and where they will be provided</p>

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Point of Entry	once eligible for Medicaid/SSI, individual receives enrollment packet in mail from state	(1) PAS (preadmission screening tool) (2) referral made by ALTCS eligibility wkr. (3) Medical eligibility confirmed (4) RN or SW does home interview (5) Dr. reviews assessment as needed (6) member contacted by CM within 7 working days	call made to PACE center enrollment rep. completes health and personal needs eval. by phone comprehensive eval. done at center in 2 or 3 visits by team enrollment conf. Is held	referrals are received from: (1) hosp. discharge planners, drs. (2) member services, UR, marketing, claim's dept. (3) friends and family (4) community resources (5) churches (6) vendors (7) self referral	all enrollment through county part of the PMAP enrollment process screening form is faxed to DHS and then info is given to contractor in appropriate service area	each site takes own referrals self referrals community referrals	referrals come from: VNS Home Care, community based organizations, drs., local social service depts., members themselves, and families when call is made to VNS Choice, VNS Choice RN speaks to member to determine interest and eligibility if criteria is met, VNS Choice RN meets with member and fam./rep. in home and with member's dr. to develop care plan

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CM Assignment	<p>members with complex needs are assigned Care Coordinator by HMO</p> <p>special teams for chronic disease members</p>	each contractor provides own case managers	<p>ID team includes: Drs., Nurses, SWs, Rehab Therapists, Rec. Therapists, Dieticians, and HHAs</p> <p>each team located at PACE center</p>	<p>Personal Care Planner assesses frail member, identifies needs, coordinates services, integrates acute and LTC services, interacts with drs., medical group and hosp. staff as needed</p> <p>monitors services provided to member for quality and effectiveness</p> <p>notifies dr. of changes</p>	<p>different among plans</p> <p>CM is provided by each plan-each CM system is different</p> <p>CM must include coordination of all medical and social needs</p>	<p>CM done by ID team that includes Dr., RN, nurse practitioner, social service coordinator</p> <p>nurse practitioner integrates acute and LTC services</p>	<p>VNS Choice RN is assigned to each member</p> <p>VNS Choice RN coordinates care and services and provides case management</p> <p>also responsible for enrollment and SNF care as well as coordination</p>
CM Qualifications	<p>some RNs, some SWs, a few non-medical, non-social staff</p> <p>many former state employees</p> <p>many with geriatric backgrounds</p>	licensed nurse, SW or individual with a min. of 2 yrs. CM experience with aged and disabled	<p>RN + 1yr. exp.</p> <p>MSW + 1 yr. exp.</p> <p>Licensed Rehab Therapists + 1yr. exp.</p>	<p>utilizes both RNs and SWs</p> <p>Personal Care Planners are located at each area office</p>	<p>all must have geriatric experience</p> <p>most CMs are RNs</p> <p>frequently called Care Coordinators</p> <p>qualifications different by contractor</p> <p>many are geriatric nurse practitioners</p>	<p>RN</p> <p>Social Service Coordinator (no avail. definition of qualifications)</p> <p>Dr.</p> <p>Geriatric Nurse practitioner</p>	VNS Choice nurse must be RN and must have extensive experience in community care

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CM Ratios	depends on level of care coordination: 1:40 chronic disease 1:2,000 stable	mixed caseload assigned formula- (# of HCBS, Hospice and acute care members x 2)+(# of SNF members x .8) = 96 or less	sometimes several ID teams at each center total center population distributed among teams	1:50 to 90 members	vary 1:75 to 1:150	1:45	1:25
CM Rate \$/Mo/Member	currently 160 Care Coordinators 35 state positions deleted and money given to HMOs for CM no separate cap. for CM	\$56 set by AHCCCS	included in cap. no addl. funds given for case management	included in cap. no addl. funds received for case management services	built in cap. no addl. money pd. to contractors for CM	included in cap. no addl. funds for CM	included in cap. VNS is at full risk
CM Contact Frequency	new members receiving LTC services seen within 30 days of enrollment further contact "need" dependent all members contacted at least annually	CM must contact member every 180 days if institutionalized, every 90 days if at home or RCFE more frequent contacts upon change or emergency	ongoing re-eval. and monitoring by ID team at the center	on enrollment if triggered if triggered by annual mail-in health status form phone call at least every 3 mos.	initial assessment is done in home by CC and re-done in home every 6 months changed when situations arise that warrant change to care plan	decided by ID team member is seen as often as needed to prevent an acute episode	initial comprehensive assessment complete assessment by RN every 60 days reassessment and visits as needed when changes occur

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Risk Assessment Tool	<p>MDS completed</p> <p>4 risk groups:</p> <p>(1)high risk community members</p> <p>(2)Community Based Waiver members</p> <p>(3)new SNF eligible members</p> <p>(4)members enrolled in SNF</p>	<p>PAS tool used at interview by RN or SW to identify "at risk" members</p>	<p>PAS interview by rep. upon initial call to identify risk</p>	<p>use modified assessment tool that was developed for SHMOs in the 1980s</p> <p>health status form is completed upon enrollment</p> <p>certain responses trigger home assessment by a Personal Care Planner</p> <p>form is completed annually by mail - these may trigger home assessment as well</p>	<p>some plans use own tool</p> <p>some plans use tool developed by NCCC (Nat. Chronic Care Consortium)</p> <p>NCCC tool can be purchased</p>	<p>protocol set by Partnership</p> <p>each site developed and uses its own tool</p>	<p>upon referral, the VNS Choice RN explains program by phone and if member is interested in participating in the program the VNS RN arranges a home visit</p> <p>comprehensive assessment is performed at initial home visit</p> <p>assessment includes clinical eligibility, LTC needs and member preferences</p>
Service Assessment Tool	<p>each HMO uses own tool</p> <p>MDS completed for all members receiving LTC services</p>	<p>PAS and interview by CM</p> <p>CATS (Client Assessment and Tracking System)</p> <p>LEDS (LTC Eligibility Determination)</p>	<p>each ID team develops tool</p> <p>medical record and check lists are included in each PACE site's technical assistance package that is purchased</p>	<p>Personal Care Planner uses CM tool to develop care plan</p> <p>this tool is comprehensive and identifies gaps and functional needs</p>	<p>same as assessment tool</p> <p>some plans use own tool</p> <p>some plans use NCCC tool</p>	<p>protocol set by Partnership</p> <p>each site developed and uses its own tool</p>	<p>same as assessment tool</p> <p>documentation is entered into the office-based system by pen-based computer tablet that is carried by VNS Choice RN</p>

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Authorization Process	all services coordinated, monitored, authorized by HMO Care Coordinator	PCP and CM authorize all services - acute, SNF, ICF, RCFE, Hospice, mental health	ID team coordinates, monitors, and authorizes all acute and LTC services through the PACE center	Personal Care Planner authorizes, arranges and monitors all member services	CC seeks input from ID team but monitors, coordinates and authorizes all services	all services authorized by ID team	all services are authorized, monitored and coordinated by VNS Choice RN can be entered into computer system immediately and sent to subcontractors to begin services
Care Plan Development	Care Coordinator develops care plan as needed not all members have care plans	begins at interview by CM notify CATS of care plan implementation and changes	care plan developed initially and changed by ID team during member conferences which are held regularly members are monitored closely by ID team when not able to come to center and appropriate changes are made to the care plan	Personal Care Planner develops care plan during assessment visit and updates the care plan upon future contacts with member	CC and ID team develop care plan together	holistic and cohesive goals integrated into a single care plan care remains intact across the continuum developed by ID team	developed by VNS Choice RN plan of care is reviewed with dr., member and fam./rep. care plan is accessible by service providers via computer system changes in care plan and med updates are made immediately in the home via computer link

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Model's Technical Support	<p>no common IT</p> <p>no sys. links HMOs and providers</p> <p>each HMO has own system</p>	<p>some manual documentation</p> <p>LEDS (LTC eligibility determination)</p> <p>CATS (Client Assessment & Tracking Sys.)</p> <p>providers have access to some LEDS and CATS screens</p>	<p>4 recognized PACE Tech. Asst. Providers in country</p> <p>infrastructure and data systems are complex</p>	<p>in final stages of developing own case management software</p> <p>has developed a computerized assessment tool</p> <p>able to share information with providers and members electronically</p>	<p>each plan has own system</p> <p>whether to have an IT system or not is up to each contractor</p> <p>no protocol</p>	<p>3 out of 4 contractors developed a system together that stores info, care plan and tracks members' services</p> <p>4th contractor will purchase system from them this yr.</p> <p>Subcontractors can't access the system</p>	<p>developed on the foundation of the sponsoring organization's systems</p> <p>lightweight pen-based computer tablet used in the field which can access the mainframe computer through wireless or dial-up transmission</p> <p>member's clinical record, care plan, are accessible in field</p> <p>can input new data, change orders, write progress notes and review medications in the field</p> <p>provides information to all subcontractor agencies</p>

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QA Indicators/ Monitors	provider satisfaction surveys quality of care assessments: (1) % members satisfied with services and providers (2) # of member complaints (3) frequency of HMO changes (4) focus group results	# of flu vaccines # of pressure sores diagnosis supporting psychotropic drug use ADL status fractures related to falls medical audit of HCBS pop.	combination of process and outcome measures doesn't track disease specific problems use over 100 QA indicators also use interviews and surveys 95% members are satisfied or very satisfied	reports HEDIS data to HCFA no unique measures/indicators for frail elderly population standard QA measures used by other Sr. HMOs	using SASI tool developed by NCCC also uses parts of standard set of HEDIS UR measures client satisfaction and disenrollment surveys	Partnership contracted with Univ. of Wisconsin this contract produced the Quality Research Initiative	indicators include: member satisfaction, positive patient outcome, hospitalizations, complaints, SNF admissions and appropriate/efficient service utilization
Cost/Benefit Analysis	won't be available until Nov.	fewer hosp. days, fewer procedures, more frequent evaluations, better utilization of services, decrease institutionalization costs are increasing at a 5.6% slower rate than traditional Medicaid	SNF and hospitalization rates well below comparable population Medicare and Medicaid save between 5% and 15 % on PACE members compared to comparable group	successfully maintains over 90% of frail members in their homes serves a diverse geographic area proven decrease in number of services needed by members	high satisfaction ratings by members budget neutrality budget below 1995 predictions decrease in institutionalization	demonstrates success using community based organizations difficulty controlling costs difficulty dealing with social problems urban and rural areas served cultural diversity	94% satisfaction rate among members disenrollment is only 2% data indicates that services are helping members remain in their home and community increased independence of members