

**Pennsylvania Department of Aging,
Office of Long-Term Living**

Integrated Care Option (ICO)

Program Design Overview

Updated 12/19/09

This Program Design Overview summarizes what ICO will offer and how it will work. It has been updated as decisions have been made about ICO. Interested persons may check the ICO website to see if additional updates have been issued, and to find other information about ICO:

www.dpw.state.pa.us/about/otl/snp

Contents

1. Program Overview	4
2. Program Goals and Objectives.....	4
3. Core Consumer Principles	7
4. Target Group.....	8
5. Benefits.....	11
6. Enrolling in ICO	13
7. ICO Relationship to Existing Programs	15
8. Service Delivery	17
9. Care Management.....	19
10. Quality Monitoring and Improvement.....	19
11. Consumer Protections.....	21
12. Payments	23
Appendix A: Summary of Findings from Other States.....	26
Appendix B: Quality Requirements	29
Appendix C: Integrated Care Option Member Rights and Responsibilities.....	32
Glossary of Terms Used in this Document	35

1. Program Overview

The Department of Aging, Office of Long-Term Living (OLTL) is developing a new Integrated Care Option (ICO) for Pennsylvanians who are 60 and older and have both Medicare and Medicaid (“dual eligibles”).

This new, voluntary option will combine Medicare and Medicaid into one package, offering a single, seamless and comprehensive source of health care and long-term services and supports.

ICO will be offered through Medicare Advantage Special Needs Plans (SNPs), working in partnership with Area Agencies on Aging (AAAs). Phase 1 of the program begins on January 1, 2011, in six southwestern counties, with plans to expand the option to other parts of the Commonwealth in future years. Phase 1 counties are Allegheny, Beaver, Fayette, Greene, Washington and Westmoreland.

2. Program Goals and Objectives

The Department of Aging, OLTL, is developing multiple strategies to give Pennsylvanians more choices when they need long-term services and supports. Too often, friends and family members end up in nursing homes when they could be supported in their homes or in less intensive places.

ICO will be one of a growing set of options offered to Pennsylvanians. ICO is designed especially for dual eligibles, those who have both Medicare and Medicaid.

Integrated Care Option Goals

ICO has two primary goals. They are to:

- A. Improve the quality and efficiency of medical and long-term living services and supports for dually eligible beneficiaries; and*
- B. Fully integrate Medicare and Medicaid benefits in a coordinated care delivery system focused on the specialized needs of dual eligibles.*

Medicare is administered by the federal government. It is the primary, or first payer, but it does not cover everything. It covers doctors, many types of specialists, hospitals, lab tests, prescription drugs and limited home health care services. Following a hospital stay of 3 or more days, it also

covers up to 100 days in a skilled nursing facility for rehabilitation purposes. For most of these services, a Medicare beneficiary is usually responsible for paying a portion of the cost.

Medicare does not cover long-term living services and supports, such as chore and personal assistance services in the home, adult day center services, or long-term stays in nursing homes. Medicaid does cover these services for dual eligibles. Medicaid pays for long-term living services at home, in alternative community settings, and in nursing homes. Medicaid also pays for an array of other services not covered by Medicare. For dual eligibles, Medicaid also covers the portion of Medicare costs that would otherwise fall to the beneficiary.

Together, these two programs (Medicare and Medicaid) cover a comprehensive range of primary, acute and long-term service and support needs of dual eligibles, but they are not well coordinated. They offer different, sometimes conflicting incentives to providers and health plans. Medicare is run by the federal government, and Medicaid is run by the Commonwealth. Neither program is responsible for all of a person's health and long-term service needs, creating confusion and coordination problems for older persons and their families. Common consumer problems include:

- Receiving bills from Medicare providers that instead should have been submitted to Medicaid;
- Finding that some Medicare providers do not accept Medicaid coverage; and
- Finding that Medicare-reimbursed physicians are not familiar with or do not have the time to arrange for Medicaid-reimbursed community services and supports.

ICO is designed to make these two programs work together as if they were one program by giving participating SNPs responsibility for the full range of Medicare and Medicaid services, and holding them accountable for achieving better consumer outcomes.

Integrated Care Option Objectives

By combining Medicare and Medicaid into one, easy to use package, the Commonwealth wishes to achieve the following objectives.

- i. Improve consumer health outcomes: create proactive and preventive incentives to avoid hospitalizations, nursing home admissions and deterioration of chronic disease.*

- ICO will make participating SNPs responsible for nearly all health and long-term services, and will provide incentives for the plans to keep people healthy.
- ii. Improve coordination of services.*
Consumers who need both Medicare and Medicaid services will benefit from care coordinators who will help them put together a comprehensive plan for their services, and help arrange for those services.
 - iii. Improve scope of benefits available through SNPs.*
ICO will give consumers an option for receiving a very broad scope of Medicare and Medicaid services through a single plan.
 - iv. Encourage home and community-based services (HCBS).*
ICO provides participating SNPs with incentives to keep members out of nursing homes and in the settings of their choice by providing community-based alternatives. SNPs will partner with Area Agencies on Aging to ensure good access to community services expertise.
 - v. Rebalance the long-term care system.*
In other states, programs like ICO have reduced the use of nursing homes and increased the use of community-based alternatives.
 - vi. Eliminate balance billing.*
In ICO, the SNP will be responsible for working with providers to avoid balance billing, and to address it when it does occur.
 - vii. Improve value for consumers, the Commonwealth and the federal government.*
In ICO, the Commonwealth seeks to increase the effectiveness of services without spending any more money. By making Medicare and Medicaid work better together, consumers, families and taxpayers should all achieve better value for the dollars spent.

Research about programs similar to ICO in other states has been promising. In Massachusetts, Wisconsin, Minnesota and elsewhere, programs have been found to reduce the use of institutional services and increase community-based services. Findings from other states are summarized in Appendix A.

3. Core Consumer Principles

ICO will be centered on the needs and preferences of consumers. The following set of consumer principles, developed in the planning phase of ICO, will guide implementation.

Core Principles for Consumers of Integrated Care in Pennsylvania

1. **Consumer Input.** The consumer's voice will be heard in ICO development, implementation and continuous improvement by:
 - Including consumers in planning and implementation activities;
 - Requiring ICO plans to have regular consumer feedback sessions; and
 - Including consumer perspectives in independent program evaluation.
2. **Holistic and Consumer Centered.** ICO focuses on the consumer and the consumer's individual situation, preferences and health and functional status. ICO plans work with consumers and/or their representatives as partners in developing comprehensive, individualized service plans and in selecting options.
3. **Self-Direction.** Consumers or their representatives should have the opportunity to self-direct personal assistance services and to purchase allowable goods and services. Fiscal management support would be provided for consumers who choose this option.
4. **Independent Living.** ICO promotes independent living with appropriate social and health supports by assuring, to the greatest extent possible, home and community living options are pursued and utilized over institutional options. The nature and delivery of services facilitates and enables aging in place in the setting of the enrollee's choice.
5. **Long-Term Living Competency.** ICO networks include knowledgeable community organizations and providers to ensure competent planning and delivery of long-term services and supports. ICO plans ensure that long-term living experts, health experts and consumers work together to integrate long-term services and supports with health services.
6. **Accessibility.** The integrated care system, its staff, providers and

Core Principles for Consumers of Integrated Care in Pennsylvania

other partnering organizations are accessible to persons with disabilities as well as those with low literacy or Limited English Proficiency. Accessibility includes adequate numbers of appropriately trained staff in all service settings; physical accessibility of service sites; accessible formatting of written information; and availability of equipment needed by consumers to access sites and receive services appropriately and safely.

7. ***Appropriate Financial Incentives.*** Payments to participating SNPs provide incentives to expand high quality, cost-effective, community based support services and reduce inappropriate use of institutional care. Payments also guard against excess profits or unsustainable losses.
8. ***Consumer Advocate.*** ICO members will have access to and support from the independent ICO Consumer Advocate, who will be available to provide advice, information, referral or direct assistance to members.

4. Target Group

The target group for this program is older persons (60 or older) who have both Medicaid and Medicare (dual eligibles). To join the program when Phase 1 begins in January, 2011, a person must:

- Be at least 60 years of age;
- Be eligible to receive Medicaid services. This includes people who are entitled to full Medicaid benefits and those for whom Medicaid only pays all or some of their Medicare cost-sharing (such as premiums, deductibles and coinsurance); and
- Be eligible for and willing to join a participating Medicare Advantage SNP in a Phase 1 county: Allegheny, Beaver, Fayette, Greene, Washington and Westmoreland. (In order to join a Medicare Advantage Plan, a beneficiary must have both Medicare Part A and B.)

Type of Residence

If they meet all of the criteria above and choose to enroll, persons in nursing facilities are eligible, as are persons residing in other community-based long-term living facilities.

The program is not currently designed to serve people in certain settings. Persons living in State Mental Retardation Centers, Intermediate Care Facilities for Persons with Mental Retardation, Intermediate Care Facilities for Other Related Conditions, State Mental Hospitals and Drug and Alcohol Treatment facilities are not eligible. Also ineligible are persons living in Veterans' Homes.

Waiver Participation

If they meet eligibility criteria and choose to enroll, persons participating in existing waiver programs may apply. However, because ICO will have its own waiver services built into it, a person in an existing waiver program will have to disenroll from that program and enroll in the ICO HCBS Waiver. This is explained in more detail below in Section 7: *ICO Relationship to Existing Programs*.

Geographic Location

In Phase 1, (beginning January, 2011) ICO will be available in the six southwestern counties shown in Figure 1. SNPs operating in these 6 counties that have expressed interest in ICO to date are:

- Bravo;
- Gateway;
- Highmark/Keystone Health Plan West;
- Unison/United Health Care; and
- UPMC.¹

In future phases, ICO could be offered in any county where eligible SNPs operate. At least one eligible SNP operates currently in most Pennsylvania counties.

¹ This list is subject to change and does not guarantee participation by these plans.

Figure 1. ICO Phase 1 Counties (shaded).



5. Benefits

SNPs are already responsible for providing all Medicare services to their members, including Medicare Parts A, B and D. In ICO, the State Medicaid program will pay participating SNPs to also provide nearly all Medicaid services, making the ICO Plans responsible and accountable for the full range of primary, acute and long-term services and supports. The table below summarizes what ICO will include.

Integrated Care Option includes:	
All Medicare Services	Nearly All Medicaid Services
<ul style="list-style-type: none"> • Hospital and other Part A services; • Physician and other Part B services; and • Part D Prescription Drugs • Extra services offered by the Medicare plan but not normally included in traditional Medicare. 	<ul style="list-style-type: none"> • Long-term living services, including home and community-based supports, and nursing facility services; • Waiver services comparable to the Aging 60+ Waiver; • Prescription Drugs not covered by Medicare; • Vision services; • Dental services; • Durable Medical Equipment; • Therapies and diagnostics; • Medicare cost sharing (premiums, deductibles and coinsurance); and • Any other Medicaid services not specifically excluded.
<p>For more on Medicare coverage, see <i>Medicare and You, 2009</i>, available on line at: http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf</p>	<p>For more details on Medicaid services in ICO, see <i>How Medicaid Benefits Will be Treated in the Integrated Care Option</i> at: http://www.dpw.state.pa.us/about/oltil/snp/default.htm</p>

What Medicaid services will remain separate from ICO?

At least for the first year, the following services will not be included in ICO:

- 1) *Medicaid-funded behavioral health services.* Most Medicaid-funded behavioral health services will continue to be provided separately from the ICO program. All dual eligibles in the Phase 1 counties receive their Medicaid behavioral health services from the HealthChoices Behavioral Health program, and more planning time

is needed to explore how best to incorporate those services for ICO members. ICO plans will provide behavioral health services covered by Medicare and by the ICO HCBS Waiver. They will work to coordinate these behavioral health services with those provided through HealthChoices.

- 2) *Funeral director services.* Consumers will still have access to these services but they will be provided outside the regular ICO network.
- 3) *Non-emergency Medical transportation.* The Medical Assistance Transportation Program will continue to provide coverage of non-emergency medical transportation. ICO Plans will be responsible for covering emergency medical transportation. The ICO plan will be responsible for coordinating medical transportation for members that require assistance with coordination. Additionally, ICO plans will be responsible for transportation covered by the ICO HCBS Waiver.

When will long-term services and supports be included in ICO?

Long-term services and supports will be offered through ICO on January 1, 2011, the same date that all other ICO services are offered in the Phase 1 counties.

Without long-term services and supports, there would be little opportunity for ICO plans to integrate Medicaid services. For older dual eligibles, most Medicaid spending is for long-term services and supports. Figure 2 shows that 92% of Medicaid expenditures for older duals was for long-term services in 2007. This is because Medicare pays for doctor visits, hospitalizations and other primary and acute services for dual eligibles.

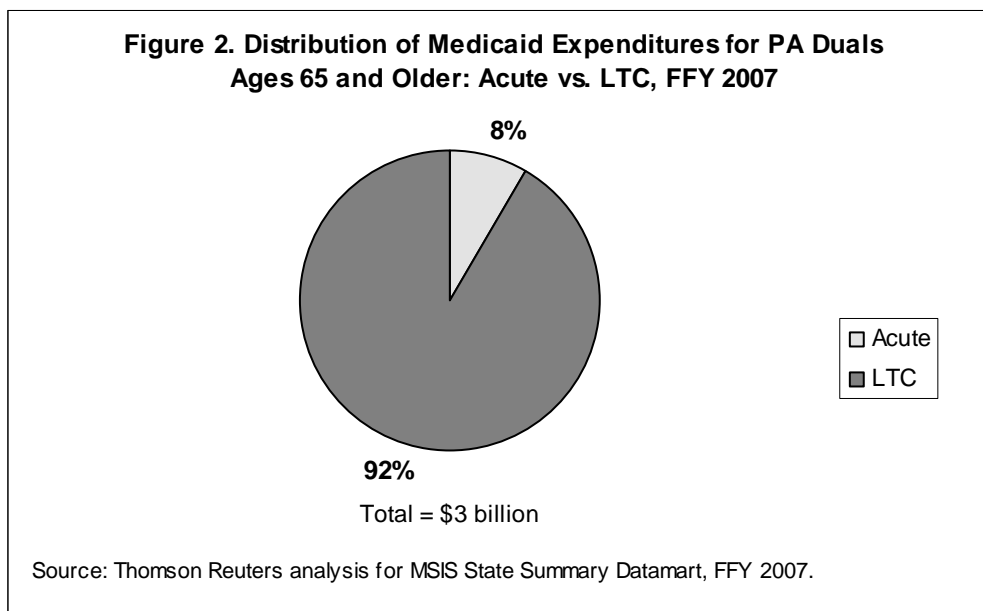
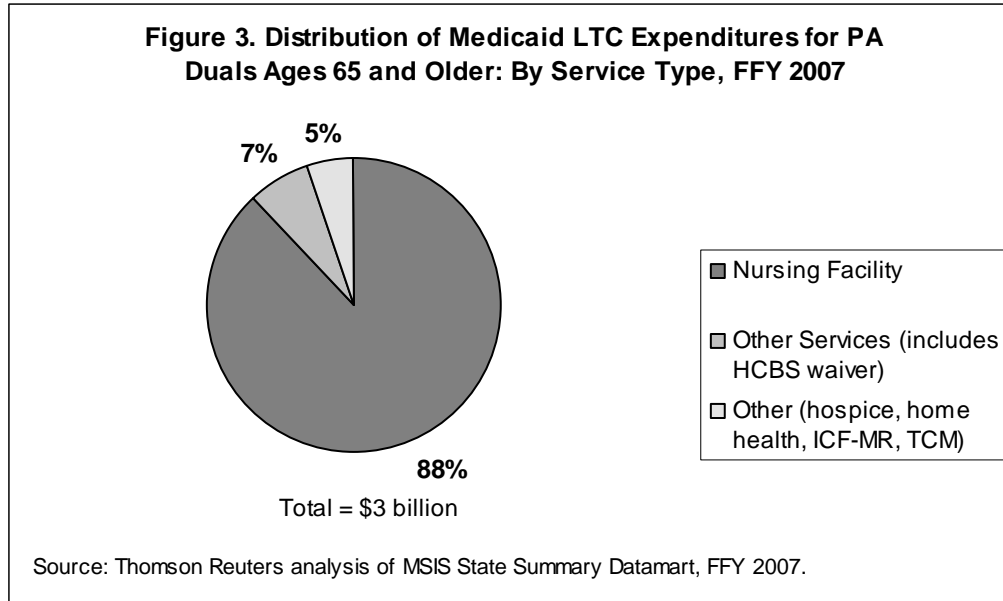


Figure 3 shows that, of the total Medicaid long-term services expenditures for duals 65 and older in 2007, 88% was spent on nursing homes. This represents a key opportunity for the ICO to contribute to rebalancing the State's system for older persons.



6. Enrolling in ICO

ICO will be an additional voluntary option from which dual eligibles who are at least 60 years old may choose. People who are already enrolled in a participating SNP for their Medicare services, and who are not receiving long-term waiver services or nursing facility services will have preference for automatic enrollment when ICO begins in their areas. Others will need to take specific actions in order to enroll. Each situation is explained below.

Preferential Enrollment when ICO Begins

One of the reasons the Commonwealth is partnering with SNPs on ICO is because a large number of dual eligibles already get their Medicare services from these plans, and many have had problems coordinating their separate Medicare and Medicaid benefits. In the six Phase 1 counties, there are about 15,000 dual eligibles who are at least 60 years old and already enrolled in SNPs. Based on feedback received directly from members at statewide listening sessions, the Department believes that eligible SNP members will want to combine their Medicaid services into their existing plans by joining ICO.

To make the ICO enrollment process as simple as possible for existing SNP members, an easy enrollment option (preferential enrollment) will be offered to most participating SNP members when ICO begins in their service areas. In order to qualify for preferential enrollment, a person must:

- Already be getting Medicare from a SNP that is participating in ICO;
- Be eligible for ICO (be 60+ years of age and dual eligible); and
- NOT be using long-term services provided through a waiver or nursing facility.

Those who qualify for preferential enrollment during Phase 1 will be notified by mail 3 times before their enrollment takes effect. They will receive letters at least 90 days, 60 days and 30 days before being enrolled automatically in ICO. Each notice will tell them that they will be enrolled in ICO as of January 1, 2011, but can decide not to enroll if that is their preference. The letters will tell them who to call if they have questions or if they want to opt out.

Those who decide not to enroll will have at least 3 ways to say no: they will be given a toll-free number to call, a business reply mail card to send it, and a secure web site where they can say no electronically.

Enrollment through an Enrollment Broker

All other eligible persons will need to take specific actions if they want to enroll in ICO. Action must be taken to enroll if a person:

- Uses long-term services provided through a waiver or nursing facility; or
- Is not already a member of a participating SNP when ICO first begins in the person's service area.

Action will be taken through an enrollment broker. The enrollment broker will be an organization chosen by the Commonwealth to provide impartial counseling to interested persons about their ICO enrollment and disenrollment options. The enrollment broker will be empowered to act on a person's choice by officially enrolling or disenrolling the person.

People will learn about the program and be referred to an enrollment broker in several possible ways:

- They may receive notices from the Department when ICO is available in their areas;
- They may be told about ICO by a county office when they first become eligible for Medicaid;

- They may be told about ICO by an Area Agency on Aging when they receive a Level of Care Assessment (LOCA) to determine if they qualify for nursing facility-level services;
- They may be told about ICO by their doctors or other providers;
- They may be told about ICO when they choose a Medicare Advantage Plan in the fall of each year.

The Department is working with stakeholders to make sure that people know about ICO, can exercise their options easily, and have continuous care as they move in or out of ICO.

Will anyone be forced to join the program?

No one will be forced to join ICO. It is voluntary for all eligible persons. Those who do join will be able to disenroll on a month-to-month basis to change plans, to return to the services they were receiving previously or to exercise any other options offered for which they are eligible. The enrollment broker will be available through a toll-free number to help people join or leave ICO, and to help people understand their options.

7. ICO Relationship to Existing Programs

Individuals currently enrolled in a HCBS waiver or LIFE will have to terminate their enrollment in order to enroll in ICO. The only waiver available to ICO members is the ICO HCBS waiver, which offers services similar to the Aging 60+ Waiver. An ICO member must be Nursing Facility Clinically Eligible in order to enroll in the ICO HCBS Waiver. The details of how ICO relates to existing programs follow.

What is the relationship to the Aging 60+ Waiver?

The ICO program will include community-based waiver services designed for persons who are at least 60 years old and who are nursing facility clinically eligible (NFCE). ICO HCBS Waiver services will be comparable to those in the existing Aging 60+ Waiver, making smooth transitions possible for those who choose to join ICO from the existing Aging 60+ Waiver. To ensure that services are not interrupted during the transition, ICO Plans will be required to pay for an enrollee's existing Aging 60+ waiver services until such time as they are able to put ICO HCBS Waiver services into place. Also, ICO Plans will be required to offer contracts to existing Aging 60+ service providers, making it likely that the two waiver programs will have the same networks of providers.

What is the relationship to the Attendant Care Waiver?

If they meet eligibility criteria (60+ and dually eligible), persons in the Attendant Care waiver may join ICO. If they do so, they will need to qualify for and be willing to transition to the ICO HCBS Waiver program. If they do make that choice, the same continuity of care requirement as identified in the above discussion about the Aging 60+ Waiver would apply (meaning the ICO Plan will be required to pay for existing attendant care waiver services until such time as they are able to put their own ICO HCBS Waiver services in place). Persons in the Attendant Care Waiver will want to work with the enrollment broker to assess carefully whether or not the ICO HCBS Waiver would meet their care needs and preferences.

What is the relationship to other waiver programs?

The only waiver services available in ICO will be those offered through the ICO HCBS Waiver, a new waiver program being developed exclusively for ICO members. The ICO HCBS Waiver is limited to persons who meet Nursing Facility Clinical Eligibility. Pennsylvania offers several other waiver programs outside of ICO that are specialized to the needs of their target groups. These include the AIDS, COMMCare, Autism, Consolidated, Person and Family Directed Support, OBRA, CSPPPD, and Michael Dallas waivers. Many specialized services included in these waiver programs will not be included in the ICO HCBS Waiver. Therefore, although some participants may otherwise meet eligibility criteria (60+ and dual eligible), their needs and preferences may not be well served through ICO, and they will want to discuss pros and cons with the enrollment broker before joining ICO. Even if they do enroll, they will not be able to access long-term services and supports from ICO if they do not meet NFCE criteria, or if their health and welfare cannot be assured through the ICO HBCS Waiver as required under federal HCBS waiver regulations.

What is the relationship to the LIFE (Living Independently For Elders) Program?

Pennsylvania has developed a number of Program of All-Inclusive Care for the Elderly sites across the Commonwealth, known in Pennsylvania as the LIFE program (Living Independently For Elders). LIFE serves a sub-set of the population that will also be eligible for ICO, those who are nursing facility clinically eligible (NFCE). LIFE will continue to be an option that consumers are offered when they become NFCE. In addition, LIFE programs may develop business relationships with SNPs that could range from being contracted service providers to offering technical assistance.

What is the relationship to the behavioral health system?

As noted in Section 5 above, in general, ICO Plans will not be financially responsible for Medicaid behavioral health services that are delivered

through the HealthChoices Behavioral Health System.² SNPs are responsible for the mental health benefits provided through Medicare, and will need to establish referral protocols with Behavioral Health System contractors to ensure good access and effective coordination of behavioral health overall.

The Department of Aging and the Department of Public Welfare are exploring the feasibility of integrating behavioral health services in future years.

8. Service Delivery

The SNPs that contract with the State to offer the ICO program will have designated networks of approved providers for members to use. For dually eligible beneficiaries, this may improve access to services. For some types of services, such as dental, Medicaid providers can be very difficult to find in the existing system. In ICO, a participating SNP will need to demonstrate that it has sufficient capacity in its network.

SNPs currently have networks of Medicare providers that have met federal Medicare requirements for participation. This means that they have networks of doctors, hospitals, laboratories, pharmacies and others who offer the range of Medicare Part A, B and D services. It does not necessarily mean, however, that they have Medicaid providers who offer Medicaid services in their existing networks.

Before the Department agrees to contract with a SNP for the ICO program, it must be satisfied that the Plan has adequate network capacity for Medicaid services, including the full range of long-term services and supports. The Department will confirm adequate and appropriate access to services by conducting on-site readiness reviews with SNPs before they are allowed to enroll members into ICO. The readiness review tool will build on the experience of the HealthChoices and LIFE programs in developing specific indicators of capacity, such as number of providers in network and distance required to reach those providers.

Rules will also be established to define when and how ICO members may access out-of-network services to deliver their needed healthcare.

² The exception is the mental health benefit included in the ICO HCBS Waiver. ICO plans will be responsible for that benefit as part of their overall responsibility for ICO HCBS Waiver services.

Critical provisions relating to transitions into and out of ICO (or between providers) will also be implemented to ensure continuity of care and compliance with ongoing courses of treatment during enrollment, disenrollment, or other transition.

What will be the role of Area Agencies on Aging?

The target group for ICO is people age 60 and over, who are dually eligible for Medicare and Medicaid. To ensure that the expertise of the aging network is a resource to the Plans, the Department will require in its contract with ICO plans that the plans specifically have agreements in place with AAAs. The agreements will include participation of an AAA representative on a Service Coordination Team whenever a member is certified as nursing facility clinically eligible (NFCE).

The Department is also encouraging SNPs and AAAs to develop relationships that go beyond the required partnership. This could include being involved with members before waiver services are needed, and delivering a range of community services as part of the Plans' networks.

In addition to this new role, AAAs will continue to perform Level of Care Assessments (LOCA) to determine clinical eligibility for nursing facility level of care. To avoid any conflict of interest, that role will continue to be a direct contractual arrangement between the AAAs and the Department. The LOCA will be used to determine the level of payment to ICO plans, so it would be inappropriate for the plans to pay for that assessment process.

What will the relationship to existing home- and community-based services (HCBS) providers be?

In ICO, HCBS providers will need to be part of the SNPs' networks in order to participate in the program. To ensure sufficient long-term services capacity and encourage smooth transitions for people moving in and out of ICO, participating Medicare plans will be required to offer contracts to providers that participate in the Aging 60+ Waiver.

How will consumer-directed service options work within the Integrated Care Option?

At present, consumer-directed service options are available to people in the Aging 60+ Waiver, and the Department will require that a similar option be available to members using ICO HCBS Waiver services. ICO plans will offer consumer-directed services as part of the care planning process, and for those who choose it, will provide fiscal management services through a waiver enrolled existing fiscal management agency.

9. Care Management

Care management is the single most important factor to integrating care and simplifying things for members and their families. Currently, the Medicare and Medicaid systems operate separately. Each may have care management systems—limited to one part of a person’s health or long-term service needs. The person, often with assistance from family and friends, is left to be his or her own care manager, trying to bridge two systems that do not work well together.

In ICO, the participating SNPs will be responsible for bridging these systems and ensuring that care management addresses all of a member’s health and long-term service needs.



In order to integrate care, the SNPs participating in ICO must combine the Medicare services they are already providing (on the left) with the Medicaid services they will be providing (on the right). They must bring them together into a seamless system for dually eligible beneficiaries (in the middle). As discussed in the previous section, they will partner with at least one Area Agency on Aging (AAA) to do so. The SNP will be responsible for the overall management and coordination of all Medicare and Medicaid services, including authorization of care plans. When ICO HCBS Waiver services are needed, the SNP will work with a community services care manager from its partnering AAA to develop a community services plan and ensure that it is well integrated with all of the other Medicare and Medicaid services needed by the member.

10. Quality Monitoring and Improvement

SNPs are already required to meet federal Medicare Advantage quality provisions, which were recently expanded by the federal government. As the Department contracts with SNPs to add Medicaid, including long-term services and supports, it will ensure that the SNP also meets Medicaid quality requirements.

In its contract with SNPs, the Department will ensure that all Medicaid requirements are met, and will require that plans submit to the Department all quality reports that they must already submit to federal Medicare officials. In addition, the Department is developing quality of life measures to ensure that quality activities address both quality of care and quality of life.

The two sets of quality requirements (Medicare and Medicaid) are summarized in the table below. Attachment B contains more details on quality requirements.

SNPs Must Bring Together Two Quality Systems	
<u>Medicare SNP Requirements</u>	<u>Medicaid Requirements</u>
<ul style="list-style-type: none"> • Report on performance measures developed by the National Committee for Quality Assurance (NCQA): Healthcare Effectiveness Data and Information Set (HEDIS), Structure and Process Measures • Conduct the Consumer Assessment of Health Providers and Systems (CAHPS) survey and the Health Outcomes Survey (HOS) • Conduct quality improvement projects • Implement a chronic care improvement program 	<ul style="list-style-type: none"> • Cooperate with an External Quality Review Organization (EQRO) to evaluate outcomes and access to care (timeliness, provider capacity, coordination and continuity of care) • Implement a continuous improvement program, including performance improvement projects for health status and outcomes • Provide assurances related to Section 1915(c) waiver services: <ul style="list-style-type: none"> – Level of Care – Service Plan – Qualified Providers – Health and Welfare – Financial Accountability – Administrative Authority

Consumer protections are also critical to a comprehensive quality system. Those are discussed next.

11. Consumer Protections

Several mechanisms will be built into ICO to prevent and resolve disputes between SNPs and their members.

Member Rights and Responsibilities

The Department and stakeholders have developed a statement of Member Rights and Responsibilities for ICO, included as Appendix C. The document states clearly what rights consumers have as members of an ICO plan, as well as what responsibilities they have as members. SNPs will be contractually required to publish and honor the Member Rights and Responsibilities.

Training of Service Coordination Teams

The Department will require training for SNP Service Coordination Teams to ensure that teams understand the member's role in the planning process. The training will include:

- Understanding and acting on the Member Rights and Responsibilities;
- "Consumer-centeredness" in the care planning process;
- Consumer-directed care;
- Integration of medical and social models of care; and
- Placing value on quality of life outcome measures.

Grievance and Appeal Processes

Participating SNPs will need to meet both Medicare and Medicaid requirements pertaining to grievances and appeals. Over time, the goal is that stakeholders (consumers, SNPs, the federal Centers for Medicare & Medicaid Services, and the State) will agree to a single, easy-to-use, integrated grievance and appeal process, but until an integrated approach is developed, both existing procedures must be met to ensure that consumer rights are protected.

Consumer Advocate

The Department will create an independent advocate to whom members can turn for advice and assistance when they are uncertain of their rights or need help in understanding how ICO works, accessing services, asserting their rights, and resolving disputes with their ICO plan.

Consumer Advisory Committee

Participating SNPs will be contractually obligated to convene Consumer Advisory Committees. The majority of committee members will be ICO members and or family representatives. Membership will also include representatives of advocacy organizations with an interest in elder health care issues and long-term care. Examples include, but are not limited to, AARP, Alzheimer's Association, and legal services organizations. Providers may be included but may not represent more than twenty-five percent (25%) of the CAC's membership.

The Consumer Advisory Committee will:

- Advise the SNP on issues concerning the Member Bill of Rights and Responsibilities, resolution of member complaints, grievances and appeals, network capacity, performance improvement and quality management, the consumer experience, and unmet consumer needs.
- Hold centrally located meetings at least twice per year and keep a written or electronic record of all attempts to invite and include CAC members in its meetings. Minutes shall be maintained and made available for review by OLTL.

The SNP will:

- Implement procedures whereby, when specific recommendations are made by the CAC, representatives of the Plan with responsibility for the substantive areas addressed in the recommendation will consider the matters raised in the recommendation and timely respond to the CAC.
- Inform members of the CAC's existence and role in enrollment materials.

Member Feedback Sessions

SNPs will be required to host Member Feedback Sessions to provide direct input about pertinent member issues. SNPs will:

- Host at least two culturally appropriate sessions per year to ensure that members' concerns are heard and addressed, solicit feedback regarding members' experiences and identify unmet needs.
- Demonstrate concerted effort to invite and encourage members to attend feedback sessions. Such efforts may include but not be limited to convenient timing, choosing locations with access to public transportation, coordinating and/or transportation, providing translation services, ensuring accessibility of location and communication, and providing personal care aides so care givers can attend.

- Implement procedures whereby, when specific recommendations are made, representatives of the SNP with responsibility for the substantive areas addressed in the recommendation will consider and act upon the matters raised in the recommendation.
- Provide written documentation to the Department articulating how they have and will continue to respond to members' concerns.
- Demonstrate to the Department how feedback obtained at the sessions is incorporated into ongoing quality improvement activities.

12. Payments

The Department is working with its actuaries to develop payment approaches that help achieve the program's goals.

In general, how will payment work in this program?

SNPs will receive two separate payments for each member: one from the Medicare program (as they do currently) and one from the Commonwealth for Medicaid services. The Commonwealth will pay each SNP an actuarially sound, fixed amount per enrollee per month, based on historical costs for providing covered Medicaid services to the eligible population. This payment is called a "capitation rate" because it is a per capita (per person) amount.

The program's target group, persons 60 years and older who have both Medicare and Medicaid, has sub-groups within it. The Department is currently considering a rate structure with 3 subgroups, as illustrated in the following table.

Example of Possible Capitation Rate Structure		
Sub-Group A	Persons not needing long-term services and supports.	Payment would be Medicaid Capitation Rate A
Sub-Group B	Individuals who require nursing home level of care and currently reside in, or have a moderate to high likelihood of being rehabilitated back into a community setting.	Payment would be Medicaid Capitation Rate B
Sub-Group C	Individuals who require nursing home level of care and have a low likelihood of being rehabilitated back into a community setting.	Payment would be Medicaid Capitation Rate C

Paying different Medicaid capitation rates for different sub-groups better ensures that the Department does not under- or over-pay a SNP for the associated Medicaid costs, which could lead to program instability. It also enables the Commonwealth to incentivize SNPs to affect the program objectives and desired consumer outcomes (described further below).

How will payments simplify access to services for consumers?

The Department will pay the SNPs an all-inclusive Medicaid rate, including what Medicaid would pay for Medicare cost-sharing obligations (premiums, deductibles and coinsurance) in the traditional Medicaid system. For ICO members, this should eliminate the balance billing issues that have been a problem for dual eligibles in the past. (As noted above, the SNPs separately receive payment from the federal government for Medicare services.)

How will payments encourage greater use of community services?

By paying a separate capitation rate for individuals in Sub-Group B, as described above, the Department is explicitly creating a financial incentive for the SNPs to avoid sending members to nursing homes except when absolutely necessary. Furthermore, the Department is working on additional incentives that will encourage SNPs to identify members currently residing in a nursing home who are capable of living in a

community setting with the appropriate set of services and supports and assisting them in making that transition.

How will payments support improved health and functional outcomes for consumers?

OLTL can complement the basic Medicaid capitation rate structure with performance incentives that reward SNPs if they achieve certain measureable quality of life and quality of care indicators. Examples of areas that could be considered include: length of time a member remains in community care; turnover rate of SNP care management staff that work directly with consumers; frequency of hospital readmissions; number of people transitioned from a nursing home to the community; and percent of long-term living members served in community settings.

How will payments encourage cost-effective use of Medicare and Medicaid dollars?

Since the Medicaid capitation rate is a set amount that does not vary from month to month, the SNP is encouraged to be creative and innovative to ensure all appropriate services are being delivered effectively and efficiently, and that members are staying healthy and out of the hospital and the nursing home. In addition to OLTL's financial monitoring of the SNPs, the Department will annually update/revise the Medicaid capitation rates to ensure the program's financial performance (e.g., gains or losses) is being effectively balanced with the program's outcome/quality goals.

Appendix A: Summary of Findings from Other States

Systems of care that make a single entity accountable for a broad range of community and institutional services have been shown to promote greater use of community services:

- The Arizona Long-term Care System has progressively increased the use of home and community services over time. From 1998 to 2002, the percentage of ALTCS members being served in their own homes or in alternative residential settings increased from 41.1 percent to 63.3 percent (Arizona Health Care Cost Containment System, Arizona Department of Economic Security, and Arizona Department of Health Services, 2002).³
- An independent assessment of Wisconsin Family Care found that waiting lists for long-term care services in Family Care counties were eliminated, while waiting lists in comparison counties continued to increase (APS Healthcare, Inc., 2003).
- In an independent evaluation, Kane et al. (2003b) found that homemaker services, home-delivered meals, and outpatient rehabilitation all increased for Minnesota Senior Health Options community members relative to control groups.

The money for expanded community services comes from better coordination of care early and over time, which reduces avoidable hospital and nursing home use:

- In their evaluation for CMS of the program, Kane and Homyak (2003a) found that Minnesota Senior Health Options members experienced shorter hospital length of stay and fewer preventable emergency room visits than control group members.
- In their evaluation of PACE, Chatterji et al. (1998) found decreased inpatient hospital admissions and days and decreased nursing home days.
- The independent assessment of the Wisconsin Family Care program found that hospital length of stay decreased

³ ALTCS serves only persons certified to need nursing facility level of care. In comparison, in 2009, among Pennsylvanians age 60 and older certified to need nursing facility level of care, 27% were in home and community-based waiver programs, and 73% were in nursing facilities. (Pennsylvania OLTL, 2009)

significantly following enrollment in Family Care, though no change occurred in inpatient hospital admission rates (APS Healthcare, Inc., 2003).

- In an evaluation comparing Senior Care Options members with a comparison group of non-members in Massachusetts, JEN Associates (2009) found that SCO enrollees enter nursing facilities at a lower rate. They also found that time to first nursing facility use is greater and the time spent in a nursing facility episode is shorter than in the comparison group. SCO enrollees that did use a nursing facility were substantially less likely to become long-term residents. The evaluators conclude that... “the data strongly indicate a SCO impact in reducing nursing facility use in both the first and second years of operation....[and] that SCO financed community care is effective in maintaining more frail populations in the community...”

Finally, studies of programs in other states show improvements in health and functional outcomes:

- Kane et al. (2003b) found that Community members in the Minnesota Senior Health Options program were less likely to report moderate to severe pain over time than control group members.
- Chatterji et al. (1998) found improved quality of life, satisfaction, and functional status among PACE members. The study also found that PACE members lived longer and spent more days in the community than members of a comparison group.
- The assessment of Wisconsin Family Care found clear reductions in institutionalization, illness burden and functional impairment among participants. (APS Healthcare, 2005)

References

APS Healthcare, Inc. 2003. “Family Care Independent Assessment: An Evaluation of Access, Quality and Cost-Effectiveness for Calendar Year 2002.” Washington, DC: APS Healthcare, Inc.

APS Healthcare, Inc. 2005. “Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness for Calendar Year 2003 – 2004.” Washington, DC: APS Healthcare, Inc.

Arizona Health Care Cost Containment System, Arizona Department of Economic Security, and Arizona Department of Health Services. 2002. "Arizona's Community-Based Services and Settings Report, 3rd Biennial." Phoenix: State of Arizona.

Chatterji, Pinka, Nancy R. Burstein, David Kidder, and Alan J. White. 1998. "The Impact of PACE on Participant Outcomes." Cambridge, MA: Abt Associates. Prepared under HCFA Contract No. 500-96-0003/T04.

JEN Associates, Inc. 2009. "MassHealth SCO Program Evaluation: Nursing Facility Entry Rate in CY 2004-2005 Enrollment Cohorts." Cambridge, MA.

Kane, Robert L., and Patricia Homyak. 2003a. "Minnesota Senior Health Options Evaluation Focusing on Utilization, Cost and Quality of Care." Minneapolis: University of Minnesota School of Public Health, Division of Health Services Research and Policy. Final version (revised August 2003). Prepared under HCFA Contract No. 500-96-0008/TO3.

Kane, Robert L., Patricia Homyak, Boris Bershady, Yat-Sang Lum, and Mir Said Siadat. 2003b. "Outcomes of Managed Care of Dually Eligible Older Persons." *Gerontologist*, v. 43, no. 2: 165-74.

Pennsylvania Office of Long-term Living. Derived from current nursing home and HCBS waiver census data, June 23, 2009.

Appendix B: Quality Requirements

1. Medicare HEDIS Outcome Measures Required of SNPs⁴

- (COL) Colorectal Cancer Screening
- (GSO) Glaucoma Screening in Older Adults
- (COA) Care for Older Adults
- (SPR) Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- (PCE) Pharmacotherapy of COPD Exacerbation
- (CBP) Controlling High Blood Pressure
- (PBH) Persistence of Beta Blocker Treatment After a Heart Attack
- (OMW) Osteoporosis Management in Older Women
- (AMM) Antidepressant Medication Management
- (FUH) Follow-Up After Hospitalization for Mental Illness
- (MPM) Annual Monitoring for Patients on Persistent Medications
- (DDE) Potentially Harmful Drug-Disease Interactions
- (DAE) Use of High Risk Medication in the Elderly
- (MRP) Medication Reconciliation Post-Discharge
- (BCR) Board Certification

2. Medicare Structure and Process Measures Required of SNPs

- Complex Case Management
- Improving Member Satisfaction
- Clinical Quality Improvements
- Care Transitions
- Coordination of Medicare and Medicaid Services

3. Components of Evidence-Based Model of Care (new Medicare SNP requirement as of 2010)⁵

- Conduct an initial and annual comprehensive health risk assessment.
- Establish an interdisciplinary care team to manage care.
- Develop and implement an individualized care plan having objectives, measurable outcomes, and specific services and benefits.
- Establish a provider network having medical specialists appropriate to the target special needs population.

⁴ National Committee for Quality Assurance Website, www.ncqa.org

⁵ DHHS, CMS, 2010 Call Letter, issued March 30, 2009

- Assure that providers apply nationally recognized practice protocols and guidelines that are documented.
- Establish integrated systems of communication to promote coordination of care.
- Coordinate care across healthcare settings and providers; (i.e., transitions of care).
- Train employed and contracted staff on the organization's model of care.
- Deliver services to vulnerable individuals within the target population; (i.e., the frail/disabled, those having multiple chronic conditions, and those near the end-of-life).
- Deliver add-on services and benefits that meet the specialized needs of the unique targeted special needs individuals.
- Establish lines of accountability within the D- SNP to assure full implementation of the care management system
- Evaluate the effectiveness of the model of care for each plan benefit package.

4. ICO HCBS Waiver Quality Measures

Level of care

- Percent of all new waiver members who have a NFCE level of care determination, prior to receipt of ICO HCBS Waiver services.
- Percent of waiver members who received an annual re-determination of eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC evaluation.
- Percent of LOC determinations that were accurately rendered by appropriate staff using the correct forms.

Qualified providers

- Percent of waiver providers in the SNP network that obtain appropriate licensure or certification in accordance with State law and waiver provider qualifications prior to service provision.
- Percent of waiver providers in the SNP provider network that continually meet licensure or certification in accordance with State law and waiver provider qualifications.
- Percent of non-licensed/non-certified SNP network waiver providers by provider type that meet initial waiver provider qualifications.
- Percent of non-licensed/non-certified SNP network waiver providers by provider type that continually meet waiver provider qualifications.
- Number and percent of providers, by provider type, meeting provider training requirements.

Service plan

- Percent of ICO members who have service plans that are adequate and appropriate to their needs as indicated in the assessment.
- Percent of member experience/satisfaction survey respondents who reported unmet needs. (OLTL)
- Percent of CSPs and related service plan activities that comply regarding who develops the plan, who participates in the process and the time of the plan.
- Percent of CSPs reviewed and revised before the ICO member's annual review date.
- Percent of CSPs reviewed and revised when an ICO member's needs change.
- Percent of ICO members who received services in the type, amount, frequency and duration specified in the CSP.
- Percent of ICO members whose records contain an appropriately completed and signed Freedom of Choice form that specifies choice was offered between institutional care and waiver services.
- Number and percent of ICO members whose records contain an appropriately completed and signed Freedom of Choice form that specifies choice was offered among waiver services and providers.

Health and welfare

- Percent of waiver members (or family or legal guardians) whose records reflect that they received information and education of how to report abuse, neglect or exploitation, including the use of restraints and restrictive interventions.
- Percent of waiver members (or family or legal guardians) who indicate knowledge of how to report abuse, neglect or exploitation, including the use of restraints and restrictive interventions. (OLTL)
- Percent of reportable incidents by type that were investigated within the required time frame.
- Percent of reportable incidents by type: abuse, neglect and exploitation, including the use of restraints and restrictive interventions.

Financial Accountability

- Per member per month payments are made for eligible members of the ICO-SNP at the correct per member per month rate.
- ICO members are assigned to the correct rate cell.

Appendix C: Integrated Care Option Member Rights and Responsibilities

Updated December 5, 2009

Member Rights

1. You have the right to be treated with respect, dignity, privacy, confidentiality, fairness and without discrimination or retaliation in all interactions with the plan, providers and the Office of Long Term Living (OLTL). As such, you have the right:
 - a. Not to be restrained or secluded as a means of coercion, discipline, convenience or retaliation.
 - b. Not to be neglected, intimidated, physically or verbally abused, mistreated or exploited.
2. You have the right to timely access to care. Care includes both health care and supportive services. This includes the right to:
 - a. Receive comprehensive care from providers in a safe environment.
 - b. Get care in a timely manner, including the right to see specialists if and when needed.
 - c. Have telephone access to a medical professional from the plan 24/7 in order to obtain any needed emergency or urgent care or assistance.
 - d. Access care without facing communication or physical barriers. This includes the right to be able to get in and out of a care provider's office, including barrier-free access for members with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act.
3. You have the right to receive all the information you need to use your plan and make decisions about your care including the right to:
 - a. Request and receive written and oral information about [plan name]), its health and other care providers, its benefits and services and your member rights and responsibilities in a manner you understand. This includes the right to receive materials and/or assistance in a foreign language and in alternate formats, if necessary. If you need interpreters during appointments with your providers and when talking to [plan], you have the right to have a qualified interpreter provided to you.
 - b. Talk with and receive information from your care providers on all available treatment options and alternatives, regardless of cost, and to have these presented in a manner you understand. You have the right to be told about any risks involved in your care and about whether any proposed medical care or treatment is part of a research experiment.
 - c. Be told why care or services were denied and not given.
4. You have the right to privacy in your care, your conversations with your providers, and your medical records such that you can:
 - a. Know that your medical and other records and discussions with your providers will be kept private and confidential.
 - b. Expect that [plan name] will provide you with a copy of its Notice of Privacy Practices without you having to request it.

- c. Approve or deny the release of identifiable medical or personal information, except when the release is required by law.
 - d. Request that any communication that contains protected health information from [plan name] to be sent to you by alternative means or to an alternative address.
 - e. Request that [plan name] make additions or corrections to your records. If you ask us to do this, we will review your request and decide whether the changes are appropriate.
 - f. Know how your health and other personal information has been given out and used for non-routine purposes.
 - g. Request and receive (or see) a copy of your records in accordance with applicable federal and State laws. There may be a fee charged for making copies.
5. You have the right to make a complaint about the treatment or care provided to you by healthcare and other network providers and/or to appeal decisions made by [plan name] about whether you can get services or treatments you were seeking. You likewise have the right to offer suggestions for changes in [plan name's] policies and procedures. This includes the right to:
- a. Make a complaint to [plan] or to the OLTL about your care, your providers or [plan].
 - b. Get a timely answer to your complaint.
 - c. Access the plan's appeal process and receive instructions on the procedures for doing so.
 - d. Request a State Fair Hearing from the OLTL and request information about the process for doing so.
6. You have the right to make decisions about your healthcare and long-term living services. This includes the right to:
- a. Seek and receive information from an independent, conflict free Consumer Advocate.
 - b. Choose and change your healthcare and long-term care providers within the plan network.
 - c. Change how and from whom you receive healthcare and long term living services (including the right to return to original Medicare and/or fee-for-service Medicaid/home- and community-based services waiver) at any time in a reasonably easy manner.
 - d. Work as part of a team with your provider in deciding what care is best for you.
7. You have the right to make decisions about your care without repercussion, retaliation or change to the nature or quality of your care. This includes the right to:
- a. Say yes or no to the care recommended by your providers.
 - b. Leave a hospital or other medical facility, even if your doctor advises you not to leave.
 - c. Stop taking your medication.
 - d. Make an "advance directive" and have the plan and its providers honor it.

Member Responsibilities

1. You have the responsibility to:

- a. Inform [plan] and its care providers of any known changes in eligibility or any other information that may affect your membership, care needs or access to benefits, such as address or phone number changes or if you have a special medical condition.
- b. Treat your care providers and staff with respect and dignity.
- c. Ask questions if you do not understand your rights.
- d. Share information relating to your health status with your primary care provider (PCP) and care manager and become fully informed about service and treatment options. That includes the responsibility to:
 - i. Tell your PCP about your health.
 - ii. Talk to your providers about your health and other care needs and ask questions about the different ways your health and other care problems can be addressed.
 - iii. Help your providers get your records.
- e. Actively participate in decisions relating to service and treatment options, make personal choices and take action to maintain your health. That includes the responsibility to:
 - i. Work as a team with your provider in deciding what care is best for you.
 - ii. Understand how the things you do can affect your health.
 - iii. Do the best you can to stay healthy.

Glossary of Terms Used in this Document

AAA	Area Agency on Aging.
Department	Pennsylvania Department of Aging and Office of Long Term Living
Dual Eligible	A person who is eligible for both Medicare and Medicaid.
Enrollment Broker	An organization designated by the Commonwealth that provides unbiased information about program options, and helps people enroll in or disenroll from those options.
HCBS	Home- and community-based services. HCBS is sometimes used to describe community long-term services generally, but usually the term is used to refer to HCBS waiver programs, which provide long-term services specifically to prevent or delay admission to a nursing facility or other institutional setting.
ICO	Integrated Care Option, a program developed by the Department of Aging, Office of Long-Term Living to bring together Medicare and Medicaid services for dual eligibles.
ICO Consumer Advocate	An independent organization designated by the Department to help enrollees and their families access the care they need through the ICO program.
LOCA	Level of Care Assessment. This is a specific assessment conducted in accordance with Department policy for the purpose of determining a person's clinical eligibility for nursing facility-level services.
Long-term services and supports	Long-term services and supports may include, but are not limited to: self-directed care; adult day health; personal emergency response systems; home modification and environmental accessibility options; home and personal care; nursing services; specialized medical equipment and supplies; chore services; social work and counseling; nutritional consultation; home delivered meals and alternative meal service; and nursing facility services.
Medicaid	A program operated by the Commonwealth to provide health and long-term services and supports to persons with limited income and resources. In Pennsylvania, the program is referred to as Medical Assistance.
Medicare	A program operated by the federal government to provide health services to persons 65 and older, persons with disabilities, and persons with end-stage renal disease.
NFCE	Nursing Facility Clinically Eligible means that a person has clinical needs, determined by a Level of Care Assessment (LOCA), that require nursing facility care or cost-effective community alternatives appropriate for the member's needs.

OLTL	Office of Long-Term Living, the office within the Department of Aging that is leading the development of the Integrated Care Option.
SNP	Special Needs Plan, a type of Medicare Advantage plan. As used in this document, SNP refers specifically to a Special Needs Plan for beneficiaries who have both Medicare and Medicaid (dual eligibles).
Waiver	A Medicaid program operated under special permission, or waivers, from the federal government. As used in this document, waiver refers specifically to programs that provide community-based alternatives to institutional care.