

PRIDE PLAN PROFILE

CareSource

Supporting transitions from institutional to community-based care.

CareSource, Ohio's largest Medicaid plan, has served complex populations for 25 years. In addition to its commitment to serving vulnerable populations, it is also deeply committed to partnering with providers and consumer groups to implement innovative care models that enhance current practices and delivery systems.

CareSource participates in MyCare Ohio, the Financial Alignment Initiative demonstration in Ohio. Through MyCare Ohio, CareSource's Medicare-Medicaid Plan (MMP) delivers a full spectrum of physical and behavioral health care and long-term services and supports – all within a single, fully integrated benefits package. CareSource is also the largest MMP in the state.

Quick Facts: CareSource

- **Tax status:** Not-for-profit
- **Integration model:**¹ MMP
- **MMP enrollment:** 18,694
- **Service area:** Northeast; East central; and Northeast central Ohio

Delivery System Partners: University Hospital and Direction Home

CareSource is working with several hospital systems and Area Agencies on Aging (AAAs) to restructure its care management practices to support the rebalancing of long-term services and supports from institutional to home- and community-based settings. CareSource launched this effort with the Cleveland-area University Hospital and Direction Home, an AAA in the Akron-Canton area, and it plans to expand this model to other hospital systems and AAAs. Under the MyCare Ohio demonstration structure, AAAs are delegated by MMPs to conduct case management for enrollees age 60 and over who receive Medicaid waiver services.

Partnership Focus

CareSource is deploying a multi-phase care management model to: (1) identify individuals in nursing facilities who are able to transition to the community; (2) decrease members' length of stay in nursing facilities; and (3) ensure members have services in the community to support their discharge home.

Description of the Planned Project

The components of this effort, all tied to reorganizing CareSource's care management approach to achieve the goals of reducing nursing facility length of stay and supporting transitions to the community, include:

PRIDE Promoting Integrated Care for Dual Eligibles

The *Promoting Integrated Care for Dual Eligible (PRIDE)* initiative, supported by The Commonwealth Fund and led by the Center for Health Care Strategies, is a learning collaborative of nine leading health plans to advance promising approaches to integrating Medicare and Medicaid services for dually eligible individuals.

This profile series highlights the leading-edge plans participating in *PRIDE* and how they are working with delivery system partners on specific initiatives to advance innovative care management practices for dually eligible populations.

- **Restructuring and redeploying its care manager work force.** CareSource has geographically redistributed its CareSource-employed care managers who visit nursing facilities to cover fewer facilities and limit travel time. In some cases, CareSource has also reduced care managers' caseloads so that they can devote more time to high-need individuals. It is also designing new workflow processes to coordinate communication between plan-employed and AAA care managers through a "primary, secondary, and consultative" care manager structure that is tailored to each members' type of stay and care needs. Lastly, CareSource launched a new pilot to assign a select team of care managers to focus only on coordinating services for residents who are transitioning to the community. The initial phase of the pilot has begun in Lorain County.
- **Developing a discharge readiness planning tool.** To help care managers identify individuals who no longer need skilled nursing care, CareSource is using a discharge readiness tool. The "six click" Activity Measure for Post Acute Care (AM-PAC™) tool has questions about mobility, individuals' readiness and willingness to return home, and potential barriers with leaving the facility. Once an individual is identified, AAA care managers will use this information to ensure there are sufficient waiver services in place to support the transition. CareSource is tracking this information to support transition plan development and its own analysis to help identify factors that support or create barriers for successful transitions home.
- **Coordinating with University Hospital's new program to embed advance practice nurses (APNs) in its skilled nursing facilities.** University Hospital recently hired 15 APNs to support clinical and care management activities in its post-acute care facilities. CareSource and University Hospital are developing a formal agreement to improve coordination between APNs and CareSource care management staff, focusing on assisting with discharge plans for individuals identified through AM-PAC™ who are ready to transition home. APNs will also provide clinical services to "treat in place" residents who develop conditions that might otherwise result in a hospital admission.

CareSource will use process measures to assess initial partnership progress, including: (1) establishment of formal agreements to codify relationships and coordinate between care managers, APNs, and others serving its nursing facility population; (2) deployment of AM-PAC™ to all eligible members; and (3) tracking of supports provided to individuals transitioning out of nursing facilities and any barriers they faced during and following the transition. CareSource plans to measure outcomes, including nursing facility length of stay and readmissions as well as inpatient admissions.

To advance this project, CareSource plans to: (1) execute performance-based contracts with AAAs to incentivize the outcome measures listed above; and (2) analyze the impact of program components, including enhanced coordination between care management staff and APNs, and the designation of care managers to focus solely on nursing facility residents' transitions to the community. In addition, CareSource hopes to address a challenge with project implementation, which is securing housing for individuals who want to return home, particularly if they lost their housing during their stay or if their housing situation is no longer suitable for their needs. CareSource will work with resources such as Home Choice – Ohio's Money Follow the Person program – and other community resources that may be available to assist its members in safely transitioning to the community. As the pilot matures, CareSource will seek ways to incorporate the CareSource Life services program, which provides a pathway for plan members to access food, employment, and housing.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

¹ Managed care plans can be used to promote the integration of care for dually eligible beneficiaries. The Medicaid-Medicare Plans (MMPs) operating under the Financial Alignment Initiative demonstrations are highly integrated models that combine Medicare and Medicaid services, administrative functions, and financing. Dual Eligible Special Needs Plans (D-SNPs) are specialized Medicare Advantage plans that must contract with the Medicaid agency in the states in which they operate, and seek to provide enrollees with a coordinated Medicare and Medicaid benefit package. When D-SNPs are aligned with Medicaid managed long-term services and support (MLTSS) plans, they can attain a higher degree of integration than D-SNPs operating alone. Fully Integrated D-SNPs (FIDE SNPs) are a type of D-SNP created to promote the full integration and coordination of Medicare and Medicaid benefits — primary and acute care and LTSS — and financing of services, for dually eligible beneficiaries.
