



# Case Study

## INNOVATIONS IN CARE TRANSITIONS

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### The Visiting Nurse Service of New York's Choice Health Plans: Continuous Care Management for Dually Eligible Medicare and Medicaid Beneficiaries

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**ABSTRACT:** The Visiting Nurse Service of New York created a managed care plan serving lower-income, vulnerable patients enrolled in a partially capitated Medicaid Managed Long-Term Care program or a fully capitated Medicare Advantage Special Needs Plan, or both. Every health plan member is assigned a care manager who collaborates with an interdisciplinary care team and the member's primary care physician to enhance access to appropriate services, improve care coordination and transitions, and promote optimal health outcomes and independent living. Other key components of the model include comprehensive member assessments, patient and family education, transitional and palliative care provided by nurse practitioners, and the use of risk stratification, information technology, and staff training. Over time, Medicare plan members have experienced fewer hospital admissions, readmissions, and emergency visits. The health plan's experience should inform organizations and policymakers interested in integrating care for patients with special needs.



#### THE INITIATIVE AT A GLANCE

*Organization:* VNS Choice Health Plans is a managed care organization serving adult residents of New York City who are eligible for Medicare, Medicaid, or both. It was created by the Visiting Nurse Service of New York (VNSNY), the nation's largest nonprofit home health care provider serving 30,000 patients each day in New York City and surrounding counties.<sup>1</sup>

*Objective:* Integrate care for health plan members with special needs to improve their access to appropriate preventive, medical, mental health, and social services; help them navigate a complex health care system and safely remain in their homes as long as possible; and reduce preventable hospitalizations and readmissions that can put members' health at risk.

*Target Population:* Approximately 20,000 vulnerable and ethnically diverse VNS Choice members enrolled in a Medicaid Managed Long-Term Care (MLTC) program or a Medicare Advantage Special Needs Plan or both (Exhibit 1). Most members are elderly, suffer from multiple chronic conditions, and speak a language other than English.

*Team:* A specially trained care manager—typically a nurse—is assigned to each member to coordinate services from an interdisciplinary team, which may include physicians, nurses, home health aides, rehabilitation therapists, nutritionists, social workers, behavioral health specialists, transitional care and palliative care nurse practitioners, clinical pharmacists, member services representatives, family caregivers, and community service providers.

*Approach:* Integrate care across settings with customized interventions, which include:

1. Comprehensive assessment of members, often conducted in their homes.
2. Continuous care management to meet members' medical, psychosocial, cognitive, and functional needs, with an emphasis on in-person member encounters, including home visits, and collaborative relationships with hospitals and primary care physicians.
3. Teaching and coaching for members and family caregivers about how to monitor and optimally manage health conditions.
4. Risk stratification—largely driven by patterns of prior hospitalization—to identify and intensify care management for members at highest risk for rehospitalization.
5. Interdisciplinary team meetings to review the care needs and plans of high-risk members, such as those admitted to a hospital or skilled nursing facility.

**Exhibit 1. VNS Choice Health Plans for Dually Eligible Medicare and Medicaid Beneficiaries**

	<b>Medicaid Managed Long-Term Care (MLTC)</b>	<b>Medicare Advantage Special Needs Plan (SNP) and Part D</b>
<b>Enrollment (December 2012)</b>	16,351 members	7,194 members
<b>Benefits and services provided</b>	Alternative to long-term institutional care: covers 14 home and community-based services including care management, home health care, nursing home, adult day care, home-delivered meals	Covers all Medicare services for Part A (inpatient), Part B (outpatient), and Part D (prescription drugs). Supplemental benefits: dental, vision, hearing, transportation
<b>Payment source</b>	New York State Medicaid, partially capitated, rates risk-adjusted by population (two-year payment lag)	Federal Medicare program, fully capitated, rates risk-adjusted by individual
<b>Providers</b>	1,900 network providers 29 nursing homes	2,200+ primary care physicians, 5,800+ specialists, 37 hospitals, 32 nursing homes, labs, pharmacies
<b>Staff</b>	600+	60+
	100+ staff support a shared health plan infrastructure	

**Approximately 2,500 VNS Choice members are jointly enrolled in both the Medicaid MLTC plan and the Medicare Advantage SNP**

Sources: Adapted from Visiting Nurse Service of New York; New York State Medicaid and CMS Medicare Advantage enrollment reports.

6. Transitional care by a nurse practitioner following a hospital stay.
7. Palliative care for members with life-limiting chronic disease.
8. Information technology to facilitate decision-making, communication, and monitoring.
9. Frequent staff training on protocols and skills, such as how to identify potentially preventable reasons for hospital admission and modify care plans to reduce the risk of readmission.

*Timeline:* VNS Choice began enrolling MLTC members in 1998 under a New York State Medicaid demonstration program subsequently authorized by state legislation. Its Medicare Advantage Special Needs Plan was licensed in 2006 and began enrolling members in 2007.

*Results in Brief:* A cohort of 573 continuously enrolled Medicare health plan members experienced a 54 percent decrease in hospital admissions, a 24 percent decrease in hospital readmissions within 30 days, and a 27 percent decrease in emergency visits over 24 months. Among all dually eligible Medicare and Medicaid Choice members, there was a 21 percent relative reduction in the trend for the 30-day all-cause readmission rate between the first six months of 2009 and the first six months of 2011.

## THE CHALLENGE

Almost 9 million low-income elderly or disabled adults are dually eligible for Medicare and Medicaid in the United States.<sup>2</sup> Many of these individuals are in poor health and have complex acute and long-term care needs that account for a disproportionate share of Medicare and Medicaid spending.<sup>3</sup> Lack of incentives for care coordination under separate federal and state fee-for-service payment systems often leads to fragmented and unnecessary services as well as suboptimal patient and family experiences typified by relatively high rates of preventable hospitalizations.<sup>4,5</sup> Poverty coupled with inadequate housing or social supports can

complicate efforts to help individuals maintain their health or recover after a hospital stay.

The federal government and many states are interested in improving the coordination of care for dually eligible beneficiaries through alternative payment and delivery models. Among these are federally regulated Medicare Advantage Special Needs Plans and state-regulated Medicaid Managed Long-Term Care Plans that contract to deliver a range of covered benefits in exchange for a fixed payment per beneficiary.<sup>6</sup> Participating health plans must develop special expertise to effectively meet the diverse needs of dually eligible individuals who enroll in such plans. This case study describes how a large nonprofit home health care provider created health plans to serve this population and, in particular, how its customized care management approach has led to reductions in hospitalizations and readmissions.

## THE IMPETUS FOR CHANGE

In 1994, The Commonwealth Fund made a planning grant to the State of New York to design a new payment model for integrated home, community, and facility-based long-term care.<sup>7</sup> The resulting Medicaid Managed Long-Term Care (MLTC) program pays participating health plans a fixed amount per enrollee (known as “partial capitation”) to provide a bundle of comprehensive long-term care and related services and to coordinate enrollees’ care across all settings (Exhibit 1).<sup>8</sup> MLTC serves Medicaid-eligible adults with functional impairments who qualify for long-term care services and who are able and wish to continue living safely at home with supportive services.<sup>9</sup> The goal of MLTC is to promote health and independent living in the community to avoid or delay the need for long-term institutional care.

As an experienced home health care provider, VNSNY’s leaders viewed participation in the MLTC program as an opportunity to fulfill the organization’s nonprofit mission by better meeting the needs of medically frail elderly patients with limited incomes. VNSNY created a health plan that was one of five selected to participate in New York’s initial MLTC

demonstration. The VNS Choice MLTC plan enrolled its first members in January 1998 and has since become the largest and fastest growing MLTC plan in the state.<sup>10</sup> The plan serves a culturally diverse population of members. The average MLTC member is 82 years old and has four chronic illnesses and multiple functional deficits; over half suffer moderate to severe cognitive impairment; three of five speak a language other than English.

The MLTC program covers 14 home and community-based services. Hospital and physician care are not covered but are typically paid for by Medicare—or by a Medicare Advantage plan, if the member is enrolled in one. The MLTC plan’s responsibility to coordinate care across all settings creates an indirect incentive to reduce unnecessary hospital use and readmissions. “The burden placed on the elderly from admissions and readmissions are stressful events which tend to move individuals closer to the point of such disability and risk that long-term institutional care may be needed for their own safety,” says Carol Raphael, VNSNY’s former CEO. Reducing hospitalizations supports the aim of MLTC to forestall the use of long-term care facilities, for which the MLTC plan is financially responsible. In essence, total care management acts as a mechanism to integrate care as fully as possible even though payment is only partially integrated.<sup>11</sup>

In 2006, VNSNY built on its experience with MLTC to create a Medicare Advantage Special Needs Plan regulated by the federal government. The Special Needs Plan is offered to low-income adults who are dually eligible for Medicare and Medicaid; enrollment in such plans is voluntary under federal law.<sup>12</sup> Based on consumer interest, VNS Choice also created Medicare Advantage plan options for Medicare beneficiaries who are not eligible for Medicaid, although enrollees tend to have lower incomes. Because the Medicare Advantage plans are financially at risk for providing Medicare-covered benefits including inpatient and outpatient care under a capitation arrangement, they have a direct incentive to reduce unnecessary hospital use. A subset of approximately 2,500 VNS Choice members have jointly enrolled in both the Choice Medicare

Advantage Special Needs Plan and the Choice Medicaid MLTC plan, or in a Medicare Advantage Plus plan that combines both programs, which offers the opportunity to fully integrate services across the entire care continuum including both acute and long-term care (Exhibit 1).

## THE STEPS OF CHANGE

### Building the Infrastructure

To create an infrastructure for its Choice plans, VNSNY developed expertise to manage the financial risk associated with capitation. This involved:

- building a provider network that included primary care physicians with geriatric competency, specialists, hospitals, laboratories, pharmacies, and transportation services;
- training nurse care managers and other staff for new roles;
- engaging in individual marketing to prospective members;
- establishing membership services including a call center; and
- investing in information technology, such as electronic health records.

Medicare Advantage plan members receive covered benefits from providers who participate in the health plan’s contracted network. Although Medicaid MLTC members are not required to select or use a network physician, they must have a primary doctor who is willing to coordinate care with VNS Choice.

### Establishing Continuous Care Management

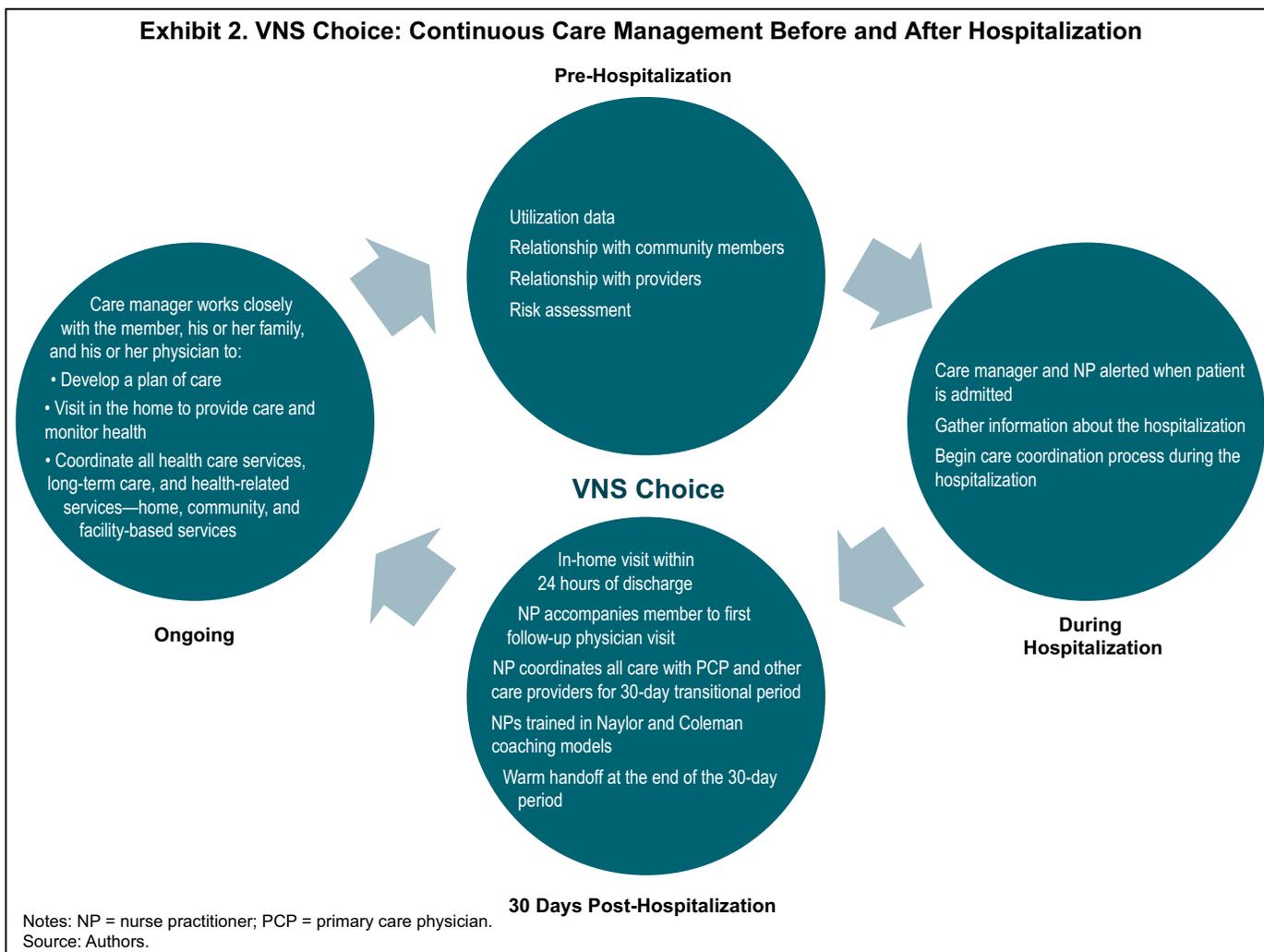
Each Choice health plan member is assigned a specially trained care manager—typically a nurse—who establishes a continuous care management relationship with the member and his or her family caregivers and who coordinates care with the member’s physician and other care providers. This role includes conducting periodic assessments, preparing and overseeing a care

plan, teaching and coaching members and family caregivers to self-manage chronic conditions, and overseeing transitional care for members at vulnerable hand-off points in the care continuum (Exhibit 2). Members also may call to speak with a nurse about health concerns 24 hours a day.

Among Choice members enrolled in the Medicaid MLTC plan, care managers—called nurse consultants—coordinate the continuum of care with the support of an interdisciplinary team that may include home health aides, nurse practitioners, psychiatric nurses, social workers, rehabilitation consultants, nutritionists, and medical directors. Any member of the care team may call a case conference when needed to review the care needs of a particular member. Ongoing routine check-ins with the care team generally cover four questions:

1. What's going well for the patient?
2. What's not going well for the patient?
3. What can be done to address problems?
4. What are the next steps?

Nurse consultants handle an average caseload of 38 to 43 MLTC members, whom they visit at home and contact by telephone as needed. Patients with more intensive needs receive more frequent contacts. A large part of the job involves supervising home health aides, who are contracted through a subsidiary licensed home health care services agency. Home health aides carry out the care plan in the member's home and provide updates on the member's condition to help identify issues for attention, such as the need for home-safety modifications to prevent falls.<sup>13</sup> For members receiving long-term custodial care in a nursing home, the MLTC



care manager is typically a social worker who coordinates with facility staff to meet members' psychosocial needs.

Among Choice members enrolled in the Medicare Advantage Special Needs Plan, care managers—called clinical evaluation managers—provide telephone care management and make evidence-based coverage decisions in consultation with a medical director. They handle an average caseload of 400 Medicare members supported by a team that includes those described above, as well as quality improvement specialists, behavioral health consultants, and clinical pharmacists. The extended care team meets biweekly in person and via conference calls to review the care needs and determine the best course of action for high-risk members who are hospitalized or receiving post-acute care. Discussion covers questions such as, “What is the situation at home?” “What are the concerns for this patient?” and “What can we do next?”

For members who are jointly enrolled in the Medicaid MLTC plan and the Medicare Advantage Special Needs Plan, the Medicaid MLTC nurse consultant acts as the principal care manager responsible for care coordination, while the Medicare clinical evaluation manager focuses on the member's coverage needs. VNSNY integrates clinical, social, and utilization data from the Medicaid MLTC and Medicare Advantage care teams to provide a “360 degree” perspective on dually enrolled members. This integration of preauthorization, concurrent review, discharge planning, member-centered care management, and identification of quality of care concerns helps avoid fragmentation of care and minimizes communication problems.

### **Assessing Member Needs**

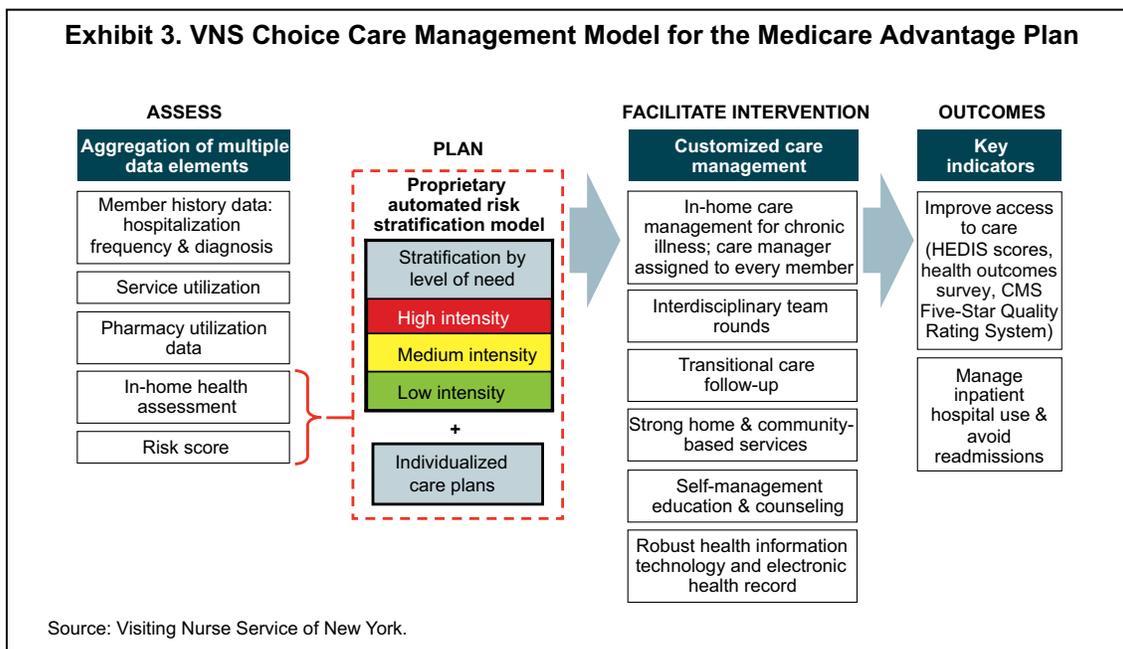
A key pillar of the Choice model is a comprehensive member assessment, typically conducted in the member's home shortly after enrollment and updated at least every six months thereafter. The assessment helps the care team build a relationship with members to understand their health risks and needs (e.g., preventive care, risk of falls, weight monitoring for heart failure patients, blood monitoring for those taking blood

thinning medications). Additional diagnostic information is obtained from hospitalizations and emergency department visits and combined with financial data to identify members whose actual costs exceed projections. Risk factors like psychosocial problems and substance abuse also are noted. Assessments by transitional care and palliative care nurse practitioners also are incorporated to form a more complete picture of a member's condition and needs.

### **Stratifying Care Management Needs**

The Medicare Advantage plan uses a risk stratification model that aggregates clinical and claims data across all settings to help predict members' care needs (Exhibit 3). It heavily weights a prior history of admissions in the risk score, consistent with research conducted by VNSNY that found prior admissions were the strongest predictor of readmissions.<sup>14</sup> The care team uses these risk profiles to tailor and prioritize care management resources and determine the frequency of member contacts. During these interactions, care plans are discussed and may include identifying the need for assistive medical equipment, gaps in the quality of care, and referral requests for in-home palliative care or assistance in obtaining medications after a hospitalization.

The Medicaid MLTC plan stratifies care management intensity based largely on members' psychosocial needs and caregiver support. The plan has found that members with relatively well-managed medical conditions and a stable home environment generally fare well with lower-intensity care management. The combination of an activated home health aide, motivated family, and a good relationship with a primary care physician means “we're going to hear if there is a problem,” says Regina Hawkey, vice president of clinical operations. “Then we'll know to make our contact more intense. If they go back in the hospital, for instance, we jump up to a higher intensity” of care management.



### Improving Transitional Care

Choice members enrolled in the Medicare Advantage plan are assigned a nurse practitioner (NP) to coordinate care and support the patient’s recovery during the critical 30-day period following a hospital stay. The transitional care protocol is based on evidence-based models and gives particular focus to the first week or 10 days following hospital discharge when most rehospitalizations occur.<sup>15</sup> The transitional care period may last up to 45 days for members who are jointly enrolled in the Choice Medicaid MLTC plan, for whom the NP provides more intensive supervision of medical and psychosocial issues in coordination with the care team. NPs are employed by a subsidiary licensed home care services agency and typically maintain a caseload of 10 to 15 transitional care patients at one time.<sup>16</sup>

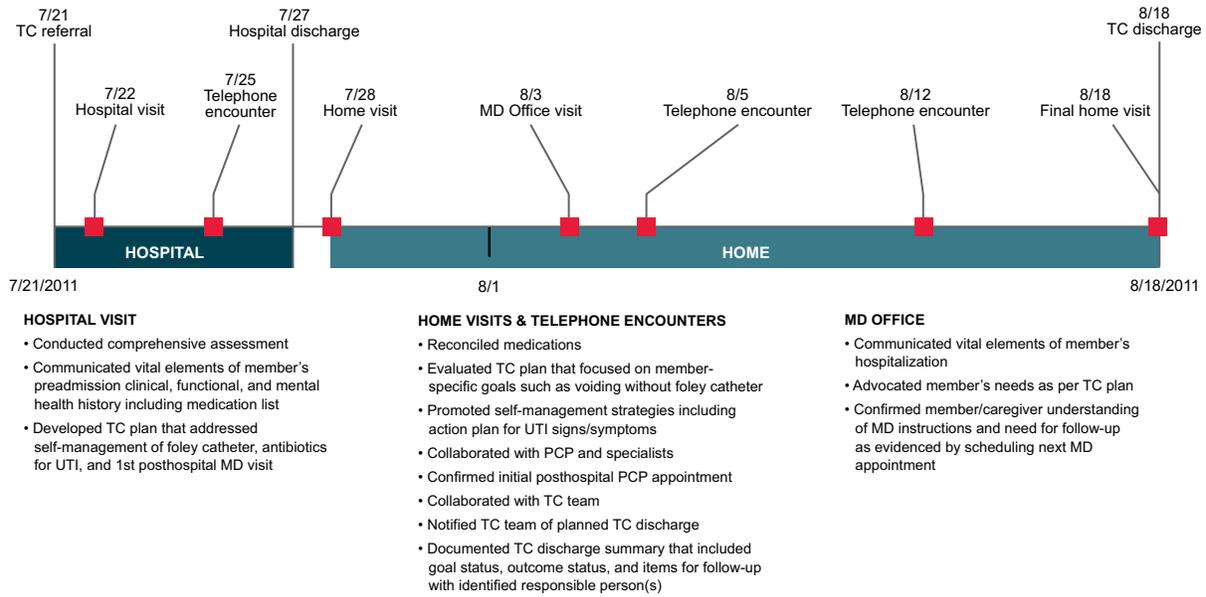
The transitional care protocol begins when a member’s Choice care manager is notified through health plan preauthorization requirements that the member has been hospitalized. The care manager sets up a discharge plan for transitional care with the NP who works in the member’s area. While the member is still in the hospital, the NP visits the hospital to make a connection with the patient and assess his or her condition. If the hospital is receptive, the nurse practitioner will collaborate with hospital staff to discuss the patient’s clinical information and transitional care

plan—some hospitals and staff are more open to connections with the nurse practitioner than others.

When the member is discharged from the hospital to home, a Choice member services representative calls to make sure the member has made a follow-up physician visit appointment and has filled medications. The NP then:

- conducts a home visit within 24 hours of hospital discharge, reconciles any discrepancies in medications, and develops a transitional care plan;
- educates the member and family caregivers on how to recognize and respond to warning signs of decompensation or worsening disease;
- helps the member navigate the care system, which often begins by arranging the member’s first follow-up appointment and ends by attending a doctor’s visit with the member to make a deliberate hand-off; and
- collaborates with the member’s care manager, primary care physician, and the interdisciplinary care team to “connect the dots” so that care providers receive all needed information (e.g., imaging and lab tests) and the member receives all needed services.

### Exhibit 4. VNS Choice: Case Example of Transitional Care for “Mrs. S.”



Note: TC = transitional care; UTI = urinary tract infection; PCP = primary care physician; MD = physician.  
Source: Visiting Nurse Service of New York.

The care transition program is less intensive for members who are discharged from the hospital to a postacute care facility, where the NP does not have the authority to affect care practices. NPs are given discretion on how to interact with a postacute care facility or to wait until the patient is discharged home from the facility to follow up. This substantially reduces their ability to intervene within the 30-to-45-day period following hospital discharge.

The transitional care process is illustrated in the case of “Mrs. S.,” an 80-year old, widowed, African American woman who lives with her son in a two-bedroom apartment (Exhibit 4). Mrs. S. has a past medical history of high blood pressure and type 2 diabetes. She was initially hospitalized because of a urinary tract infection.

### Improving Palliative Care

VNSNY recently developed a palliative care management program called Spark for Medicare Advantage plan members who have a life-limiting chronic condition. Medicare care managers review claims data to identify high-risk members with complex care needs for referral to the program. Spark aims to help these members and their family caregivers establish goals

for care at the end of life. The delivery model centers around telephone and home-based interventions by a palliative care team composed of a nurse practitioner, a licensed clinical social worker, and a physician. The nurse practitioner acts as a case manager, team leader, and comanager of medical services for an average caseload of 30 members. The team focuses on meeting members' palliative care needs including pain and symptom management, psychosocial support and teaching (e.g., when to call the nurse practitioner rather than 911), and advanced care planning. Specific goals of the program include reductions in hospitalizations, referrals to hospice, improvement in quality of life, and completion of advanced directives.

### Applying Information Technology

Information technology allows for proactive care management that targets problems rather than waiting for them to occur. On home visits, MLTC nurse consultants use laptops equipped with an electronic health record (EHR) system that documents the patient's assessment, plan of care, medications, and diagnostic and laboratory data at the point of care. The EHR promotes standardized decision-making and collaboration across disciplines and care settings. Medicare clinical

evaluation managers, who are office-based, use care management and authorization software and obtain extracts of utilization, cost, diagnostic, and quality data to identify gaps in care. VNSNY monitors quality of care using an internal scorecard that reports on clinical process of care, outcomes, patient satisfaction, and utilization of services.<sup>17</sup> The organization is planning to further integrate clinical and case management information systems across product lines.

### **Continuously Training and Developing Staff**

Following intensive orientation and supervised field training, Choice care managers continue to receive frequent in-service training to keep abreast of new care management protocols and develop teamwork skills. Interdisciplinary team meetings and case conferences are seen as an opportunity for team members to coach one another in developing critical thinking and relational skills. This includes, for example, how to identify reasons for potentially preventable hospital admission and modify care plans to reduce the risk of readmission.

The organization maintains a high ratio of care managers to members so that caseloads are manageable, but it also looks for ways to increase productivity by identifying members who can benefit from a lower intensity or more efficient mode of care management. For example, a single care manager may be assigned to the Choice members enrolled in an adult day care program. To free up time for care managers to focus on clinical tasks, the health plan is training some member service representatives to take on the role of care management assistants with responsibility for routine nonclinical tasks, such as calling members to make sure they have scheduled an appointment with their physician following a hospital stay.

### **RESULTS**

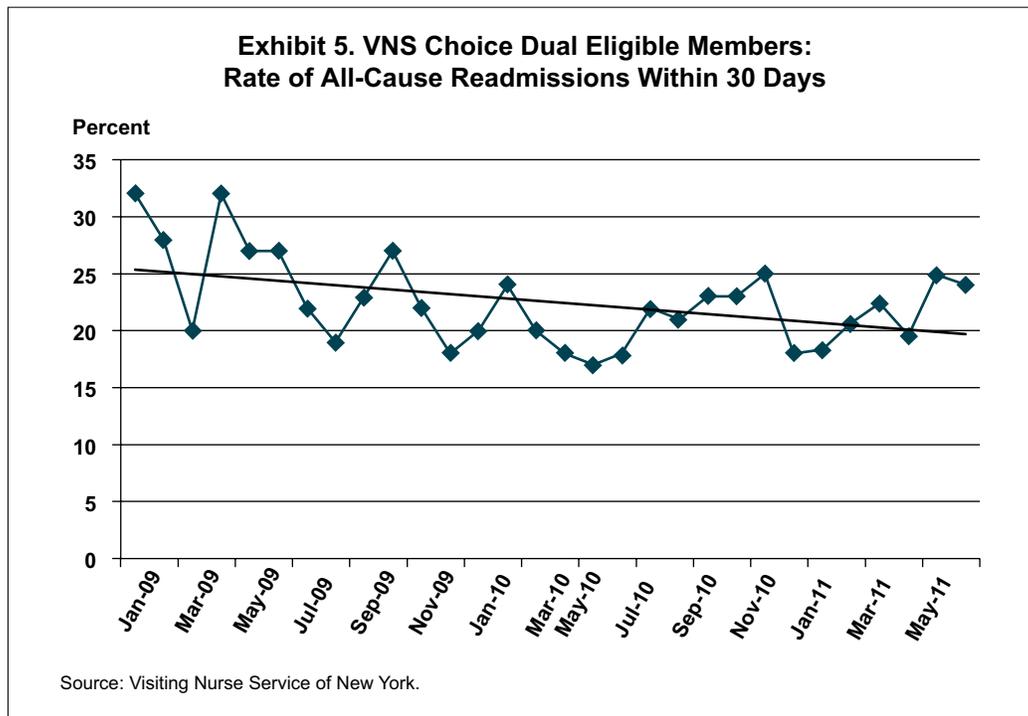
VNSNY reported promising results of its care management model. For example, among Choice Medicaid MLTC members, more than 90 percent have a physician follow-up visit within two weeks of

hospitalization. In comparison, a national study found that only half of Medicare beneficiaries had a physician visit within 30 days of a hospital stay.<sup>18</sup> In 2010, the rate of all-cause rehospitalization within 30 days of a hospital discharge was 25 percent in this population. VNSNY estimates that the comparable rate is 30 percent for similar frail elderly beneficiaries in the New York City area. Most Choice Medicaid MLTC members (95%) reported they are satisfied with care management, compared with 87 percent of members in all MLTC plans statewide who rated their care manager good or excellent.<sup>19</sup>

VNSNY examined data for a cohort of 573 dually eligible members continuously enrolled in the Medicare Advantage Special Needs Plan for 24 months to determine the impact of engagement in the VNS Choice care management model. This study showed a 54 percent decrease in hospital admissions, a 24 percent decrease in readmissions within 30 days, and a 27 percent decrease in emergency room visits. These results also may reflect coordination with primary care; VNSNY reported that 96 percent of its Medicare Advantage members had an annual primary care visit in 2010.

Among all dually eligible Medicare and Medicaid Choice members, VNSNY's data show a 21 percent relative reduction in the trend for the 30-day all-cause readmission rate, from a median monthly rate of 28 percent during the first six months of 2009 to 22 percent during the first six months of 2011 (Exhibit 5). VNSNY reports that this improvement has been sustained at a rate between 20 percent and 21 percent through August 2012.

Early results from an initial cohort of members enrolled in the Spark palliative care management program indicate that 94 percent of 150 participants completed advanced directives, compared with a benchmark of 69 percent of members in a published intervention study.<sup>20</sup> In an evaluation of 103 Spark participants, 88 percent reported that they improved or maintained their quality of life in the program, compared with a benchmark of 67 percent reported in the literature.<sup>21</sup> VNSNY reports that the hospitalization rate



fell by 30 percent among Spark participants enrolled during the first two years of the program.

## LIMITATIONS

The experience of VNS Choice is based on a relatively small member population that resides in a large urban area. Results may be limited in applicability to similar kinds of environments. The Centers for Medicare and Medicaid Services (CMS) reported that the VNS Choice Medicare Advantage plan received only 2.5 out of five possible stars on standardized performance metrics, indicating that the plan has substantial opportunity to improve the quality of care provided to its members.<sup>22</sup> Nationally, special needs plans such as VNSNY Choice tend to perform lower than general Medicare Advantage plans on the CMS star rating system.<sup>23</sup> VNSNY notes that most of the quality metrics used in the CMS star rating system do not adjust for challenges associated with members' socioeconomic factors and frailty.

## LESSONS LEARNED

VNSNY has learned a number of lessons from its experience developing customized care management approaches that may inform current policy concerns for

improving transitional care and reducing unnecessary rehospitalizations.

*Effective care management of a special needs population requires a holistic, individualized approach that encompasses the patient in the context of their home, family, and community.* VNSNY care managers do not focus narrowly on managing specific diseases or episodes of care, but look broadly at chronic conditions and hospitalizations in a larger life context geared toward attaining the best possible outcomes. The keys to this care model are the proactive identification of needs and problems coupled with interdisciplinary collaboration and coordination of resources to plan and execute the best course of action for each patient across all care settings.

*In-person home encounters are essential for effectively assessing members' needs in the context of their environment and for determining how to support independent living at home.* Although this high-touch interaction is more expensive than telephone contact—the cost of conducting a complete initial assessment and developing a care plan is equivalent to about six to eight months of health plan premiums—the plan's

leaders believe that it pays off in the long run. Carol Raphael, the former CEO of VNSNY, says, “When you enter a home, you enter a world and a life. We really see what is going on with medications, with the family’s ability to help with the member’s behavior. You may have a doctor’s visit for seven or 10 minutes, and you may speak to a discharge planner in a hospital, but there’s no substitute for that home visit and building that relationship where you spend time listening to and seeing what is going on” with the member.

Comprehensive assessment and care management must include behavioral health and psychosocial issues that affect the use of medical care, as well as palliative care needs for those nearing the end of life. A complete understanding of the member’s needs enables better coordination of community and behavioral health resources with medical care. Richard Bernstein, M.D., chief medical officer of VNS Choice Health Plans, notes, “There is a distinct subset of community members for whom we will not prevent readmission if we only address the medical disease producing the admissions and avoid discussing the member’s goals of care.” Addressing the member’s goals “will often result in focusing on the quality of care at the end of life and a decision to remain comfortable at home instead of cycling repeatedly to the hospital for symptom management.” VNSNY is developing a community-based mental health unit to address the needs of patients who resist going out of their home to visit a therapist.

***Integrated care and payment provides information and flexibility to identify and meet members’ needs in innovative ways.*** Bernstein explains: “We’re following people throughout time and throughout all settings, not with just managing an acute hospital episode or an acute or chronic illness. Our relationship is more long term and we have the benefit of collecting data from specialists, facilities, pharmacy claims, and a whole range of diagnostic information that allows us to define who is the most likely to have unmet care needs, which may involve functional deficits, psychosocial services, or medical equipment in the home. We can provide intensive telephone follow-up or in-home follow-up

or help our members transition to palliative or hospice care when they feel it will best meet their goals of care.”

In the current fee-for-service payment environment, a care transitions system requires a “gap-filler”—some entity to ensure that primary and specialty care services are available and functioning in a coordinated way to address member needs. With so many different providers working independently across a community, there can be gaps as well as redundancies in care. The collection of programs that VNSNY has assembled to meet the needs of vulnerable members shows how challenging this role can be in the current environment.

In explaining its ability to fill this niche, VNSNY’s leaders credit its position as both a home health care agency and a health plan. As a home care agency, VNSNY has face-to-face connections with members in the community, which gives its staff a frontline perspective that fosters a culture they describe as doing “whatever it takes” to meet the needs of patients. “To honor our commitment to the populations we serve, we must be in neighborhoods with families so that it is natural and organic for people to turn to us for services,” says Mary Ann Christopher, VNSNY’s current president and CEO.

As a health plan, VNS Choice creates an infrastructure to provide an integrated care delivery model in which care managers can dynamically allocate resources across settings of care to better meet member needs. They can be creative in using resources outside the usual benefit framework to promote better outcomes. For example, the plan can offer oxygen to someone who might not meet traditional Medicare reimbursement criteria but would otherwise likely experience an acute exacerbation resulting in hospitalization. Likewise, the plan can provide better transitional care by paying for postacute care for a member who would not meet Medicare’s rule for a minimum three-day hospital stay.

## NEXT STEPS

The New York State legislature recently lifted a moratorium that it had placed on the expansion of Medicaid MLTC plans in the state. The legislature also mandated that most dually eligible adult Medicaid beneficiaries who need more than 120 days of community-based long-term care services must enroll in a MLTC plan to obtain Medicaid coverage for those services (enrollment in MLTC had previously been voluntary).<sup>24</sup> The mandatory enrollment process is being phased in over time, beginning with New York City residents in July 2012. These changes are bringing an influx of demand and supply in the MLTC market—an estimated 24,000 Medicaid beneficiaries are expected to be newly enrolled in MLTC plans during the first phase of the expansion—with consequent changes in marketing practices and new challenges in managing care for a more diverse member population.<sup>25</sup>

In response to this policy change, VNS Choice is expanding its MLTC service area from New York City to nearby counties and eventually throughout the state. The expansion will require partnering with local providers and making adjustments in approach to accommodate differences in the local environment, such as greater use of adult day care centers and longer distances to cover for transportation services. VNSNY has found that it can extend its MLTC product to a new area in three to six months. “We don’t fear the influx of new members because scale is critical; it’s part of our culture,” says Regina Hawkey, vice president of clinical operations. Enrollment in the Choice MLTC plan grew 65 percent from 2011 to 2012. In contrast, expanding the Medicare Advantage product to a new area can require one to three years because of regulatory requirements and the logistics of contracting to establish a full-service provider network.

Future steps for the Choice program include exploring how to leverage core competencies to develop new accountable care models to integrate care for dually eligible beneficiaries, improving efficiencies in medical expense management and infrastructure, and continuing to improve care quality and member satisfaction. VNSNY is testing wider application of the

successful elements of its care model. For example, it recently formed a new business unit to offer nurse practitioner–led transitional care services to interested hospitals. At the federal level, Medicare Advantage Special Needs Plans have been reauthorized only through 2013, which creates uncertainty about the future of that program.

## POLICY IMPLICATIONS

Medicare and Medicaid are structured and regulated as two separate programs with little or no incentive to integrate services for dually enrolled individuals. As a result, integrated care programs are not widely available to dually eligible beneficiaries. The Centers for Medicare and Medicaid Services recently noted, “Except in a very small number of specialized plans covering only about 120,000 of the 9.2 million dual eligibles, people do not have a team of caregivers that direct and manage their care across Medicaid and Medicare and states do not have access to information about the care delivered across the two programs.”<sup>26</sup>

Even in states like New York that have created innovative programs, differences in state and federal regulations complicate enrollment and financing for those who wish to enroll in both state Medicaid MLTC and federal Medicare Advantage plans. For example, the state MLTC premium-setting process is not integrated with Medicare’s to fully capture the baseline risk of dually eligible beneficiaries. The ability to switch health plans monthly can also make it difficult to establish stable relationships for effective care coordination. Moreover, an individual may be enrolled in competing Medicare Advantage and Medicaid MLTC plans, which limits the ability to fully integrate care coordination across programs.

The federal government recently created a Coordinated Health Care Office to fund state demonstrations and identify new care models for dually eligible beneficiaries, which may result in the development of more effective integrated financing mechanisms for programs in the future. A study conducted by Emory University professor Kenneth Thorpe for America’s Health Insurance Plans estimated that enrolling dual

eligible beneficiaries in effective evidence-based care coordination programs could yield 10-year savings of up to \$125 billion in federal Medicare and Medicaid spending and up to \$34 billion for state Medicaid programs.<sup>27</sup> Although hospital use and readmissions represent only a subset of measurable outcomes, they are important indicators to assess the success of efforts to better integrate care for vulnerable member populations and to achieve the triple aim of improved patient health, improved care experiences, and lower costs.

The other case studies in our *Innovations in Care Transitions* series examine UCSF Medical Center's heart failure care management initiative and the Cincinnati Children's Hospital Medical Center's asthma care collaborative. To read them, along with a synthesis of findings from all three case studies, visit our website at <http://www.commonwealthfund.org/Publications/Case-Studies/2013/Jan/Care-Transitions-Synthesis.aspx>.

## NOTES

- <sup>1</sup> Information for the case study was gathered from interviews with VNSNY leaders, a presentation by Carol Raphael to The Commonwealth Fund's board of directors and to an Alliance for Health Reform briefing ([www.allhealth.org/BriefingMaterials/CarolRaphael-2142.ppt](http://www.allhealth.org/BriefingMaterials/CarolRaphael-2142.ppt)), and other publicly available sources.
- <sup>2</sup> Kaiser Commission on Medicaid and the Uninsured, *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, May 2011).
- <sup>3</sup> J. Kasper, M. O. Watts, and B. Lyons, *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, July 2010).
- <sup>4</sup> Medicare Payment Advisory Commission, "Coordinating the Care of Dual-Eligible Beneficiaries," Chapter 5 in *Report to the Congress: Aligning Incentives in Medicare* (Washington, D.C.: MedPAC, June 2010).
- <sup>5</sup> H. J. Jiang, L. M. Wier, D. E. B. Potter et al., *Hospitalizations for Potentially Preventable Conditions among Medicare–Medicaid Dual Eligibles, 2008*, Statistical Brief #96 (Rockville, Md.: Agency for Healthcare Research and Quality, Sept. 2010).
- <sup>6</sup> C. J. Milligan and C. H. Woodcock, *Coordinating Care for Dual Eligibles: Options for Linking State Medicaid Programs with Medicare Advantage Special Needs Plans* (New York: The Commonwealth Fund, Feb. 2008); J. M. Verdier, M. Au, and J. Gillooly, *Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans* (Washington, D.C.: Medicare Payment Advisory Commission, June 2011).
- <sup>7</sup> The Commonwealth Fund project was developed under state Medicaid demonstration authority and implemented under federal regulations governing prepaid health plans. Subsequently, the state legislature enacted the 1997 Long-Term Care Finance and Integration Act, which consolidated and expanded the demonstration and applied regulatory standards to MLTC plans. Today, a variety of organizations operate MLTC plans in New York State including hospitals, nursing homes, home care agencies, managed care organizations, and community nonprofit organizations. See: H. M. Fisher and T. G. Raphael, "Managed Long-Term Care: Care Integration Through Care Coordination," *Journal of Aging and Health*, Feb. 2003 15(1):223–45; and K. Liu, S. Long, S. Wallin et al., *Integrating Care for the Elderly: A Case Study of a Medicaid Long-Term Care Capitation Program in New York* (Washington, D.C.: The Urban Institute, 2001).
- <sup>8</sup> New York State is transitioning to a risk-adjusted capitation rate-setting process for MLTC plans. See: C. Murphy-Brown and K. V. Fitch, *Managed Long-Term Care Plans in New York State: Critical Factors for Financial Viability* (New York: Milliman, Inc., April 2012).
- <sup>9</sup> Enrollment in New York State's MLTC program was originally voluntary. In 2012, the State began making enrollment in MLTC mandatory for most adult Medicaid beneficiaries (starting with residents of New York City) who need home and community-based long-term care services for more than 120 days.
- <sup>10</sup> As of December 2012, the VNS Choice Medicaid Managed Long-Term Care Plan enrolled 16,351 members (of which 15,913 resided in New York City), representing almost 23 percent of the statewide MLTC enrollment of 71,770 people. One year earlier, VNS Choice enrolled 9,893 MLTC members, about the same proportion of the statewide MLTC enrollment of 43,523 people. See: New York State Department of Health, Monthly Medicaid Managed Care Enrollment Reports, [http://www.health.ny.gov/health\\_care/managed\\_care/reports/enrollment/monthly/](http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/).
- <sup>11</sup> H. M. Fisher and S. McCabe, "Managing Chronic Conditions for Elderly Adults: The VNS CHOICE Model," *Health Care Financing Review*, Fall 2005 27(1):33–45.
- <sup>12</sup> As of December, 2012, the VNS Choice Medicare Preferred Special Needs Plan enrolled 7,194 members and the VNS Choice Total Special Needs Plan enrolled 89 members. Nationwide, Medicare Advantage Special Needs Plans enrolled 1,585,652 beneficiaries. See: Centers for Medicare and Medicaid Services, Medicare Advantage/Part D Contract and Enrollment Data, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/index.html>.

- <sup>13</sup> VNSNY developed a home health aide assessment tool that guides care managers to determine the optimal number of home health aide hours to assign to members based on members' clinical and functional status.
- <sup>14</sup> VNSNY's home health agency developed a predictive modeling algorithm that uses demographic, financial, clinical, and health status factors to notify the home care team that a particular patient is at risk of hospitalization. A validation study found that the primary driver of readmissions was prior hospital admissions. See: R. J. Rosati and L. Huang, "Development and Testing of an Analytic Model to Identify Home Healthcare Patients at Risk for Hospitalization Within the First 60 Days of Care," *Home Health Care Services Quarterly*, 2007 26(4):21–36.
- <sup>15</sup> M. D. Naylor, D. Broton, R. Campbell et al., "Comprehensive Discharge Planning and Home Follow-Up of Hospitalized Elders: A Randomized Clinical Trial," *Journal of the American Medical Association*, Feb. 17, 1999 281(7):613–20; E. A. Coleman, C. Parry, S. Chalmers et al., "The Care Transitions Intervention: Results of a Randomized Controlled Trial," *Archives of Internal Medicine*, Sept. 25, 2006 166(17):1822–28.
- <sup>16</sup> In addition to their care transition duties, the VNSNY nurse practitioners maintain a primary care caseload of five homebound VNS Choice members who are unable to visit a primary care physician. This role enables them to maintain their skills and a supervisory relationship with a physician for purposes of professional licensure.
- <sup>17</sup> D. Russell, P. Rosenfeld, S. Ames et al., "Using Technology to Enhance the Quality of Home Health Care: Three Case Studies of Health Information Technology Initiatives at the Visiting Nurse Service of New York," *Journal for Healthcare Quality*, Sept.–Oct. 2010 32(5):22–29.
- <sup>18</sup> S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, April 2, 2009 360(14):1418–28.
- <sup>19</sup> IPRO, *Managed Long-Term Care Plan Member Satisfaction Survey Report* (Lake Success, N.Y.: IPRO, Sept. 2011).
- <sup>20</sup> J. B. Engelhardt, K. P. McClive-Reed, R. W. Toseland et al., "Effects of a Program for Coordinated Care of Advance Illness on Patients, Surrogates, and Healthcare Costs: A Randomized Trial," *American Journal of Managed Care*, Feb. 2006 12(2):93–100.
- <sup>21</sup> T. A. Rummans, M. M. Clark, J. A. Sloan et al., "Impacting Quality of Life for Patients with Advanced Cancer with a Structured Multidisciplinary Intervention: A Randomized Controlled Trial," *Journal of Clinical Oncology*, Feb. 1, 2006 24(4):635–42.
- <sup>22</sup> Medicare Plan Finder website, [https://www.cms.gov/PrescriptionDrugCovGenIn/06\\_Performance-Data.asp](https://www.cms.gov/PrescriptionDrugCovGenIn/06_Performance-Data.asp).
- <sup>23</sup> C. Aguiar and C. Zarabozo, "Medicare Advantage Special Needs Plans," staff presentation to the Medicare Payment Advisory Commission (Washington, D.C.: MedPAC, Oct. 2012).
- <sup>24</sup> LeadingAgeNewYork, *Managed Care: the Current Landscape*, New York Association of Homes and Services for the Aging, May 26, 2011, Teleconference, [http://resources.leadingagency.org/nyahsa\\_org/policy\\_communications/managed\\_care/n00005134.pdf](http://resources.leadingagency.org/nyahsa_org/policy_communications/managed_care/n00005134.pdf).
- <sup>25</sup> N. R. Shah, *Managed Long-Term Care Mandatory Enrollment: Report to the Governor and Legislature* (Albany, N.Y.: New York State Department of Health, Sept. 2012).
- <sup>26</sup> U.S. Department of Health and Human Services, *Medicaid Cost-Savings Opportunities* (Washington, D.C.: HHS, Feb. 3, 2011), <http://www.hhs.gov/news/press/2011pres/02/20110203tech.html>.
- <sup>27</sup> K. E. Thorpe, *Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles* (Washington, D.C.: America's Health Insurance Plans, Sept. 2011), <http://www.ahipcoverage.com/wp-content/uploads/2011/09/Dual-Eligible-Study-September-2011.pdf>.

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