CHCS Center for Health Care Strategies, Inc.

PRIDE PLAN PROFILE

Independent Care (*i*Care) Health Plan Health Plan

Reducing preventable hospital admissions.

Independent Care Health Plan (*i*Care) serves older adults and people with disabilities in southeastern Wisconsin. The plan was formed in 1994 through a partnership between Humana, a managed care organization operating nationwide, and the Centers for Independence, a locally based social service organization serving people with special needs (from children to older adults) and their families. *i*Care has several Dual Eligible Special Needs Plans (D-SNPs), including a Fully Integrated D-SNP (FIDE SNP) that provides all Medicare and Medicaid services through Wisconsin's FamilyCare Partnership program. *i*Care recently launched co-branded, closed panel D-SNPs — Aurora Complete Care and Lakeland Care + Health — with two large providers.

Quick Facts: *i*Care

- **Tax status:** For-profit
- **Integration model:**[1] FIDE SNP, D-SNP
- **FIDE SNP enrollment:** 628
- **D-SNP enrollment:** 7,834
- **Service area:** Eastern, South central and Western Wisconsin

Delivery System Partner: Aurora Health Care

For its project, *i*Care will be working with Aurora Health Care, Wisconsin's largest delivery system and largest employer. Aurora provides nearly all the Medicare and Medicaid inpatient, outpatient, ancillary, and pharmacy services covered in *i*Care's health plans. In 2017, *i*Care and Aurora launched the Aurora Complete Care D-SNP, formed around a comprehensive, closed-panel network of Aurora providers that provides highly integrated care for its enrollees.

Partnership Focus

*i*Care's partnership with Aurora is testing a follow-to-home care management program that focuses on reducing preventable hospital readmissions, specifically targeting individuals who are at high-risk for readmission.

Description of the Planned Project

*i*Care recently redesigned its care management model to focus on reducing preventable hospital readmissions. The model includes a follow-to-home program, under which eligible members receive in-home visits from a care manager for 90 days after hospital discharge. The follow-to-home program has several important components:

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.

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- **A predictive modeling tool** that assesses individuals' risk of readmission post-discharge from an Aurora inpatient or post-acute care unit. Individuals who meet risk criteria, nearly 30 percent of patients thus far, receive a referral for the follow-to-home program.
- **An assigned care manager** who conducts a comprehensive home assessment, makes referrals to primary care or other physicians as needed, performs a medication review, and identifies additional supports that individuals and, as appropriate, their caregivers need to keep the member out of the hospital. Serving as the "eyes and ears at home," care mangers can also monitor the provision of any additional skilled care, such as wound care and medication management.
- **Financial incentives for high-quality care** in which home health agencies receive a flat fee for conducting an environmental assessment, and may receive additional payments if the member stays out of the hospital for 30, 60, and 90 days. These payments are risk-adjusted based on an individual's clinical profile.
- **Frequent communication** between care managers, primary care physicians, and *i*Care care management staff.

The plan is implementing the follow-to-home program across all its D-SNPs, but its partnership with Aurora allows it to test the effectiveness of the program in a controlled environment. Specifically, members who use Aurora providers generally stay within the same network for all covered services. Aurora providers refer to each other and work to provide all care and services within the Aurora system, providing a good platform to test the follow-to-home model because it is less prone to factors (e.g., dueling prescribers, unmanaged medications, overlapping care plans, PCP/specialist fragmentation, separate records among behavioral health and physical medicine providers, lost prescriptions) that can lead to readmissions. Aurora is also *i*Care's only provider with its own pharmacy chain, which allows the plan to review medication use in a very systematic way. Lastly, Aurora's contractual relationship with *i*Care builds in incentives and penalties around the HEDIS all cause readmission measure.

The primary measure of the project's success is reduction of preventable hospital readmissions based on the HEDIS/5-Star all-cause readmission rate. *i*Care anticipates that this project could also improve measures related to assessment timeliness, primary care appointment scheduling, medication reconciliation, and home health agency follow-up. In addition, to advance its organization-wide goal of reducing preventable hospital readmissions, *i*Care has or will soon launch additional programs for at-risk members, including:

- A follow-to-home program for individuals discharged from Aurora's inpatient psychiatric division to improve access to community-based resources;
- A targeted intervention for homeless members to provide temporary housing and community supports post- discharge; and
- An IET (or Initiation and Engagement of Alcohol and other Drug Dependence Treatment) effort to provide access to recovery and other supports for members identified as needing those services while in the emergency department or on admission to the hospital.

[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 Medicare benefits — primary and acute care and LTSS — and financing of services, for dually eligible beneficiaries.