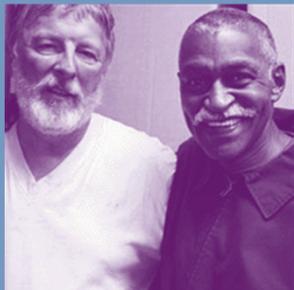


CHCS

Center for
Health Care Strategies, Inc.



Medicare-Medicaid Integration: Achieving Higher Quality and Cost- Effective Care



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Why Focus on Dual Eligibles?

- 7.2 M full-benefit duals nationally (9.2 M total).
- 87% have one or more chronic conditions.
- 3X more likely than others on Medicare to have multiple chronic illnesses/LTSS needs.
- \$350B in combined Medicare-Medicaid costs.
- One study (Lewin) predicted integrated care can result in 6% (\$21B) in savings; others predict 10-20% in savings.

Significant opportunities to improve access, quality, and cost of care for this high-cost, high-need population

What does care look like now?

WITHOUT INTEGRATED CARE INDIVIDUALS MAY HAVE:

- x Three ID cards: Medicare, Medicaid, and prescription drugs
- x Three different sets of benefits
- x Multiple providers who rarely communicate
- x Health care decisions uncoordinated and not made from the patient-centered perspective
- x Serious consideration for nursing home placement; Medicare/Medicaid only pays for very limited home health aide services

- Fragmented
- Not Coordinated
- Complicated
- Difficult to Navigate
- Not Focused on the Individual
- Gaps in Care

Why Focus on Dual Eligibles Now?

- Existing vehicles for integration (e.g., PACE, Special Needs Plans (SNPs), and Medi/Medi demos) have not achieved broad scale, full integration, or anticipated budget savings.
- ACA established the Medicare-Medicaid Coordination Office, which is providing technical assistance to states to design integrated care programs for duals.
- States are looking for ways to improve the cost-effectiveness of budget-strapped programs.

The Value of Integration

- Creates one accountable entity to coordinate delivery of primary/preventive, acute, behavioral, and long-term supports and services
- Promotes and measures improvements in health outcomes
- Promotes the use of home- and community-based long-term supports and services
- Blends/aligns Medicare and Medicaid's services and financing to streamline care and eliminate cost shifting
- Slows the rate of both Medicare and Medicaid cost growth

AND, most importantly...

- Provides high-quality, patient-centered care for dual eligibles that is sensitive to their needs and preferences

What Ideal Care CAN Look Like:

<u>WITHOUT INTEGRATED CARE</u>	INTEGRATED CARE
x Three ID cards: Medicare, Medicaid, and prescription drugs	✓ One ID card
x Three different sets of benefits	✓ One set of comprehensive benefits: primary, acute, prescription drug, and long-term care supports and services
x Multiple providers who rarely communicate	✓ Single and coordinated care team
x Health care decisions uncoordinated and not made from the patient-centered perspective	✓ Health care decisions based on the individual's needs and preferences
x Serious consideration for nursing home placement; Medicare/Medicaid only pays for very limited home health aide services	✓ Availability of flexible, non-medical benefits that help beneficiaries stay in their homes

Evolution of Integrated Care

- 1990's Dual Eligible Demonstrations
 - ▶ Massachusetts, Minnesota, Wisconsin, and New York
- 2000's SNP Programs
 - ▶ Texas, Arizona, and New Mexico
- Programs provide improved care, but these integrated care models are very difficult to implement, replicate, and scale
- Only about 120,000 dual eligibles are currently enrolled in some kind of integrated care

Challenges to Integrating Care

- Administrative and operational hurdles
- Stakeholder (advocates, providers) concern/resistance
- Lack of good data (access to, analysis of and linkage between Medicare and Medicaid)
- Financial and administrative misalignments between Medicare and Medicaid
- Enrollment issues
- Network adequacy (especially LTSS)
- Difficulties in developing and bringing SNPs to scale

Profiles in State Innovation Project

- ▶ Medicaid funds more than 40% of long-term supports and services (LTSS) in the US, most in unmanaged fee-for-service
- ▶ Nearly 75% of Medicaid LTSS dollars for seniors and adults with physical disabilities support nursing home care



- ▶ With support from The SCAN Foundation, CHCS conducted an environmental scan to identify state best practices for:
 1. Rebalancing LTSS to support home- and community based options as well as nursing facility alternatives;
 2. **Developing a managed long-term supports and services program;** and
 3. Integrating care for adults who are dually eligible for Medicare and Medicaid.

States Interviewed for MLTS/Duals

- Arizona: ALTCS
- Hawaii: QExA
- Tennessee: Choices
- Texas: Star+Plus
- Wisconsin: Family Care

Top Ten MLTS Mileposts for States

1. Communicate a clear vision for MLTS to promote program goals.
2. Engage stakeholders to achieve buy-in and foster smooth program implementation.
3. Use a uniform assessment tool to ensure consistent access to necessary LTSS services.
4. Structure benefits to appropriately incentivize the right care in the right setting at the right time.
5. Include attendant care and/or paid family caregivers in the benefit package.

Top Ten MLTS Mileposts *(continued)*

6. Ensure that program design addresses the varied needs of beneficiaries.
7. Recognize that moving to risk-based managed care is a fundamental shift in how the state and managed care organizations think about LTSS financing, and plan accordingly.
8. Develop financial incentives to influence behavior and achieve program goals.
9. Establish robust contractor oversight and monitoring requirements.
10. Recognize that performance measurement is not possible without LTSS-focused measures.

1. Communicate a clear vision for MLTS

Hawaii's QExA Goals:

- Improve the health status of Seniors and Persons with Disabilities (SPD);
- Establish a “provider home”;
- Empower beneficiaries by promoting independence and choice;
- Assure access to high-quality, cost-effective care (in homes/communities when possible);
- Coordinate all care (acute, behavioral, LTSS).

2. Engage stakeholders to achieve buy-in

- Texas STAR+Plus: Healthcare Matters held beneficiary focus groups and meetings with health plans and providers;
- Tennessee CHOICES: States staff identified roles for Area Agency on Aging and Disability;
- Wisconsin Family Care: Contractors developed local committees with provider and consumer representatives

3. Use a uniform assessment tool

Wisconsin Long Term Care Functional Screen:

- Activities of daily living (ADLs) such as bathing, dressing, transferring, mobility, and eating;
- Instrumental activities of daily living (IADLs), e.g. meal preparation and medication management;
- Diagnoses and health-related services or tasks;
- Communication and cognition (e.g., memory loss, decision-making ability);
- Behaviors and/or mental health (e.g., wandering, substance abuse); and
- Available transportation or employment.

4. Structure benefits to appropriately incentivize the right care

Best practice, e.g. Tennessee CHOICES:

- ▶ TennCare managed care organizations are responsible and at-risk for providing the full continuum of LTSS services, including nursing facility and HCBS, in addition to all primary, acute, and behavioral health services for eligible members.
- ▶ Care management/coordination is included.
- ▶ Fewest exclusions are the ideal!

5. Include attendant care and/or paid family caregivers in benefit package

Arizona's ALTCS program:

- ▶ Includes paid family members as caregivers through traditional attendant or self-directed attendant care program;
- ▶ Family members in traditional attendant care program are hired by home health/attendant care agency;
- ▶ Training includes CPR, first aid, infection/disease control;
- ▶ Spouse as paid caregiver (up to 40 hours per week) recently added to program.

6. Ensure that program design addresses needs of beneficiaries.

Arizona ALTCS includes:

- ▶ Interdisciplinary care team approach to help determine the needs for services;
- ▶ Behavioral health (as part of health plans' IDT) coordinates care for beneficiaries identified as having behavioral health needs.

Other states' health plans may coordinate with behavioral health services outside the health plan.

7. Recognize the fundamental shift in move to risk-based managed care

States vary in their approach to contracting out vs. building in-house expertise:

- ▶ Rate-setting and risk adjustment
- ▶ Financial oversight and monitoring
- ▶ Data collection and analysis

Very few actuaries have experience in setting rates for MLTS, so states need to develop some capacity for understanding rate development.

8. Develop financial incentives to achieve program goals

- If the state has a specific objective to shift care toward home and community-based services, the rates should include realistic incentives for plans. May include:
 - ▶ Incentive payments based on achieving objectives;
 - ▶ Case-mix payment system;
 - ▶ Penalties for increased reliance on institutions.
- Money Follows the Person and other state initiatives can complement the health plans' strategies.

9. Establish robust contractor oversight/monitoring requirements

- Most states start with very prescriptive contracts and monitoring practices.
- Over time, if health plan performance is found to be consistently high, the state may focus on a few high-risk, high-cost areas.
- Beneficiaries living outside facilities with state financial support always represent an area of risk for state managers.
- TN best practice: HCBS monitored/reported monthly.

10. Recognize need for LTSS-focused performance measurement

- Many states track process measures (days to assessment; care plan completion).
- Wisconsin best practice: PEONIES interview
 - ▶ Living in a preferred setting; Making one's own decisions;
 - ▶ Deciding one's own daily schedule; Maintaining personal relationships;
 - ▶ Working or pursuing other interests; Being involved in the community; Having stable/predictable living conditions;
 - ▶ Being treated fairly and with respect; Having the amount of privacy desired;
 - ▶ Being comfortable with one's health situation; Feeling safe; and
 - ▶ Feeling free from abuse and neglect.

State Ideas for Integration: Remove Obstacles to Existing Models

Examples of obstacles that states would like to revise include:

- Bidding process for MA/SNP capitated rates
- Marketing and outreach limitations
- Enrollment rules (opt in vs. opt out)
- Quality measures
- Grievance and appeals
- CMS authority

Emerging Vehicles to Integrate Medicare and Medicaid

The ACA expands CMS' authority to approve new models of care.

CMS is seeking states to develop models that:

- ▶ Adopt a person-centered model of care
- ▶ Align the full range of Medicare and Medicaid covered services including:
 - medical,
 - behavioral health, and
 - long-term supports and services
- ▶ Improve the actual care experience and lives of dual eligible beneficiaries.

Financial Models to Support States

- State Medicaid Director Letter July 8, 2011
- Offers States two paths:
 - ▶ Capitated Model
 - ▶ Managed Fee for Service
- Open to all interested states
- State letter of intent must go in by October 1
 - ▶ Model being pursued
 - ▶ High-level description
 - ▶ Service area, date

Capitated Model

- Three-way contract (state, CMS, health plan)
- Prospective blended payment with “aggressive savings” built in
- Single set of rules for appeals, marketing, and audits
- Joint procurement of “selected high-performing health plans”
- Network adequacy important
- Enrollment: seamless but with opt-out allowed

Managed Fee for Service

- Improve coordination of care through fee-for-service providers, including Medicaid health home or Accountable Care Organization
- Retrospective payment based on performance
- Must exceed quality thresholds and meet a target for savings
- Program will provide seamless integration and access to all necessary services based on an individual's needs

Requirements and benefits for all states

States must:

- Participate in evaluation
- Collect and report data:
 - ▶ Individual-level quality, cost, enrollment, utilization data for participants and non-participants
- If using capitated model, health plans required to submit encounter data and quality indicators

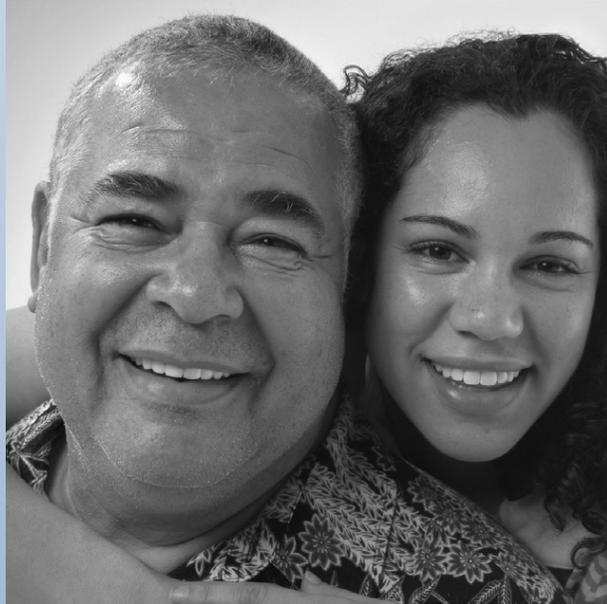
States may:

- Request technical assistance and Medicare data

Helpful links

- CMS Innovation Center:
<http://www.innovations.cms.gov/>
- State Innovation Center Proposals:
 - ▶ Ohio:
<http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=8bjGIWI2V2w%3d&tabid=40>
 - ▶ California:
<http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupDE.aspx>

Thank you!



Questions?

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