D-SNP / AAA Care Coordination

New D-SNPs in 2022

Division of Aging and Indiana Medicaid, Indiana FSSA

October 2021

Agenda

1. Introductions and Review Agenda (10 min)
2. D-SNP Learnings and AAA Learnings (10 min)
3. D-SNP/AAA Care Coordination Workgroup Purpose (5 min)
4. Care Coordination for A&D Waiver Participants (15 min)
    a) D-SNP/AAA Care Coordination Process and Metrics
    b) Updates/Progress to Date
5. D-SNP Proactive Referrals to AAAs (5 min)
    a) Non-Waiver D-SNP Members with SNF Admission
    b) Referral Process and Metrics
6. D-SNP MOC: Care Coordination/Care Transitions (10 min)
7. Next Steps (5 min)

D-SNP Learnings

Division of Aging, Indiana FSSA

- Division of Aging programs include:
  - Aged & Disabled (A&D) Waiver
  - CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled)
  - Money Follows the Person (MFP) Demonstration
  - Older Americans Act Title III Support Services
  - Social Services Block Grant (SSBG)
  - Adult Protective Services
  - Adult Guardianship
  - LTC Ombudsman
- Most services accessed via Aging Network, or Indiana's 15 **Area Agencies on Aging (AAAs)** covering 16 Planning & Service Areas – see map.

Services Available under the A&D Waiver Program

- **Care Management**
- **Attendant Care**
- Home & Community Assistance
- **Home-Delivered Meals**
- Home Modifications
- Pest Control
- **Personal Emergency Response System**
- Vehicle Modification
- Non-Medical Transportation
- Home Health Aide/Nurse
- Healthcare Coordination
- Respite Care
- Structured Family Caregiving
- Adult Family Care
- Adult Day Services
- Assisted Living

Who Benefits Most from Care Coordination?

Older Person with Chronic Diseases and Functional Limitations

- Multiple chronic illnesses: HTN, CHF, and DM
- Multiple medications: Rx, OTC, herbs and vitamins
- Geriatric conditions: dementia, falls, and ADLs
- Family and caregiver support needs
- Medicaid home & community-based services
- Primary and specialty care physicians
- Limited geriatrics expertise of healthcare providers
- Poor communication and coordination of care

AAA Transitions Project

ACL Grant: No Cost Extension – Year 3

Hospital-to-Home Transitions in Waiver Participants

Typical Scenario

- Hospital admitted and discharged
- Hospital staff not aware of AAA involvement with patient
- 1 of 5 readmitted within 30-days
- AAA Care Manager finds out 2 months later

Ideal

- AAA notified of hospital admission
- AAA Care Manager coordinated transition with hospital staff
- Discharged home with AAA Care Manager follow-up
- Readmission avoided

ACL Results

- AIHS (Area 3) Transition Coaches
  - Parkview Regional Medical Center
  - Parkview Hospital Randalia
- 6 Month Pilot (July 2019 – December 2019)
- 83 discharges involving 66 waiver participants
- 69% aged 65 or older; 66% women

- **43% reduction in 30-day readmission rate**
  - 9.6% AAA transition group (8 of 83)
  - 16.8% comparison group (95 of 564)*

**Comparison Group: All other hospital discharges to home of Allen County waiver participants over the same time period*

AAA Learnings

Who are Dual Eligibles?

- 12 million Americans:
  - 48% minority race/ethnic group
  - Mix of chronic illnesses, behavioral health conditions, disabilities, and functional limitations
  - Social and financial challenges
  - High utilization/costs
- Medicare due to age or disability; covers acute and post-acute care, primary and specialty care, medications
- Medicaid due to low income and assets; covers BH services and LTSS (institutional and HCBS)
- Two distinct insurance programs; typically fragmented and poorly coordinated care

What is a D-SNP?

- Traditional (or Original) Medicare - Part A/B/D
  - Acute and post-acute services, primary and specialty care, and drug coverage
- Medicare Advantage (MA) – Part C (includes A/B/D)
  - Medicare approved private companies/health plans
- MA Special Needs Plan (SNP)
  - MA coordinated care plan designed to limit enrollment to special needs individuals:
    - Institutional (I-SNP) or Institutional Equivalent (IE-SNP)
    - Chronic Condition (C-SNP)
    - **Dual Eligible (D-SNP)**

What is D-SNP Model of Care?

- SNPs Model of Care (MOC) is the plan for delivering coordinated care and care management to members
- SNP Model of Care Elements:
  - **Description of the SNP Population**
  - **Care Coordination**
    - **SNP Staff Structure**
    - **Health Risk Assessment Tool**
    - **Individualized Care Plan**
    - **Interdisciplinary Care Team**
    - **Care Transitions Protocol**
  - SNP Provider Network
  - Quality Measurement & Performance Improvement
- *Key Point: Medicare D-SNP drives care coordination and care management for members (vs. Medicaid plan)*

D-SNP Information Sharing

- New CMS rule for D-SNPs effective January 2021
- Goal: To ensure timely initiation of Medicaid care management in care transitions to lower readmission rates and help return individuals to the community
- D-SNPs are required to notify the state Medicaid agency (or the state's designee) of hospital and SNF admissions of at least one group of high-risk individuals enrolled in the D-SNP
- High Risk Group: Aged and Disabled (A&D) Waiver participants
  - 26,000 (21,000 DE and 5,000 Medicaid only)
  - 5,000 enrolled in D-SNPs (Anthem, Humana, and United Healthcare)

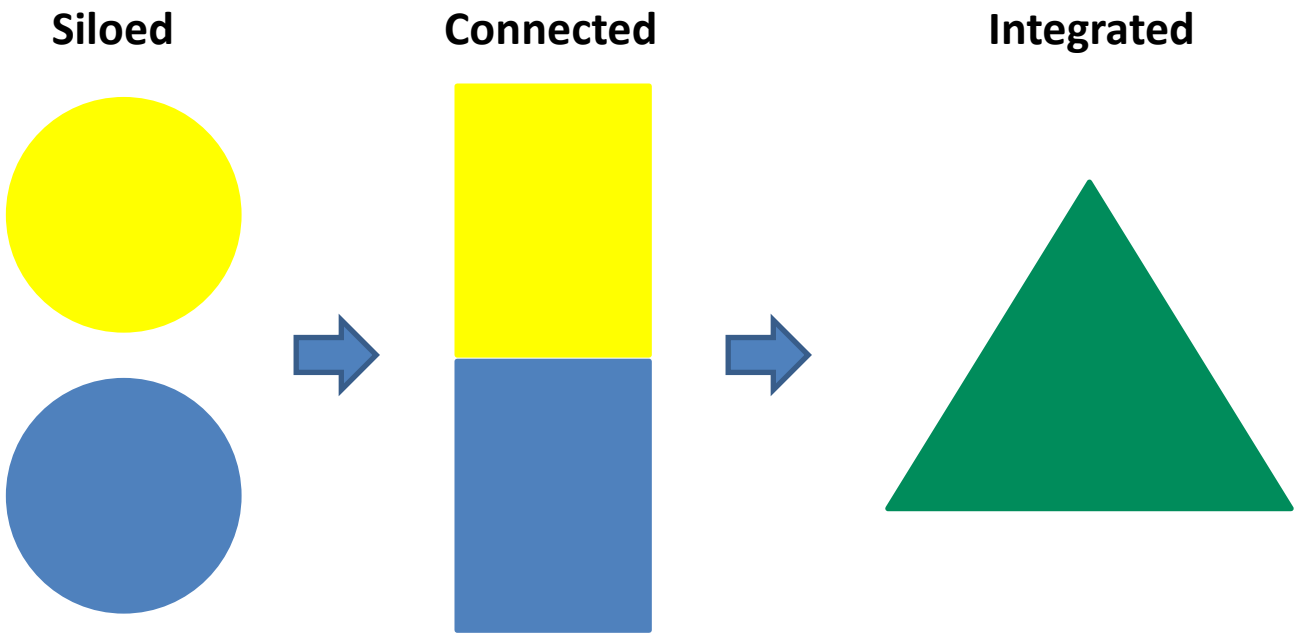
Indiana Medicaid/DA Planning

- D-SNP information into CaMSS; D-SNP record created
  - Member Medicaid RID and phone
  - Health plan care manager, email, and phone
  - Care support person, email, and phone
  - Primary care provider and phone
  - Admit date, facility, admitting diagnosis, other diagnoses
  - Days pre-authorized by D-SNP
  - Discharge date, discharge diagnosis, other diagnoses, and disposition (including if discharged to home living alone)
  - Utilization past 12 months: ED, hospital, SNF
- Waiver Service Coordinator receives email notification on admission (and again at discharge) for each D-SNP record; and initiates care coordination

D-SNP/AAA Care Coordination Workgroup

D-SNP / AAA
Care Coordination Workgroup

Purpose: To increase care coordination for A&D waiver participants between their D-SNP Interdisciplinary Care Team and AAA Waiver Service Coordinator to improve health outcomes.



Waiver Service Coordinator Procedure

Hospital-to-Home Transition

Hospital Admission

1. New D-SNP record created in CaMSS; email notification to WSC
2. WSC to start coordinating care within one (1) business day
3. Provide hospital staff with current in-home services
4. Discuss with hospital staff service needs for return home
5. Exchange contact information with hospital staff
6. Contact participant/designated representative and/or caregiver

Hospital Discharge

7. D-SNP record shows discharge; email notification to WSC
8. WSC to contact participant/designated representative and/or caregiver within one (1) business day

Waiver Service Coordinator Procedure

Hospital-to-Home Transition

Hospital Discharge (continued)

9. Assess health, functional, nutritional, and social support status
10. Assess caregiver well-being; complete caregiver assessment tool
11. Ensure in-home waiver services and supports have resumed
12. Determine changes to goals of care, functioning or support needs; adjust service plan as appropriate
13. Identify medication discrepancies needing physician clarification
14. Ensure availability of transportation to upcoming appointments
15. WSC contacts D-SNP Point Person
16. D-SNP Point Person connects WSC with D-SNP care manager for ongoing care coordination

Care Coordination Templates

D-SNP Care Manager (CM)

Information to Send to Waiver Service Coordinator

1. CM name & contact information
2. Plan benefits/services currently provided/authorized to D-SNP member including Medicare supplemental benefits
3. Reason for admission
4. New diagnoses
5. Medication changes
6. Diagnosis of dementia if known
7. Advance directives

Waiver Service Coordinator (SC)

Information to Send to D-SNP Care Manager

1. SC name & contact information
2. Waiver services currently provided/authorized to waiver participant
3. Caregiver information
4. New functional, nutritional, or social support needs
5. Medication changes
6. Diagnosis of dementia if known
7. Advance directives

Metrics

1. Process Measures – Phase I (Division of Aging/AAAs)
   a) Hospital/SNF Admit Date vs D-SNP Record Created Date
   b) D-SNP Record Created Date vs Start of Care Coordination Date
2. Process Measures – Phase II (D-SNPs)
   a) Admit Date vs Email to D-SNP Point Person Date
   b) Email to D-SNP Point Person Date vs D-SNP Email Response Date
3. Outcome Measures (Indiana Medicaid)
   a) Hospital Discharges to Home: Hospital 30-day Readmission Rate
   b) SNF Admissions: SNF 30-day Discharge back to HCBS Rate

Updates/Progress to Date

1. Reconciliation of Waiver Participants / D-SNP Members
2. D-SNP Information Sharing Completeness
3. CaMSS Email Notifications to Waiver Service Coordinators
4. Waiver Service Coordinator Procedure & Success Stories
5. D-SNP Point Person Contacts and Care Coordination
6. AAA and D-SNP Metrics
7. D-SNP/AAA Information Repository

DRAFT
(Version 3)

D-SNP Proactive Referrals to AAAs

Non-Waiver D-SNP Member with SNF Admission

1. D-SNP identifies non-waiver D-SNP member admitted to SNF
2. D-SNP flags member's record for outreach by care manager
3. Care Manager outreach to member or designated representative
   - D-SNP Care Manager offers to make referral to AAA Options Counselor for information on in-home supports and help with SNF discharge planning
4. Care Manager completes member's local AAA online referral form via INconnect Alliance website: https://www.in.gov/fssa/inconnectalliance/
5. Care Manager discusses referral with local AAA Referral Liaison
6. AAA contacts D-SNP member for options counseling
7. AAA contacts SNF social worker for SNF discharge planning
8. AAA follows up with D-SNP Care Manager for care coordination

Proposed Initial Metrics

a) D-SNP: # non-waiver members admitted to SNF; # (%) contacted

b) AAA: # D-SNP referrals received; # (%) contacted

Next Steps

Next Steps

- **Ongoing collaboration and process improvement:**

1. Twice monthly meetings: 1st & 3rd Wednesdays (2-3PM)
   - Wednesday, November 3 (2-3PM)
   - ~~Wednesday, November 17 (2-3PM)~~
2. Provide D-SNP Primary Contact Person for AAAs
   - Name, Email, and Phone
3. Provide D-SNP Documents
   - Summary of Benefits
   - Evidence of Coverage