State of Colorado Department of Health Care Policy and Financing

INTEGRATED CARE FOR DUAL ELIGIBLES Program Admin Research Report





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Introduction

In April 2009, the State of Colorado jumped into the world of health care reform. With the passage of the Colorado Health Care Affordability Act (CHCAA), the state proactively decided to provide health coverage to more than 100,000 uninsured Colorado citizens and families. The legislation also aimed at stemming rising health insurance costs for businesses and families.

The landmark legislation includes multiple components, each requiring subject matter expertise and project management leadership. The Department of Health Care Policy and Financing selected Public Consulting Group (PCG) through a competitive procurement process (RFP # HCPFPB1102BNFTDSGN) to assist with six different projects in the areas of financial modeling, rate setting, and Medicaid benefit program expansion design. One of these projects, Integrated Programs for Dual Eligibles, is designed to develop a program that will offer a coordinated benefit package- including care coordination and care management- that is evidence based, promotes value, and contributes to the overall improved health for persons who are jointly eligible for both Medicaid and Medicare. Individuals who are entitled to Medicare coverage and are eligible for some form of Medicaid benefit are usually referred to as a "dual eligible".

As of December 30, 2009 there were 8,606,568 dually-eligible persons, including both full and partial, of which 70,693 were in Colorado. The Health Institute of Colorado reported on characteristics of Colorado dual eligibles in 2006:²

- Dual eligibles make up 15 percent of the state's Medicaid enrollees and 15 percent of the state's Medicare beneficiaries.
- The age distribution of dual eligibles in Colorado is 63 percent elders and 37 percent working-age adults with disabilities.

¹ Centers for Medicare and Medicaid Services, Dual Eligible Enrollment As Of December 31, 2009. Retrieved on 3-8-11 from https://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/Dec09DualEligiblesf.pdf.

² Colorado Health Institute, (2006 November), Meeting the Needs of Colorado's Dual Eligibles, Denver, CO.



- 92 percent of elder Medicaid enrollees are Medicare beneficiaries.
- 40 percent of working-age adults with disabilities on Medicaid qualify for both programs.
- 43 percent of the Colorado Medicaid budget is spent on the dual eligible population,

To gain a full understanding of the administration as well as the financial and benefit structure of existing integrated dual eligible programs, PCG analyzed publicly available information and conducted a literature review. PCG also conducted key informant interviews with state and federal officials to obtain relevant information to help assist the State of Colorado in developing an integrated care program for individuals dually eligible for Medicare and Medicaid. This report is based on the findings of the aforementioned environmental scan and is a key undertaking, within the scope of this project, to develop an integrated care program unique to Colorado.

Although dual eligibles are a challenging population for government assisted medical care, there are numerous models for Colorado to consider; some of which have taken pointers from initial Medicare integration waivers and demonstrations. Regardless of the particular model Colorado will ultimately adopt, the re-occurring theme of this report is the importance of adopting a model that will assume full responsibility of coordinate care, reduce administrative burdens, achieves relevant measures of performance, and create a reimbursement methodology that effectively recognizes the complex delivery of care.





Characteristics of Dual Eligibles

Creating an integrated care model for dual eligibles will be one of the most significant adaptations to Medicaid that Colorado will make in the coming years. The dual eligible population represents the sickest and the poorest of the state and of the nation, requiring coordinated primary and acute and long-term services from two complex and independent government health care programs.

Available literature has clearly demonstrated that the care of dual eligibles entails significant health care costs. Data on national costs varies by source and availability. The following comments use available data to make approximate estimates of total spending on dual eligibles. In 2006, dual eligibles were 16% of Medicare beneficiaries nationally, but accounted for 27% of Medicare spending.³ Medicare spending in 2009 was \$502.3 billion; implying that the costs of dual eligibles to Medicare was approximately \$135.6 billion.⁴

In 2005, dual eligibles were 18% of Medicaid enrollment and 46% of Medicaid spending.⁵ Medicaid spending in 2009 was \$380.6 billion; implying that the costs of dual eligibles to Medicaid was approximately \$175 billion. Roughly speaking, total spending on dual-eligible persons in the 2008-2009 period was approximately \$310.6 billion, or around \$36,000 per person. In contrast, the average cost of a Medicare beneficiary in 2009 was approximately \$10,895 assuming 46.1 million Medicare beneficiaries.⁶ Per enrollee spending for Medicaid services was \$6,890 in 2009.⁷ These per capital estimations show the substantially higher costs that care of the dual eligibles entails compared to costs of the average Medicaid and Medicare beneficiary.

³ Medicare Payment Advisory Commission, (2010, June), *A Data Book: Healthcare Spending and the Medicare* Program, Washington, D.C.

⁴ Centers for Medicare and Medicaid Services, *National Health Expenditures Data*, Washington, D.C.

⁵ Medicaid and CHIP Payment and Access Commission, (2010, October 28-29), *Session Brief*, Washington, D.C.

⁶ Kaiser Family Foundation, (2010) *Medicare Chartbook*, Menlo Park, CA.

⁷ Department of Health and Human Services, (2010) 2010 Actuarial Report on the Financial Outlook for Medicaid, Washington, D.C.



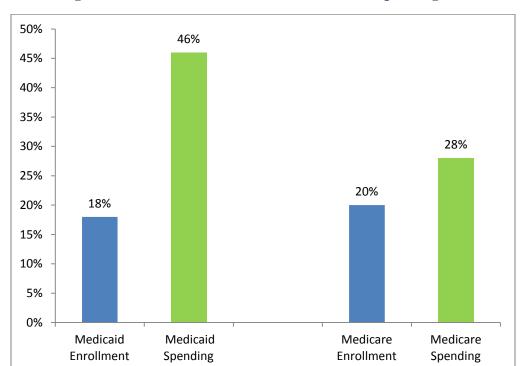


Figure 1: Dual Eligibles as a Share of Medicaid and Medicare Spending and Enrollment⁸

Medicaid research has shown that a small percentage of Medicaid beneficiaries account for a sizeable percentage of Medicaid costs⁹. Not only is the average cost of dual eligibles substantially higher than the cost of the average Medicare and average Medicaid beneficiary, but dual eligible costs are concentrated in a small percent of high cost cases. 20 percent of dual eligibles account for 68 percent of Medicare spending and 62 percent of the total spending on dual-eligible beneficiaries. In contrast, the least costly 50 percent of dual-eligible beneficiaries account for only 8 percent of Medicare spending and 9 percent of total spending on dual-eligible beneficiaries.¹⁰

¹⁰ Ibid. Medicare Payment Advisory Commission, (2010, June)

⁸ Date Source: Urban Institute estimates based on data from MSIS and CMS from 64, prepared for the Kaiser Commission on Medicaid and the Uninsured. Medicare data from Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2005. Total Medicare spending includes Medicare spending on services for all beneficiaries and Medicare capitation payments for Medicare Advantage enrollees

⁹ Sommers, A. and Cohen, M. (2006, March), *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?*, Kaiser Family Foundation, Menlo Park, CA.



Dual eligibles incur a disproportionate share of costs because they have significantly more health problems and fewer resources than Medicare and Medicaid beneficiaries who are not dual eligibles. Dual eligibles are among the sickest and poorest individuals covered by either Medicare or Medicaid. Most dual eligibles are low-income individuals with health problems. The following table from the Medicare Payment Advisory Commission shows other characteristics of Medicare beneficiaries who are duals and non-duals.¹¹

Table 1: Characteristics of Medicare Beneficiaries who are Duals and Non-Duals 12

Characteristic	Dual-Eligible Beneficiaries	Other Medicare Beneficiaries	
Sex			
Male	39%	45%	
Female	61%	55%	
Race/ethnicity			
White, non-Hispanic	58%	82%	
African American, non-Hispanic	18%	7%	
Hispanic	15%	6%	
Limitations in Activities of Daily Living (ADLs)			
No ADLs	49%	71%	
1-2 ADLs	23%	19%	
3-6 ADLs	29%	10%	
Residence			
Urban	70%	77%	
Rural	30%	23%	
Living arrangement			
Institution	19%	3%	
Alone	31%	27%	
Spouse	17%	55%	
Children, nonrelatives, others	32%	15%	
Education			
No high school diploma	54%	22%	
High school diploma only	24%	31%	
Some college or more	18%	45%	

¹¹ Ibid. Medicare Payment Advisory Commission, (2010, June)

¹² Data Source: MedPAC analysis of Revised Medicare Current Beneficiary Survey Cost and Use File, 2006.



Characteristic	Dual-Eligible Beneficiaries	Other Medicare Beneficiaries
Income status		
Below poverty	51%	8%
100-125% of poverty	22%	7%
125-200% of poverty	19%	21%
200-400% of poverty	5%	36%
Over 400% of poverty	2%	29%

The table clearly highlights the lower socio-economic characteristics of persons who are dually eligible and rely primarily on public medical assistance programs:

- Higher percentage of females
- Higher percentage of minority populations
- Substantially more limitations in activities of daily living (ADLs)
- More rural
- More live in institutions, alone, or with their children
- Lower educational levels-- over half have less than a high school education
- Higher rates of poverty

The prevalence of many serious health conditions, such as cognitive or mental impairments, depression, and diabetes is also high for persons who are dually eligible.¹³ Generally, the prevalence of chronic disease, as wells as mental and cognitive conditions is significantly higher among dual eligibles compared to all other Medicare beneficiaries.

¹³ Mathematica Policy Research, (2010, June) Medicare and Medicaid Spending on Dual Eligibles, Presentation at the AcademyHealth Annual Research Meeting, Boston, MA.



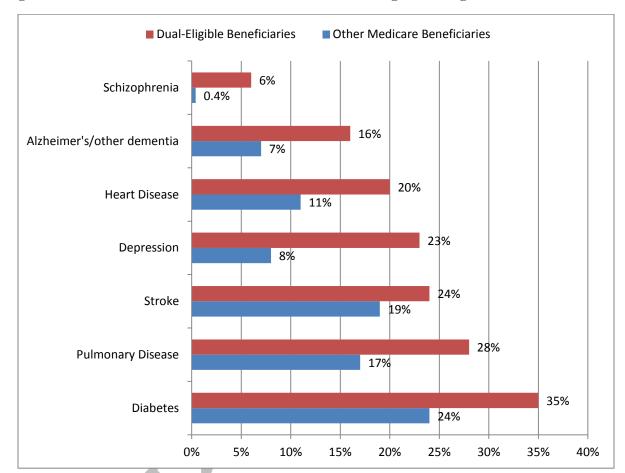


Figure 2: Prevalence of Select Chronic Conditions Among Dual Eligibles¹⁴

There is also a difference in per capita spending for dual eligibles according to disease. Combined Medicaid and Medicare program spending varies widely by diagnosis. The following table shows the impact of select chronic conditions on costs. For example, as noted in the table below, chronic obstructive pulmonary disorder (COPD) and heart failure are conditions associated with common hospitalizations. As a result, these patients have higher combined spending on inpatient hospital services.

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¹⁴ Data Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of linked 2003 MSIS data and MCBS Access to Care File.



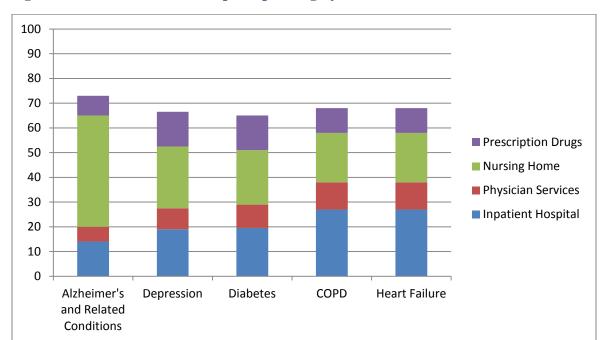


Figure 3: Differences in Per Capita Spending by Select Chronic Condition¹⁵

Significant co-morbidities among dual eligibles make service use high and care coordination across Medicare and Medicaid particularly challenging. Three in five dual eligibles have multiple chronic physical conditions and 20 percent have more than one mental/cognitive condition, such as dementia. In contrast, roughly half of all other Medicare beneficiaries have more than one chronic physical condition and only five percent have more than one mental/cognitive condition. Almost three in five dual eligibles have both a physical disease and mental condition compared to only 17 percent of all other Medicare beneficiaries. ¹⁶

 $^{15\} Data\ Source:\ Mathematica\ Policy\ Research,\ prepared\ for\ MedPAC\ using\ CMS\ merged\ MAX\ and\ Medicare\ summary\ spending\ files\ for\ 2005$

¹⁶ Kasper, J., O'Malley Watts, M., Lyons, B., (2010, July), *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*, Kaiser Family Foundation, Washington, D.C.



10%
20%
11%
1 Chronic Condition
2 Chronic Conditions
2 Chronic Conditions
3-4 Chronic Conditions
5 Chronic Conditions
With Dementia 0-4 Chronic Conditions
Conditions

Figure 4: Number of Chronic Conditions and Dementia Prevalence for Dual-Eligibles¹⁷

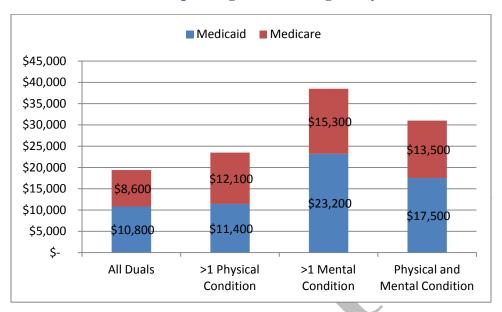
Duals with multiple chronic conditions rely heavily on Medicare for hospital services. Nearly four in ten dual eligibles with more than one physical condition use inpatient hospital services in a given year. Use of inpatient hospital services is even greater for dual eligibles with multiple mental conditions; half if these duals access the service in a given year. Dual eligibles access Medicaid for long-term services and supports. Nearly four in ten duals with more than one mental condition also use nursing facility services in a given year, while nearly three in ten with both a physical and mental condition access nursing facility care. Medicare and Medicaid per capita spending is substantially higher for dual eligibles with multiple chronic conditions, particularly when mental/cognitive conditions are present.¹⁸

¹⁷ Data Source: Mathematica Policy Research, prepared for MedPAC using CMS merged MAX and Medicare summary spending files for 2005

¹⁸ Ibid. Kasper, J., O'Malley Watts, M., Lyons, B., (2010, July)



Figure 5: Medicaid and Medicare Spending Per Dual Eligible by Chronic Condition¹⁹



Both the Medicaid and Medicare population comprise distinct sub-groups. Two such groups are the elderly and persons with disabilities. Elders make up about two-thirds of all dually eligible beneficiaries. Among older dual eligible beneficiaries, more than half have one or no physical impairment, 26 percent are mentally ill, and 16 percent have dementia. High proportions have dementia or at least two physical impairments and are institutionalized. Younger adults with disabilities make up approximately one-third of all dually eligible individuals. Of the group of beneficiaries with disabilities, 44 percent are mentally ill, and 18 percent are developmentally disabled.²⁰ Rates of institutionalization are highly variable ranging from 9-42% among states nationally²¹

¹⁹ Data Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of linked 2003 MSIS data and MCBS Access to Care File.

²⁰ Ibid. Medicare Payment Advisory Commission, (2010, June)

²¹ Material synthesized from Medicare Payment Advisory Commission, (2010, June) Report to the Congress: Aligning Incentives in Medicare Washington, D.C.





There are two kinds of dual eligibles with respect to Medicaid coverage. An individual who is eligible for all Medicaid services is called a full-dual. About 80% of all duals are full-duals.²² An individual who is eligible for some limited Medicaid benefits to pay for out-of-pocket Medicare cost sharing expenses is called a partial dual. Partial dual eligibles are not eligible for full Medicaid benefits but may receive assistance with some or all of their Medicare premiums and cost sharing. State Medicare Savings Programs cover low-income Medicare beneficiaries and pay some or all of Medicare's premiums and may pay Medicare deductibles and coinsurance.

There are four Medicare Savings Programs covering the following categories of partial duals:

- Qualified Medicare Beneficiaries (QMBs), with resources at or below twice the standard allowed under the Supplemental Security Income (SSI) program and income at or below 100% of the Federal poverty level (FPL), do not have to pay their monthly Medicare premiums, deductibles, and coinsurance.
- Specified Low-Income Medicare Beneficiaries (SLMBs), with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level, but less than 120% of the FPL, do not have to pay the monthly Medicare Part B premiums.
- Qualifying Individuals (QIs), who are not otherwise eligible for full Medicaid benefits
 and with resources at or below twice the standard allowed under the SSI program, will
 get help with their monthly Medicare Part B premiums, if their income exceeds the
 SLMB level, but is less than 135% of the FPL.
- Qualified Disabled and Working Individual (QDWI), who have a disabling impairment, are working, but lost their Part A eligibility only because they went back to work, are only eligible for Medicaid payment of Part A premiums assuming they continue to meet income guidelines.

²² Medicaid and CHIP Payment and Access Commission, (2010, October 28-29), Session Brief, Washington, D.C.





There is significant variation among states in the share of duals that receive full or partial Medicaid assistance. Partial duals served through Colorado's Medicare Savings Programs represent a small proportion of (8%) of the state's total dual eligible population compared to the national average (23%).²³ However, expenditures for the population of partial duals are not insignificant. Expenses for partial dual eligibles were estimated to cost Colorado Medicaid approximately \$19.5 million in FY 2009-2010.²⁴

The characteristics of the dual eligible population thus present substantive challenges to organizing their care in an integrated care program. These challenges range from preparing educational materials about program benefits and health information, providing effective care coordination, managing high rates of utilization for both acute and long-term care services, to ensuring sufficient budgeting to cover higher beneficiary costs. This is a complex challenge given the tradeoffs between the costs of care, prevalence of the multiple conditions, and the efficacy of interventions. For example, Medicare research shows the there are substantial variations in the cost associated with different chronic conditions and variations like this need to be taken into account in the management of health care for dual eligibles.²⁵



²³ Rousseau, D., Clemans-Cope, L., Lawton, E., Langston, J., Connolly, J. and Howard, J., (2010, December) *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007*, Kaiser Family Foundation, Washington, D.C.

²⁴ Department of Health Care Policy and Financing, (2010, November), *FY 2011-12 DI-1 Medical Services Premiums Exhibits*: Exhibit P - Global Reasonableness, State of Colorado, Denver, CO.

²⁵ Jacobsen, C. (2010, June), *Medicare Spending for People with Multiple Chronic Conditions: A Cautionary Tale*, Presentation at the AcademyHealth Annual Research Meeting, Boston, MA.



Benefits of Integration

The high costs and numerous services associated with providing care to dual eligibles makes the promise of integration particularly poignant. A strong integrated care model is cognizant of the conflict of interests between Medicare and Medicaid, the importance of individualized care to dual eligibles subgroups, and the best practices from states with integrated care models. This section details the benefits of an integrated care model and also highlights the successes and challenges to implementing the model for dual eligibles.

Eliminate or Reduce Cost Shifting Between Programs

Integrated care has the potential to address the common practice of shifting responsibility for beneficiaries from one program to another to relieve the financial burden of providing care. There are numerous examples of cost shifting practices because care coordination is not a shared responsibility between Medicaid and Medicare. Hospitalizations are such an example. Aside from being costly, an unknown percentage of unnecessary hospitalizations are a result of poor care management. Patients are also put at risk for avoidable hospital-acquired infections.

At the program level, Medicaid has no financial incentive to reduce unnecessary hospital stays by Medicare-eligible persons because Medicare is the primary payer of their medical care. Medicaid would assume virtually all costs and oversight to administer the interventions while the financial benefits of reducing hospitalizations would solely belong to the federal government (or Medicare health plans)²⁶. Conversely, although enhanced care management would reduce or delay long-term nursing home utilization, a Medicaid covered service, such a reduction would not benefit the Medicare budget.

At the provider level time, there is a push from hospitals to transfer patients to nursing home facilities to lower their own costs and push the care and financial responsibility back on Medicare and the state-run Medicaid programs. A symptom of the lack of care integration is the tendency of hospital and nursing home advocates to assign blame to the other party for the percentage of persons who return to the hospital within 30 days of discharge. Almost one fifth (19.6%) of the

²⁶ Center for Health Care Strategies, Inc. (2009) *Encouraging Integrated Care for Dual Eligibles*. (July 2009)





11,855,702 Medicare beneficiaries who had been discharged from a hospital in 2003-2004 were re-hospitalized within 30 days, and 34.0% were re-hospitalized within 90 days. This cycle largely ignores the need of the patient to receive adequate care absent of competing agendas.²⁷

Effective integrated care models can more aptly manage hospital admissions and nursing facility placements, and the interplay between them. In 2004 Commonwealth Care, a not-for-profit health plan and provider organization in Massachusetts began a program called Senior Care Options to serve patients age sixty-five and older, most of whom are eligible for both Medicare and Medicaid. The Senior Care now has approximately 3,000 members, nearly 70 percent of whom are certified for nursing home placement and Disability Care serves about 400 persons.

- Unpublished data for Senior Care Options in 2007 show that the number of hospital days per 1,000 members was equal to just 55 percent of hospital days for comparable dual eligibles cared for in a fee-for-service payment environment.
- During 2005–09, the rate of nursing home placements for elderly people eligible for them was 30 percent the rate of comparable seniors in Medicaid fee-for-service.
- Total medical spending in Senior Care Options for seniors eligible for nursing home
 placements grew by an average of 2.1 percent from 2004 to 2009, and by an average of
 0.02 percent annually for ambulatory seniors from 2006 to 2009—much lower than feefor service growth rates.
- For Disability Care Program patients, unpublished data show that total monthly costs were \$3,601 in 2008, compared with \$5,210 for Medicaid fee-for-service patients with conditions of similar severity.²⁸

Greater Care Coordination to Improve Health Outcomes

The differing payment structures of Medicaid and Medicare are at times misaligned with quality care. Improved coordination between the programs can not only help mitigate cost shifting, but

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²⁷ Jencks, S., Williams, M. & Coleman, E. (2009, April 2), *Rehospitalizations among Patients in the Medicare Fee-for-Service Program*, New England Journal of Medicine, 2009; 360:1418-1428

²⁸ This descriptive material on Commonwealth is taken from Meyer, H. (2011, March), *A New Care Paradigm Slashes Hospital Use And Nursing Home Stays For the Elderly and the Physically and Mentally Disabled, <u>Health Affairs</u>, 30, no.3 (2011):412-415*



also promote improved health outcomes for dual eligibles. A major advantage to care integration is individualized care. Ideally, an integrated care model will address the complete medical, behavioral, and social needs of the patient. An individualized approach to care delivery and coordination, which aligns with a patient-centered model, can produce tangible benefit from care integration.

Dual eligibles are affected by co-morbidity, disability, institutionalization, mental impairment, and a host of other challenges. As a general guideline, care plans must take into consideration disease, age, chronic disabilities, and the social supports of the person and their place of residence when developing the most effective coordinated care plan. A significant percent of dual eligibles suffer from four or more chronic diseases and have specific utilization and spending patterns based on their diagnoses. Thus, dually eligible beneficiaries require a comprehensive set of acute and long-term services and supports and need an effective, coordinated system of care.

While some providers are required to coordinate care services such as hospital discharge planning, this is not a standard even though coordinated care is directly linked to improving quality measures and financial performance. The Medicare Payment Advisory Commission estimates that Medicare spends as much as \$12 billion annually on hospital readmissions that could have been prevented by better communication between inpatient and outpatient care teams, better post-discharge follow-up, and other proven methods that are crucial for patients with complex, potentially life-threatening medical conditions.²⁹

Lack of real-time data sharing compromises coordinated care because patient information is divided between the two programs. Patient care plans, utilization patterns, and drug coverage information have yet to be consolidated causing delayed or unnecessary care. ³⁰ Improved data sharing to promote care coordination across settings will result in more efficient care and improved outcomes. Specifically, real-time exchange of beneficiary level Medicaid and Medicare administrative data on eligibility coverage, services utilization, and health diagnoses is

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²⁹ Ibid. Medicare Payment Advisory Commission (2010 June)

³⁰ Saucier, P. (1998, Winter), *Linked Data Analysis of Dually Eligible Beneficiaries in New England*, Health Care Financing Review, Vol. 20, No. 2 pp. 91-108.





needed to improve care management. Robust administrative data sets would also integrate assessment data such as activities of daily living (ADLs) and instrumental activities of daily living (IADLs) information.

By coordinating Medicaid and Medicare services for dual eligibles, and their personal and social resources, an integrated care programs can enhance individualized care to improve health outcomes. Wishard Health Services in Indiana is the third largest safety net health organization in the United States and its Geriatric Resources for Assessment and Care of Elders (GRACE) takes care of approximately 7,000 seniors, about one-third of which are dual eligibles. GRACE does not have integrated funding from Medicaid and Medicare. However, its care practices for dual eligibles are exemplary. GRACE emphasizes thorough assessment, tight coordination among treating professionals, good data information control, and ongoing care coordination by a team that includes a social worker. With funding support from the National Institute on Aging, a two-year controlled, randomized trial of 951 adults age sixty-five and older, with incomes below 200 percent of the federal poverty level found that:

- First-year results for GRACE-enrolled patients showed dramatic improvements in indicators of quality health care, both in general medical care (flu shots, care coordination during transitions) and in geriatric-specific care (evaluation of falls, treatment of depression).
- Patients enrolled in the GRACE intervention received better quality of care than patients receiving usual care and had significant improvements in health-related quality of life.
- One year after the study's end, the GRACE patients at high risk of hospitalization had a 40 percent lower hospital admission rate compared with high-risk patients in the control group.³¹

³¹ Counsell, S., et. al. (2009), Cost Analysis of the Geriatric Resources for Assessment and Care of Elders Care Management Intervention. Journal of the American Geriatric Society, 57(8):1420–26. Also see Counsell, S., et. al. (2006), Resources for Assessment and Care of Elders (GRACE): a new model of primary care for low-income seniors. Journal of the American Geriatric Society, 54(7):1136–41.



Enhance Beneficiary Experience with Care

Aside from financial conflicts and challenges to quality care, the clear division between Medicaid and Medicare causes a heavy administrative burden. Each entity has its own enrollment and grievances and appeal processes, rate setting, and monitoring and reporting guidelines. While CMS has produced information to guide states through Medicaid and Medicare differences and barriers to integration, there is still a need to increase patient and provider literacy in these areas³². Even small changes such as the development of a single plan card with a uniform set of rules for Medicare and Medicaid can make a large difference in accessing services.

Evercare, a subsidiary of UnitedHealth Group serves dual eligibles by offering integrated acute and long-term care programs³³. Customer Satisfaction Surveys that were taken by members and their families also demonstrate Evercare's success. In Arizona 93 percent of consumers were satisfied with their care coordination and 90 percent of that population felt that they were involved in the decision making process. Similarly, in Minnesota, 96 percent of surveyed members would recommend their health plan and 94 percent would recommend their care coordinator to others³⁴. Clinical Outcomes also improved under the Evercare methodology for integrated care and Evercare beneficiaries had fewer hospitalization rates, emergency room utilization and unnecessary hospital stays.³⁵

Individuals in need of long-term supports and services, including dual eligibles, have a clear preference for home and community-based services over institutional care. A number of states that have already seen the benefits of integrated care models in this regard. Results specifically stem from decreasing nursing home utilization and hospital stays.

Arizona Long Term Care System has decreased its institutionalization statistics by conducting six month assessments to determine if an institutionalized enrollee can be

³² Ibid. Center for Health Care Strategies, Inc. (2009 July)

³³ Evercare Comment: Acute and Long Term Care Integration (2006, October 18). Retrieved 3-17-11 from http://www.dmas.virginia.gov/downloads/pdfs/altc-P_comment_KathlynWee_Oct18_06.pdf

³⁴ Minnesota Health Data Institute, 2004 Consumer Assessment of Health Care: MSHO Nursing Home Population (2004, Aug). ³⁵ Ibid. Medicare Payment Commission, (2010, June)



placed in community care.³⁶ Over a period of 17 years, the percentage of dual eligibles with nursing facility levels of care now able to live in the community rose from 5 to 63 percent³⁷.

- Minnesota Senior Health Options reduced the number of nursing home visits and increased community based services. Specifically, while nursing facility utilization decreased by 22 percent over a five year period the number of beneficiaries receiving HCBS increased by 48 percent.³⁸
- Home and Community Based Long Term Care benefited members of the Texas STAR+PLUS program. Consumers in a community setting can receive personal care without being part of a 1915c waiver. Dual eligibles obtained 31 percent more personal care and 38 percent more adult day care.³⁹

States have already seen the benefits of integrated care models. Their success stories set a precedent for positive care outcomes and strong evidence of the effectiveness of integrated care programs for dual eligibles.



³⁶ Ibid. Medicare Payment Commission, (2010, June)

³⁷ State of Arizona claims analysis

³⁸ Ibid. Medicare Payment Commission, (2010, June)

³⁹ Aydede, S., *The Impact of Care Coordination on the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Patients*, Institute for Child Health Policy (2003, Sept).



History of Dual-Eligible Integration Efforts

Health care systems in multiple states have worked for the last 30 years to integrate the care of persons who are dual eligibles. A large body of research literature measures and speculates about the organizational structures used in integration work, and the impact of these efforts on the quality of care, access, and costs of the service provided to program enrollees. This brief review looks at the PACE program, the Social Health Maintenance Organization (S/HMO)projects, the Robert Wood Johnson Foundation's Medicare/Medicaid Integration Program (MMIP), and the Medicare Special Needs Programs stimulated by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

More than one commentator has made comments to the effect that "Achieving improvements in care for frail elders is very difficult, and multiple previous efforts have failed to affect Medicare costs and health care outcomes⁴⁰ A review of the literature shows the necessity for sound conceptualization, realistic expectation of success, careful planning, and a determined implementation.

The Program for All-Inclusive Care for the Elderly

The Program for All-Inclusive Care for the Elderly (PACE) was the first dual-eligible integration. PACE began in 1971 as a Senior Citizens Center called On Lok in downtown San Francisco. In 1975, in home support services, personal care, and case management were added to the Senior Center's services. In 1979, On Lok began a Medicare demonstration program emphasizing a multi-disciplinary team that provided frequent case management to the persons attending the center.

In 1983, On Lok obtained waivers from Medicare and the California Medicaid program, Medi-Cal, to test risk-based capitation. In exchange for fixed monthly payments from Medicare and Medicaid for each enrollee, On Lok was responsible for delivering a full range of healthcare

⁴⁰ Gold, M. et. al. (2005), Challenges In Improving Care for High-Risk Seniors in Medicare: Lessons and observations from past field demonstrations, Health Affairs, pp. W5199-W211.

⁴¹ Historical information and dates of the program are taken from http://www.onlok.org/seniorhealth/content.asp?catid=240000182&scatid=240000192. See also, http://www.npaonline.org/website/article.asp?id=12 retrieved on 3-17-11.



services, including hospital and nursing home care – bearing full financial risk. A permanent Medicare and Medicaid waiver followed in 1986.

Also in 1986, On Lok's model of bringing beneficiaries to a day care center, managing their care using intensive care management, and receiving both Medicaid and Medicare capitation was generalized to other states. The expansion of the program nationally was done under a new name, the Program of All-inclusive Care for the Elderly (PACE). In the Balanced Budget Act of 1997, PACE became a permanent provider type under Medicare, and states gained the option of paying a capitation rate for PACE services under Medicaid.

By 1996, there were 21 PACE programs operational in 15 states. The program was expanded by Congress in 2006 with grants of \$500,000 a piece to 15 organizations to expand rural PACE programs. As of January 2010, there were 80 sites with PACE programs in 29 states. ⁴² The program has remained small and in January 2010 there were 19,417 participants. ⁴³ Three of the 80 sites are in Colorado: Colorado Springs, Montrose and Denver. Appropriations for the PACE program in Colorado for FY 2009-2010 were \$76,158,518. ⁴⁴ The Denver site, with 1,430 participants in January 2010 was the second largest in the country.

Table 2: Program for All-inclusive Care for the Elderly (PACE) in Colorado

Contract Number	Contractor Name	Plan Name	Plan Enrollment
	Rocky Mountain Health Care Services	Rocky Mountain PACE	93
H5167	Services		
	Total Community Options,	Total Longterm Care, Inc.	1,574
H0613	Inc.		
	Volunteers of America	Senior CommUnity Care of	174
H2815	National Services	Colorado	

⁴² Program list retrieved on 3-18-11 from national PACE organization website at http://www.npaonline.org/website/download.asp?id=1741

⁴³ Ibid. Enrollment information on 10 of the 80 sites was not available.

⁴⁴ Department of Health Care Policy and Financing, (2010, November), *FY 2011-12 DI-1 Medical Services Premiums Exhibits:* Exhibit P - Estimate of FY Expenditures with Prior Year Cash Flow Pattern, State of Colorado, Denver, CO. Retrieved on 3-19-11 from

 $[\]underline{http://www.colorado.gov/cs/Satellite?blobcol=urldata\&blobheader=application\%2Fpdf\&blobkey=id\&blobtable=MungoBlobs\&blobwhere=1251667645259\&ssbinary=true$





The PACE program nationally, but not in Denver, has remained small considering its longevity. It has been periodically evaluated by researchers. Some researchers speculate the small enrollment size is attributable to the general reluctance of older individuals to change physicians and resistance to centering the care location in a day care center. Other researchers speculate that not all poor, frail elders are willing to trade nursing home care for community-based care that substitutes an interdisciplinary team for their physician, controls all care received, and expects regular participation in an adult day care program. Researchers found sixteen barriers to PACE expansion, including competition, PACE model characteristics, poor understanding of the program among referral sources, and a lack of financing for expansion.

Adverse selection also continues to be a concern in the PACE program. A 2001 study in the Health Care Financing Review found that "...those with the greatest Medicare expenditures and in the last months of life are the least likely to enroll. This finding supports the theory that capitated payments induce the avoidance of the costliest individuals." The study also found that home ownership and provider attachment also act as important and significant barriers to enrollment.⁴⁸

Social Health Maintenance Organizations

Another early demonstration program was the Social Health Maintenance Organization (S/HMO). Conceived at Brandeis University, the S/HMO model was designed to be superior to fee-for service Medicare. Four plans were enacted as S/HMOs:

- Elderplan (Metropolitan Jewish Geriatric Center) in Brooklyn, New York;
- Medicare Plus II (Kaiser Permanente Northwest Center for Health Research) in Portland, Oregon;
- Seniors Plus (Group Health Incorporated and Ebenezer Society) in Minneapolis/St. Paul, Minnesota; and

⁴⁵ Kane, R. et. al. (1992) Qualitative Analysis of the Program of All-inclusive Care for the Elderly (PACE), <u>The Gerontologist</u> 32 (6): 771-780. See also Gross, D, et. al. (2004), The growing pains of integrated health care for the elderly: lessons from the expansion of PACE, Milbank Quarterly. 82(2):257–82.

⁴⁶ Naylor, M. & Buhler-Wilkerson, K., (1999), Creating Community-based Care for the New Millennium, <u>Nursing Outlook</u>, 47:120-7.

⁴⁷ Gross, D, et. al. (2004), The growing pains of integrated health care for the elderly: lessons from the expansion of PACE, Milbank Quarterly, 82(2):257–82.

⁴⁸ Irvin, C. et. al. (1997), Determinants of Enrollment among Applicants to PACE, <u>Health Care</u> Financing Review 19, no. 2 (1997): 135–153.



• SCAN Health Plan (SHP), (Senior Health Action Network) in Long Beach, California.

The S/HMO benefit package was broad including the normal Medicare benefits of hospital, physician, skilled nursing home and home health.⁴⁹ Plus, the supplemental chronic care benefits of the S/HMO programs included:

- additional skilled nursing facility (SNF) care;
- intermediate care (ICF);
- homemaker/chore,
- personal health aide,
- medical transportation,
- adult day health care,
- respite care;
- case management;
- prescription drugs and eyeglasses; and
- dental coverage was also offered in the original benefit package in three of the sites, but it was later made optional

First generation S/HMOs, called S/HMO I plans, were paid using a modified version of the "payment factors" used to pay Medicare risk plans prior to January 2000. Special higher factors were used for the nursing home certifiable group of members who were eligible for expanded services to compensate the plans for the higher medical needs of this group. For each enrollee of plans established during the project's first phase, the S/HMO base payment was 105.3 percent of the county rate for Medicare Advantage plans. That payment was adjusted on the basis of the enrollee's age and sex as well as whether the enrollee was a nursing home resident, was enrolled in Medicaid, was working, or had end-stage renal disease.⁵⁰

An evaluation of the S/HMO I demonstration during the period 1985 to 1989 found that the sites had not integrated long-term care and acute care in the way the designers had intended.⁵¹ "For example, because coordination between S/HMO case managers (typically social workers) and

⁴⁹ Newcomer, R. (1990, August), *Social Health Maintenance Organizations: Assessing Their Initial Experience*Health Services Research 25:3 pp. 424-454.

⁵⁰ Congressional Budget Office, (2004, April), Recent Policy Initiatives Affecting Long-Term Care Financing, U.S. Congress, Washington, D.C. Retrieved on 3-18-11 from http://www.cbo.gov/doc.cfm?index=5400&type=0&sequence=6

⁵¹ Mathematica Policy Research (2001, January), *Social Health Maintenance Organizations: Transition into Medicare + Choice*, A report prepared for the Health Care Financing Administration, Baltimore, MD.



physicians was infrequent, the evaluators recommended that plans implement stronger geriatric approaches that would involve physicians in care management. The evaluation also found that hospital costs were lower and nursing home costs were higher for S/HMO members than for Medicare beneficiaries in the fee-for-service sector with similar medical conditions. However, total costs were higher in some plans and lower in others. Furthermore, frail S/HMO I members were less satisfied with almost all aspects of their care than frail fee-for-service beneficiaries. The lack of substantial reductions in both hospital and nursing home costs suggested that the S/HMO I model was not achieving its goals and was not an effective approach to care integration."⁵²

In 1990, Congress authorized an extension of the demonstrations and established the second generation of the S/HMO demonstrations, known as S/HMO II. One purpose of S/HMO II was to test the effects of linking chronic care case management services and acute care providers. The primary components of the S/HMO II projects included:

- an expanded case management system with acute and long-term care linkages
- a long-term care benefit package, and
- a risk adjusted payment method

The S/HMO II incorporated an interdisciplinary, team-based geriatric approach to care integration in the design and the intervention in the S/HMO II model was time-limited rather than long term. The S/HMO II model included primary care physicians, specialists, pharmacists, dieticians, geriatricians, and nurse case managers in the interdisciplinary care coordination team to ensure that acute and long term care services are fully integrated. While all S/HMOs used some geriatric approaches, the S/HMO II model required that the approach be implemented.

In January 1995, HCFA awarded developmental grants of \$150,000 to six S/HMO II project sites, including Rocky Mountain HMO in Colorado, to encourage rural and Medicaid-oriented plans: Of these six sites, one became operational while other, including Rocky Mountain HMO,

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⁵² Ibid. Mathematica (2001, January)

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withdrew for various reasons. Reasons why health plans opted out of the S.HMO II demonstration included concern regarding assuming financial risk under an untested payment method, the lack of infrastructure needed (particularly among the rural plans), and loss of key personnel.⁵³

In 1995 CMS offered the first generation S/HMO sites the option to convert to S/HMO II sites. They participated in the planning meetings for S/HMO II, including those in which protocols were developed for geriatric approaches and case management, and instruments were developed to screen and assess members. After considering the requirements for the S/HMO II model, none decided to convert. In early 2007, in conjunction with Medicare Part D enrollment, the S/HMOs were converted to traditional Medicare Advantage plans.

Neither S/HMO I nor S/HMO II was well received by researchers and evaluators. The evaluation by Mathematica found that the sites had mixed success. With one exception the four sites successfully managed the LTC benefit, but, did not really integrate functional status and clinical data in the management of plan members, had comparable member satisfaction to other local Medicare risk plans, experienced difficulty in reaching enrollment targets, and did not achieve the reductions in hospital and nursing home costs that were expected from effective care integration ⁵⁴

In 2003, the Medicare Payment Advisory Commission summarized Medicare's thinking about the demonstration saying "Two evaluations found no conclusive evidence of positive effects on beneficiary health or functioning. They found that the demonstration did not consistently reduce hospital use or long-term nursing facility use or consistently deliver superior quality care. Any favorable effects on service use and use of preventive care were attributable to general characteristics of tightly organized managed care rather than to the features of the model being tested in the demonstration."⁵⁵

⁵³ Wooldridge, J. et al (2001, January 5) *Social Health Maintenance Organizations: Transition into Medicare* + *Choice*, Mathematica Policy Research, Princeton, NJ.

⁵⁴ Ibid. Wooldridge, J. et al (2001, January 5)

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⁵⁵ Medicare Payment Advisory Commission, (2003, March), Report to Congress: Social Health Maintenance Organization (S/HMO): Recommendations for the Future of the Demonstration, Washington, D.C.



Robert Wood Johnson Foundation's Medicare/Medicaid Integration Program (MMIP)

From 1997 to 2006, the Robert Wood Johnson Foundation (RWJF) funded 15 state-run projects under the Medicare/Medicaid Integration Program (MMIP)⁵⁶. RWJF separately funded a Minnesota project but considered it part of the program. Seven states launched or refined projects for dual eligibles that either integrated or moved toward integration of Medicare and Medicaid financing and/or services: Florida, Maine, Massachusetts, Minnesota, Texas, Vermont, and Wisconsin. Eight other states participating in the program planned or worked on implementing projects to integrate or move toward integration of Medicare and Medicaid, but did not implement the projects: Colorado, Connecticut, New Hampshire, New York, Oregon, Rhode Island, Virginia, and Washington.

The Robert Wood Johnson Foundation described its impression of why Rocky Mountain did not become an operational integration project in the following paragraphs:

"As the first step in this demonstration, the Colorado Department of Health Care Policy and Financing applied for approval from HCFA in September, 1995, to integrate Medicare and Medicaid financing. Two years later, HCFA granted approval to the state to go ahead, but a stumbling block emerged-HCFA and the state were unable to agree on the amount of the Medicare capitation payment that HCFA should pay to the HMO. After a series of negotiations, Colorado decided to have the Medicare contract with the HMO stay as is and providers would be paid on a fee-for-service service basis. The experience illustrates some of the difficulty in agreeing on how much health plans should be paid to care for the dually eligible population."57

The states that did implement projects used three distinct models:⁵⁸

Full integration;

⁵⁶ A thorough description of the RWJ program can be found on the RWJ website. Retrieved on 3-19-11 from http://www.rwjf.org/reports/npreports/mmip.htm

⁵⁷ Alper, J. & Gibson, R., (2000), To Improve Health and Health Care Vol. 4 Section Two Programs: Integrating Acute and Long-Term Care for the Elderly, Robert Wood Johnson Foundation, Princeton, NJ

Tables and descriptions of models are taken from, retrieved on 3-19-11, http://www.rwjf.org/reports/npreports/mmip.htm#KeyStateResults



- Partial integration; and
- Fee-for-Service.

The "full-integration" model integrated primary, acute and long-term-care services at the health plan level through a Medicare Advantage organizational structure wherein Medicare and Medicaid financing were treated as one stream of capitated payments to the organizations. To implement this approach, the managed care organization had to obtain the appropriate Medicare and Medicaid waivers. Massachusetts, Minnesota and Wisconsin used this approach and, as shown below, each state had a Medicare 222 waiver plus Medicaid authorities.





Table 3: Fully Integrated MMIP Projects

Medicare/Medicaid Integration Projects (full integration)				
Fully integrated Medicare and Medi	caid funding			
Capitated primary, acute and long-term-care services				
State/Plan	Approach	Target Population	Care Coordination	Waiver(s)
Massachusetts:	Senior care organizations	Dual eligibles and Medicaid-only seniors.	Physician with	Medicare 402/2
MassHealth Senior Care Options	provide Medicare (parts A and		team: nurse,	
	B) and Medicaid primary, acute	Voluntary enrollment.	nurse	
Minnesota:	HMOs provide Medicare and	All dual eligibles.	Nurses and	Medicare
	Medicaid primary, acute and		social workers.	402/222
Minnesota Senior Health Options	long-term-care services, under			
	contract to state and CMS.	Voluntary enrollment.		Medicaid
				1915(a) and
				1915(c)
Wisconsin:	Community-based organizations	Frail nursing home certifiable seniors who	Interdisciplinary	Medicare
	(health plans) provide Medicare	are Medicaid eligible or are dually eligible	team:	402/222
	and Medicaid primary, acute	and the disabled.	Physician,	
Wisconsin Partnership Program	and long-term-care services		nurse	Medicaid 1115
	under contract to state and	Voluntary enrollment.	practitioner and	

The two "partial-integration" models implemented by Florida and Texas did not seek a Medicare 402/222 waiver. In this model, primary, acute and long-term-care services were managed by the staff of a state-designated lead organization, usually a managed care organization, under a state contract to provide capitated Medicaid and care coordination services. Beneficiaries received Medicare services via a fee-for-service arrangement, and dual eligibles were encouraged to enroll in a Medicare HMO. Care coordinators generally lacked authority over Medicare. Medicare savings attributable to the care coordination were not captured by the organization. To implement this approach, a state needed a Medicaid 1915(c) and /or (b) waiver.





Table 4: Partially Integrated MMIP Projects

Medicare/Medicaid Coordination Projects (partial integration)				
Voluntary managed care capitated primarily for Medicaid long-term care with coordination with Medicare services				
State/Plan	Approach	Target Population	Care Coordination	Waiver(s)
Florida:	Under capitation, the state	Frail seniors "at risk of nursing home	Case managers	Medicaid
	contracts with HMOs to	placement," who are dual eligibles.	at the HMOs.	1915(c).
Community-Based Diversion Pilot	provide long-term care including			
Project	a wide range of services to help			
	beneficiaries live in the	Voluntary enrollment.		
Texas:	Under capitation, the state	Dual eligibles and Medicaid-only seniors.	A nurse or	Medicaid
Texas Star+Plus	contracts with health plans to		social worker at	1915(b)/(c).
	manage all primary, acute and	Mandatory enrollment in a Medicaid HMO	the HMO.	
	long-term-care services	for some dual eligibles.		

The third model used in RWJF MMIP project was managed fee-for-service. Primary, acute and long-term care services were delivered to patients via fee-for-service; however the state emphasized the use of care coordination so there was a greater linkage between payers and providers than in traditional fee-for-service programs. No waivers were required to implement managed fee-for-service and providers bore little or no risk.

Table 5: Fee-for-Service MMIP Projects

Managed Fee-for-Service (FFS)					
State/Plan	Approach	Target Population	Care Coordination	Waiver(s)	
Maine:	Primary care case management, including long- term care.	Medicaid-only adults with disabilities; and dual eligibles receiving long-term care or with: congestive heart failure, diabetes or coronary vascular disease.	Primary care physicians.	Not required.	
M aine NET	All Medicare and Medicaid services are reimbursed via fee-for-service with little or no risk to providers. Physicians use reports based on Medicaid and Medicare claims data and meet periodically with the project manager to discuss interventions. A pharmacy consultant is also available.				
Vermont:	All Medicare and Medicaid services are reimbursed via fee-	Dual eligibles and people who would soon be dual eligibles with "complex needs."	State case managers		
Vermont Independence Project Care Partners	for-service, with little or no risk to providers.	Voluntary enrollment.	working out of		





Similar to the history of the PACE and SHMO projects, the seven MMIP projects implemented during the MMIP had a multiple evaluations done on them. The first was the 2004 evaluation of the Minnesota and Wisconsin fully integrated projects. ⁵⁹

Evaluators concluded that combining Medicare and Medicaid funding into a single pooled capitated payment program was feasible. Minnesota and Wisconsin models represented two different approaches to applying managed care for the dual eligible population that taken together addressed a wide range of target populations among the dual eligible. The Minnesota program addressed the full range of older persons in the community and the nursing home, whereas Wisconsin's addressed two distinct populations, older persons and younger disabled persons, who were nursing home eligible, but lived in the community. Wisconsin's model represented a relaxation of the PACE model, which featured restricted primary care by limited designated providers who were employed by the PACE program. Under the modified PACE approach used by Wisconsin, enrollees could generally go to the physicians they chose. Minnesota used a more traditional application of managed care through plans that contracted with a panel of providers.

Evaluators described the utilization results as mixed. There were no differences in the overall number of hospital admission and emergency room (ER) visits, but Minnesota community enrollees showed a lower rate of preventable hospital admissions and preventable emergency room visits than the control group. Nursing home enrollees had significantly fewer hospitalizations, ER visits, and preventable emergency services than either control group. Hospital days and preventable hospital admissions were also significantly lower for Minnesota nursing home enrollees compared to the control group. The reduced number of hospital days appeared to be as a result of fewer admissions, not shorter lengths of stay. Evaluators concluded that the effect of Minnesota model on hospital admissions and ER services might have reflected the extensive use of a nurse practitioner model for primary care.

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⁵⁹ Kane, R. & Homyak, P., (2004, August), *Multi State Evaluation of Dual Eligibles Demonstration Final Report*, A report prepared for the Health Care Financing Administration, Baltimore, MD.





Wisconsin elderly enrollees had fewer hospital days compared to control groups, fewer preventable hospital admissions and more physician visits. Wisconsin disabled enrollees had fewer preventable hospital admissions and fewer emergency room visits than either control group. Wisconsin disabled enrollees also had fewer preventable emergency room visits than the control group in the 18 months after enrollment.

After the CMS evaluation, Wisconsin staff did their own evaluation and found that:

- The number of inpatient hospital days decreased 52 percent for physically disabled members in the first year after enrollment.
- The number of nursing home days decreased 25 percent for elderly in the first year after enrollment. Only about 6 percent of members were in nursing homes compared to 26 percent of Medicaid recipients age 65 and older across the state.
- By close coordination and monitoring, Wisconsin had been able to keep prescription drug cost increases in the range of 9 to 12 percent, well below the national average of 18 to 21 percent.
- Some 95 percent of program members rated the services excellent or very good. Only 5 percent of members disenrolled for reasons other than death or relocation.

A second CMS evaluation of the MMIP participants was done on eleven programs in Massachusetts, Minnesota and Wisconsin. 61 The evaluation approach was substantively different and focused on how the plans delivered service. The demonstration plans not only delivered Medicaid community care services, they also assessed enrollees' needs in their homes, developed community care plans, and coordinated the delivery of these services with Medicare acute care services. The frailty of enrollees was reflected in high rates of utilization of acute hospitals and prescription drugs. Three general models for connecting community care with acute care were demonstrated:

The single coordinator. Either a nurse or social worker managed community care and also coordinated with physicians and others in the acute care system as needed and available.

http://www.rwjf.org/reports/npreports/mmip.htm#EvaluationFindings

⁶⁰ Description of findings taken from RWJ website at, retrieved on 3-19-11,

⁶¹ Brandeis University, (2007, March), Medicare Special Needs Plans: Lessons from Dual-Eligible Demonstrations for CMS, States, Health Plans, and Providers, A report prepared for the Centers for Medicare and Medicaid Services, Baltimore, MD.





- The nurse/social worker team. The team social worker managed community care and the team nurse coordinated with medical care.
- The multidisciplinary or interdisciplinary team which included a nurse, social worker, therapists, and nurse practitioner. The nurse practitioner worked closely with physicians.

There was variation in how closely community care coordinators and teams in each of these models were actually connected to physicians, and in how extensively they could use community care staff to support medical care plans. Factors that appeared to aid closer collaboration between community and acute care included:

- the interest of individual physicians;
- having a critical mass of the plan's patients in a practice;
- co-location of a care manager in the practice;
- presence of a physician "champion" in a practice; and
- use of nurse practitioners or nurses to accompany patients on visits.

In all three states, Medicaid paid a capitation that included the costs of Medicare copays and deductibles, prescription drugs, ancillary services, Medicaid home and community-based services care waiver benefits, personal care attendant benefits, and all or some risk for custodial nursing facilities. Most of the integrated plans reported that compared to managing waiver benefits, contracting for and managing the Medicaid personal care attendant (PCA) benefit posed special challenges, including: identification of staff qualified to conduct the eligibility assessment, contracts with PCA management agencies and fiscal intermediaries for training and paying PCAs, employment of family members as PCAs, and excessive expectations of new enrollees previously receiving generous PCA hours under the standard fee-for-service program

A significant lesson apparent in the history of the MMIP project is the role of CMS. After granting approval to Minnesota, the Medicare portion of CMS refused to grant similar approvals to other states. CMS Medicare staffs were reported as saying they "...disliked managed care as



health care infrastructure and would not allow states to mandate managed care in Medicare or restrict Medicare choice by individuals in any way." The staff director of the RWJF project reported that "CMS staff was slow to advise the staffs of state projects about what constituted acceptable infrastructure for integrating Medicare and Medicaid, and slow in granting the necessary waivers for demonstration projects." 62

The Balanced Budget Act of 1997, which went into effect five months after the MMIP started, produced problems for states in getting waivers and, more importantly, created an adverse environment for managed care in integrated projects. The act introduced uncertainty about key issues such as rate adjustment for patient frailty. States had to revise waiver strategies that CMS had previously accepted. In time, states faced a seemingly endless set of barriers associated with the waiver approval process.

The act changed Medicare managed care requirements and established new payment systems that lowered payments for managed care plans and health care providers. The law also created the Medicare+Choice program, now called Medicare Advantage, which allowed new types of managed care plans to participate, and capped the growth in payments at less than the growth in fee-for-service spending.

Overall, the act made participating in integrated Medicare/Medicaid projects less attractive to health plans and providers. As a result, managed care plans began leaving states, and plans that had expressed interest in participating in integration projects pulled out. Individual providers also were less interested in participating in integrated projects.

Medicare Special Needs Plans

Special Needs Plans (SNPs) were authorized as a special type of Medicare Advantage plan under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA 2003). The concept of "special" arose because such plans are intended to target any one of three special-needs populations—beneficiaries who are institutionalized, have severe or disabling chronic conditions, or qualify both for Medicare and Medicaid benefits ("dual eligibles"). The intent of

⁶² Ibid. RWJF at http://www.rwjf.org/reports/npreports/mmip.htm#EvaluationFindings





the legislation was to encourage Medicare Advantage plans to enroll persons in these three categories. ⁶³

Perceived advantages to the SNP stem from the fact that special needs populations are more expensive than regular Medicare beneficiaries. Coordinating their care using focused managed care has the promises of being both cost effective and can promote better quality of care. The advantage to beneficiaries is receiving care from an organization that specializes in a particular type of beneficiary and care is presumably more appropriate and timely.

Because the beneficiaries in special needs plans have higher medical acuities, Medicare is willing to pay more for these higher cost beneficiaries. Thus one advantage to health care plans from sponsoring a SNP is the higher reimbursement level that can be received from Medicare. For example, in 2007 the payment level to SNPs was 11% higher than the payments made for fee-for-service beneficiaries.⁶⁴

Despite the perceived advantages, enrollment was a significant problem in the years immediately after passage of the MMA.

"...enrollment remains low in the majority of programs that fully integrate care via SNPs. This may be due to a number of reasons, not the least of which is the issue of voluntary enrollment. While states can mandate enrollment into Medicaid programs, Medicare is voluntary due to the "freedom of choice" requirement. As a result, even when integrated programs are available, there is no mechanism to ensure that dual eligibles will receive their Medicare and Medicaid services from a single plan. This has posed a significant challenge for enrollment in integrated programs.

In addition, low enrollment may result from the sometimes complicated processes that hamper beneficiary participation. For example, many programs do not yet have integrated enrollment processes, meaning duals must complete separate forms in order to enroll in one plan for both the Medicare and Medicaid benefit. This can be quite cumbersome for the beneficiary. And while experts and policymakers have discussed the idea of integrated care for years, it is a concept unfamiliar to most dual eligibles and their families. Beneficiaries (and their caregivers) may be reluctant to participate in these new

⁶⁴ Medicare Payment Advisory Commission, (2007, March), Report to the Congress: Medicare Payment Policy, Washington D.C.

⁶³ See, retrieved on 3-19-11 for text of P.L. 108-173, http://www.gpo.gov/fdsys/pkg/PLAW-108publ173.pdf Section 231 of Title II established the Special Needs Plans



programs/plans for fear that doing so will disrupt their relationships with current providers." 65

Among other factors, SNPs had limited resources to identify dual eligibles and marketing was a significant impediment.

In 2005, CMS allowed 42 SNPs in 13 states to "passively enroll" dual eligibles, effective January 1, 2006, if the individual was already enrolled in a Medicaid managed care plan offered by the same health plan. This enrollment was done in conjunction with Medicare's new Part D prescription benefit. Because of Medicare's freedom-of-choice rights, individuals were allowed to opt out of this passive enrollment and elect to go back to Medicare fee-for-service. The "passive enrollment" was controversial and generated some pushback from advocacy organizations. ⁶⁶

Although passive enrollment did result in improved SNP enrollment it also tended to concentrate enrollment. By 2006, 88% of all SNP dual eligibles were concentrated in 9 states.⁶⁷ As of March 2010, approximately 1.4 million out of 8.8 million dual eligibles, about 16%, are enrolled in SNPs⁶⁸. Some commentators take the view that this is still too small. Data from the Medicare data base for February 2011 shows that SNPs still tend to have small enrollment sizes.⁶⁹

Table 6: Average Enrollment by Type of SNP, February 2011



⁶⁶ See Pennsylvania Health Law Project letter of September 28, 2005 to CMS. Retrieved on 3-19-11 from http://www.phlp.org/Website/Medicare%20Part%20D/09.28.05%20Letter%20to%20HealthChoices%20MCOs.pdf

⁶⁷ Verdier, J., (2006, November 6), *Challenges and Opportunities in Caring For Medicare --Medicaid Dual Eligibles: the Role of Special Needs Plans*, Online Chat Kennedy School of Government.

⁶⁸ List of SNP programs and beneficiary enrollment levels retrieved on 3-19-11, from https://www.cms.gov/MCRAdvPartDEnrolData/SNP/list.asp

⁶⁹ Îbid. https://www.cms.gov/MCRAdvPartDEnrolData/SNP/list.asp



SNP Type	Number of Contracts	Number of Plans	Sub Total Enrollment	Average Enrollment per Plan
Chronic or Disabling Condition	46	92	162,207	1763
Dual- Eligible	218	298	1,050,864	3526
Institutional	42	65	80,508	1239
Totals	306	455	1,293,579	2843

The national averages are skewed as only 27 of the 455 plans have enrollments over 10,000 and these larger plans pull the average up. Nationally, 294 plans have enrollment levels of 2,000 or less. In February 2011, Colorado had six programs listed in the CMS database of SNPs. Colorado's SNP enrollment is consistent with national enrollment averages if you take this skewed distribution into account. These six Colorado programs are shown below:





Table 7: Colorado's Dual Eligible Special Needs Plans

Contract Number	Contractor Name	Plan Name	Plan Enrollment
H0621	Colorado Access	Colorado Access Advantage - Plan D	1,482
H0621	Colorado Access	Colorado Access Advantage Select D	759
H0624	UnitedHealthcare Insurance Company	Evercare Plan DH	2,238
H0630	Kaiser Foundation Health Plan of Colorado	Senior Advantage Medicare Medicaid Plan	2,450
H5608	Denver Health Medical Plan, Inc.	Denver Health Medicare Choice	1,155

In 2007 only seven states had operational programs with SNPs that coordinated Medicaid and Medicare benefits. 70 National policy makers were dissatisfied with the development of the SNP programs since many of them did not develop relationships with Medicaid and thus a hoped for integration of care was not generally occurring.

This lack of integration was understandable since the MMA establishing SNPs did not require SNPs to contract with states and nor did it require states to contract with SNPs. Added to this was the long standing reluctance of Medicare to require mandatory participation by its members in managed care. Thus none of the three parties necessary to achieve integration were incentivized to cooperate with one another. This lack of integration was addressed in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 which required new SNPs and SNPs expanding their service area to enter into contracts with Medicaid agencies effective in 2010. The Affordable Care Act 2010 extends to January 2013 the requirement for all dual SNPs to have contracts in place with states.

The contracting requirement made sense to policy makers because SNP penetration of the dual eligible market was higher in states with a cooperating Medicaid managed care program. In the twenty states that cover some dual eligibles in a comprehensive Medicaid managed care plan, the

⁷⁰ Milligan, C., & Woodcock, C., (2008, February), Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer, Commonwealth Fund, New York, NY.





penetration rate is 12.6 percent, compared to 2.8 percent in states that do not offer such coverage. Finally, the nine states with Medicaid managed care that includes some long-term care benefits have a 12.6 percent penetration rate, compared to 6.1 percent in the remaining states.⁷¹

These developments are still too new to be captured in retrospective evaluations. However, prior to 2008, those SNPs that did enter into arrangements with state Medicaid agencies primarily did so through capitated Medicaid payments for the Medicaid services provided to duals. Arrangements that relied on coordination or information and did not involve risk-related capitation were less frequent.



⁷¹ Grabowski, D., (2009), Special *Needs Plans and the Coordination of Benefits and Services for Dual Eligibles*, Health Affairs, 28, no.1:136-146.



Current Federal Initiatives for Integrated Care

In late 2010, under the authority of Section 2602 of the Affordable Care Act (ACA), CMS established the Federal Coordinated Health Care Office (CHCO). This new office is charged with coordinating care for the millions of dual eligibles and ensuring quality health care and cost-effectiveness. The main goals of the office outline the benefits of integration and the necessary steps to achieving innovative care for dual eligibles:

- Improve quality, reduce costs, and improve the beneficiary experience.
- Ensure dually eligible individuals have full access to the services to which they are entitled.
- Improve the coordination between the federal government and states.
- Develop innovative care coordination and integration models, and
- Eliminate financial misalignments that lead to poor quality and cost shifting.⁷²

The creation of the Coordinated Health Care Office considers care integration to be a major priority. The conflicting incentives and policies of Medicare and Medicaid are a major challenge, financially and administratively, to coordinating care for dual eligibles. While efforts are underway to better coordinate Medicaid and Medicare programs from the federal level, integrated care models at the state or regional level also have an opportunity for leadership. However, there are challenges in integrating care.

On November 16, 2010, CMS formally announced the establishment of the Center for Medicare and Medicaid Innovation (Innovation Center) created by the ACA. The Innovation Center is charged with exploring new health care delivery and payment models that will enhance the quality of care for Medicare and Medicaid beneficiaries, improve the health of the population, and lower costs through improvement. One of the Innovation Center's first initiatives to support

⁷² See SCAN Foundation webinar of February 3, 2011 for the Director's slides explaining the new office. Retrieved on 3-19-11 from http://www.thescanfoundation.org/foundation-publications/scan-foundation-webinar-highlights-new-resources-improve-system-care-dual-el



the Coordinated Health Care Office in implementing State Demonstrations to Integrate Care for Dual Eligible Individuals. Through the State Demonstrations to Integrate Care for Dual Eligible Individuals, CMS will provide funding for up to 15 states to support the design of integrated service delivery and payment models for dual eligible individuals. The overall goal of these demonstrations is to rapidly test integrated care models that can be replicated in other states.

Another relevant initiative emerging from the ACA is the Medicare Shared Saving Program (MSSP). CMS issued proposed rules on March 31, 2011 on requirements and payment incentives for accountable care organizations (ACOs), the centerpiece of the MSSP that will be implemented on January 1, 2012 under section 3022 of the ACA. The proposed rules show how ACOs may qualify for Medicare incentive payments if they collectively achieve savings targets as well as quality and performance benchmarks. Savings targets are subject to case mix adjustments and other variables. Each provider participating in an ACO may continue to receive Medicare fee-for-service payments in the usual manner but the ACO may receive incentive payments from Medicare as a percentage of actual Medicare savings. The proposed rules address Medicare incentive payments only but participation in ACOs is open to Medicaid recipients, dually entitled recipients, and others.





Models of Integration for Dual Eligibles

Attempts have been made to classify the options available to states for integrating care for dual eligibles. Most of the literature on integrated care programs has focused on models involving Medicare Advantage Special Needs Plans. Other models for integrating care, while largely untested, are emerging that may hold promise as alternative approaches. In this section, we have selected specific state examples to examine both traditional SNP models and new models for integrating care for dual eligibles.

The Center for Health Care Strategies (CHCS) is a national non-profit organization that works directly with states and federal agencies to improve the quality of health services for beneficiaries served by publicly financed care, especially those with chronic illnesses and disabilities. Since 2005, CHCS has worked closely with CMS on the *Integrated Care Program* that focused on planning requirements for state contracts with SNPs. The *Transforming Care for Dual Eligibles* initiative was later developed by CHCS in 2009 to increase the number of dual eligibles who benefit from the improved quality and cost-effectiveness associated with integrating care. CHCS has grouped options for integrated care programs into four broad categories: (1) Special Needs Plans; (2) Program for All-Inclusive Care for the Elderly (PACE); (3) Shared Savings Models; and (4) States as Integrated Care Entities.⁷³

A 2008 Issue Brief published by The Commonwealth Fund examined three potential models for coordinating federal Medicare benefits with state-administered Medicaid benefits. These models included: (1) Voluntary Integrated Programs; (2) Mandatory Programs with Potential Side Agreements; and (3) Program with an Administrative Services Organization Arrangements. All three models classified by researchers with the Center for Health Program Development and Management at the University of Maryland, Baltimore County (UMBC) are variations of the SNP model. The ASO arrangement envisions the state executing contract arrangements with one

⁷³ Bella, M & Barnette, L. (2010, March) *Options for Integrating Care for Dual Eligible Beneficiaries*, Center for Health Care Strategies, Hamilton, NJ.





or more SNPs to administer Medicaid benefits for an administrative fee. UMBC researchers did note that the ASO could be an entity entirely unrelated to the SNP(s), as long as it had competencies in administrative services and coordination of care.⁷⁴

Irrespective of the particular model, there is high variation in covered Medicaid benefits and levels of integration, even within similar models. A CMS review of existing integrated contracts between states and organizations providing Medicaid managed care plans in concurrence with a SNP revealed a significant amount of variability regarding the scope of Medicaid benefits provided or arranged for by the SNP.⁷⁵ Generally, State options include covering:

- Medicare Part B premium/coinsurance/deductibles;
- Medicaid only benefits (e.g. non-emergency transportation, dental, vision, hearing and covered durable medical equipment/medical supplies); and
- Institutional and community based long-term supports and services.

Special Needs Plan Models

Medicare SNPs are often noted as the most proven means for successfully integrating care for dual eligibles. As discussed in the previous section, SNPs were authorized in Section 231 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). SNPs are a special type of Medicare Advantage plan specifically designed to provide services to high-need Medicare beneficiaries. As noted above, targeted subpopulations permitted to enroll in SNPs are:

- Beneficiaries with chronic conditions;
- Beneficiaries requiring an institutional level of care; and
- Dual eligibles.

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Advantage Organizations that Adhere to MIPPA Requirements

Milligan, C. & Woodcock, C., (2008, February), Coordinating Care for Dual Eligibles: Options for Linking State Medicaid Programs with Medicare Advantage Special Needs Plans, The Commonwealth Fund, New York, NY
 Booz, Allen, Hamilton, (2009, December 2) State Options for Designing Dual SNP Contracts with Medicare





Medicaid managed care programs for dual eligibles predated the enactment of the MMA. Minnesota, Wisconsin and Massachusetts represent an early generation of integrated care programs emerging from the Robert Wood Johnson Foundation's Medicare/Medicaid Integration Program. These states used Medicare payment waivers to create programs with truly integrated financing for dual eligibles. Receipt of Medicare payment waivers allowed a single combined capitated payment for each beneficiary. CMS elected to discontinue Medicare waivers once the authority for Medicare SNPs were authorized in the MMA and required the early integrators to transition to SNP-based models.

Another long standing model that leverages Medicare Advantage SNPs is the Medicare Cost Sharing Only approach. Medicare Cost-Share Only contracts/agreements with Medicare Advantage plans cover the Medicare premiums and beneficiary cost sharing that Medicaid is required or chooses to pay for dual eligibles. When dual eligibles voluntarily enroll in a participating Medicare health plan, the state pays the plan a capitated payment for required Medicaid reimbursement for Medicare copays, deductibles, and coinsurance. These contracting arrangements with Medicare Advantage plans have preceded the MMA and creation of SNPs. Alabama Medicaid has been contracting with Medicare Advantage Plans to provide cost sharing for dual eligibles since 1998. Alabama has 23,000 beneficiaries, roughly 12% of the total dual eligible population, enrolled in one of the five Medicare Advantage plans that contract with the state. The Medicaid Agency has reported costs savings of \$45-\$65 per member per month by having Medicare health plans administer Medicaid's cost sharing obligations. ⁷⁶

Maryland and Texas are other states that employ Medicare Cost-Share Only agreements. Texas has developed contracts for Medicare cost-sharing and coordination of care with all SNPs in the state. In addition to simply administering Medicaid's cost sharing obligations, these contracts include requirements to promote improved care coordination. For example, contracts include requirements for prompt notification to the state when a dual eligible beneficiary enters into a nursing facility. The intent of this required notice is to allow the state to ensure that appropriate

76 "Edwards, B., et. al. (2009, September), Integrating Medicare and Medicaid: State Experience with Dual





discharge planning occurs so that the individual has the option to return to the community if feasible.

While integration of Medicare and Medicaid benefits in Medicare Cost-Sharing Agreements is limited to Medicaid cost sharing, such an arrangement can foster relationships with Medicare SNPs in states that have limited experience working with Medicare SNPs. Contractual provisions to improve care coordination, as in the Texas example, were bolstered as a result of the Medicare Improvements for Patients and Providers Act (MIPPA), signed into law on July 15, 2008. MIPPA §164 required that all dual SNPs contract with the state Medicaid agency to provide benefits for the dual eligibles enrolled in its plan. Initially, such SNP contracts with states were required by 2011; however, the Affordable Care Act amended this timeline through 2012. Also, Medicare Cost-Share Only contracts could serve as a vehicle for partial duals enrolled in Medicare Savings Program who are not eligible for a full range of Medicaid benefits.

The use of SNPs is the dominant model used by states to integrate care for dual eligibles. As previously noted, CMS forced early adopter programs to convert from Medicare payment waivers to a SNP model following. This change occurred after the passage of MMA. For example, Massachusetts' Senior Care Options program, initially authorized under a Medicare payment waiver, now operates under 1915(a) authority. Minnesota also now operates its Special Needs Basic Care (SNBC) as a voluntary program for dual eligibles with disabilities under 1915(a). Section 1915(a) simply conveys authority for the state to enter into a voluntary contract with an entity to provide Medicaid services. Both states use 1915(a) with concurrent and 1915(c) home and community-based services waivers to cover individuals eligible for Medicaid long-term supports and services (LTSS) at higher income levels. The Wisconsin Partnership Program operates under a 1932(a) State Plan option to use managed care.

Voluntary enrollment in integrated care programs through SNPs is the most common approach used by states. Under this model, Medicare dual eligibles voluntarily choose a Medicare Advantage-SNP for their Medicare benefits and also voluntarily enroll in the same health plan for their Medicaid benefits. The benefits of this model are clear. The care provided under both the Medicaid and Medicare programs is managed by a single managed care organization.



Financing under this model is not truly integrated as the managed care organization holds one capitated contract with the state Medicaid agency to deliver Medicaid services and a separate capitated contract CMS to deliver Medicare services as a SNP. However, because a single managed care organization carries full risk for both Medicare and covered Medicaid benefits, there is a strong incentive for the health plan to coordinate care.

In recent years, states have attempted to develop integrated care programs for dual eligibles by taking advantage of the MMA's establishment of SNPs. Other state Medicaid programs have developed separate capitation payment for SNPs to deliver Medicaid benefits in coordination with covered Medicare benefits. They include:

- New York Medicaid Advantage;
- New York Medicaid Advantage Plus (includes LTSS);
- Idaho Coordinated Care Plan;
- Florida Senior Care (includes LTSS)

Because participation in this model is entirely voluntary for dual eligibles, achieving high levels of enrollment has been difficult. Thus, a state must typically weigh the likelihood of moving to scale against the administrative challenges of continuing to operate its regular Medicaid fee-for-service program for those dual eligibles that choose not to enroll in the voluntary program. Also, in order to minimize the impact of selection bias in a voluntary program, the program must have a well conceived rate-setting system that takes the appropriate risk factors into account.⁷⁷

A variation of the SNP model for integrating care for dual eligibles is the use of mandatory Medicaid managed care with arrangements with SNPs. Mandatory Medicaid managed care in some states requires dual eligible beneficiaries to enroll with a Medicaid managed care organization. To foster care integration, states require that Medicaid health plans either be SNPs or have tangible arrangements with SNPs in place.

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⁷⁷ Milligan, C. & Woodcock, C., (2008, February), *Coordinating Care for Dual Eligibles: Options for Linking State Medicaid Programs with Medicare Advantage Special Needs Plans*, The Commonwealth Fund, New York, NY





Arizona Long Term Care System (ALTCS) section 1115 waiver requires that all contractors must either be certified as a SNP or have a connection to a SNP to ensure coordination with Medicare for dual eligibles. About half of the ALTCS plans also operate as SNPs. Despite these efforts, misalignment of administrative, operational, and regulatory processes continues to be an ongoing challenge for providing an integrated and well-coordinated system of care to dual eligibles. Hawaii amended its existing 1115 waiver in 2009 to implement QUEST Expanded Access (QExA) for aged, blind and disabled beneficiaries. QExA contractors are required to have SNP agreements in place or are ready to start the agreement process. Both Arizona and Hawaii cover long-term care services in mandatory managed care plans for dual eligibles as part of their 1115 waivers.

Texas STAR+PLUS operates a mandatory managed care program through combined section 1915(b)/(c) waivers. STAR+PLUS provides a continuum of care including acute health care and long-term services and support. Dual-eligible members are enrolled in STAR+PLUS, in which Medicaid only covers community based long-term services and supports. Texas did not initially require Medicaid MCOs under STAR+PLUS to be SNPs, as the program was initially approved in 1997. However, all of the current STAR+PLUS contractors now also serve as SNPs. Medicaid plans participating in the new STAR+PLUS expansion area (in Dallas/Ft. Worth) will now be required to also be designated as a SNP.

New Mexico began a statewide program called Coordinated Long-Term Services (CoLTS) in August 2008 under §1915 (b)/(c) waiver authority. Enrollment is targeted to 38,000 adults that need long-term care, including dual eligibles, and contracted plans that cover all Medicaid services including LTSS. New Mexico requires that its CoLTS contractors become SNPs in as many counties as possible to help coordinate care between both Medicaid and Medicare.

States cannot require dual eligibles to enroll in a Medicare Advantage plan for their Medicare benefits. Even in states with mandatory enrollment in Medicaid managed care plan that also seek to integrate care through SNPs, actual SNP enrollment remains voluntary. The beneficiary may

⁷⁸ Huff Redman, L., *Health Care Reform Hits Arizona*, Impact Arizona Retrieved 3-17-11 from www.slhi.org/healthcarereform





choose to enroll in the SNP that also serves as his or her Medicaid managed care organization. The beneficiary may choose to remain in Medicare fee-for-service, requiring that the Medicaid health plan coordinate the contractual Medicaid benefits with a myriad of Medicare FFS providers. The beneficiary could even enroll in a different SNP (or other Medicare Advantage plan) that is not the same as the beneficiary's Medicaid MCO, creating coordination challenges across the two separate health plans.

State as Managed Care Organization

One emerging model that is attracting significant attention is the State as Managed Care Organization. Under the model, the state essentially functions as a Medicare managed care organization, taking on the responsibility for the provision of Medicare services to dual eligible beneficiaries. The leading example of a state exploring this model is Vermont.

Under Vermont's Global Commitment and Choices for Care LTC 1115 waivers, the Office of Vermont Health Access, the state Medicaid agency, functions as a public managed care organization for all Medicaid services. Dual eligibles are covered under both section 1115 waivers. Vermont hopes to combine its existing Medicaid 1115 waivers with Medicare authority and funding and implement a program where the state would administer all services for dual eligibles as a Medicare plan. Vermont also seeks authority to operate under one set of rules and regulations and construct the financing arrangement to allow for shared savings.

This model would allow for a complete blending of Medicare and Medicaid funding streams to better coordinate care for dual eligible beneficiaries. In that sense, the model returns full circle to the early integrated care models developed under Medicare payment waivers prior to the enactment of the MMA. A key benefit is that potential savings from Medicaid acute care services could be realized by the state and reinvested in the system to enhance overall care to dual eligibles. The downside correlation is that the state would bear financial risk for covered Medicare benefits. The potential impacts of a voluntary enrollment due to potential adverse risk selection could be a great concern because the state bears full Medicare risk.





As discussed previously, Federal law contains broad demonstration authority that permits CMS to test new approaches to provider reimbursement, delivery systems, and additional coverage in Medicare and Medicaid. This authority may be broad enough to permit mandatory enrollment under such a model. Whether CMS would allow any limitations on Medicare beneficiaries freedom of choice is doubtful, but remains to be seen. Vermont, which plans to include all dual eligibles in its proposed integrated care program, is currently discussing a passive enrollment with an opt-out provision. That is to say, dual eligibles would automatically be enrolled in the state's Medicare managed care plan but have the option to disenroll at any time. Over 200,000 dual eligibles were passively enrolled from Medicaid managed care plans into SNPs following the implementation of the MMA. Such actions have resulted in past and present legal actions asserting violations of the Medicare statute, (especially the Medicare Modernization Act), the Administrative Procedure Act, and the Due Process Clause.

PCCM with Shared Savings

Another innovative model that stops short of the state managing full risk for Medicare benefits for dual eligibles is the Primary Care Case Management (PCCM) with Shared Savings approach being tested in North Carolina. This model builds on a robust PCCM program, called Community Care of North Carolina (CCNC), which has enrolled Medicaid-only seniors and people with disabilities for several years. Starting in January 2010, the state began auto-assigning the dually eligible population residing in roughly one-third of the state's counties participating in a Medicare Health Care Quality (MHCQ) demonstration. MHCQ demonstrations were mandated by section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

North Carolina Community Care Network (NC-CCN), a nonprofit, physician-led organization established in May 2006, applied for and received the MHCQ demonstration contract because the demonstration required a contractual relationship with an entity representing the provider

⁷⁹ Rosenbaum, S., et. al. (2009, November), *Supporting Alternative Integrated Models for Dual Eligibles: A Legal Analysis of Current and Future Options*, Center for Health Care Strategies. Princeton, NJ

Verdier, J., (2007, December 12), *The Future of Medicare Special Needs Plans*, Center for Health Care Strategies, Integrated Care Program Policy Summit, Princeton, NJ.





networks, and governmental organizations such as CCNC were not eligible to apply. NC-CCN has assumed some of the responsibilities that were previously performed by Community Care of North Carolina (CCNC). NC-CCN provides clinical and technical assistance to 14 regional networks representing more than 4,000 physicians in all 100 NC counties. NC-CCN helps the networks to identify their patient population and to develop performance measures, supports training for networks and providers on new quality improvement initiatives, and provides legislative reporting for the state Medicaid program. NC-CCN plans to implement targeted interventions for chronically ill patients that include services similar to those provided by CCNC. Regional networks will assist assigned primary care providers in developing transitional care plans, disease management initiatives, and a behavioral health integration effort. Networks are also developing clinical protocols for coordinating services (e.g., ancillary services, therapies, home health, pharmacy, etc.).

The NC-CCN Informatics Center is an electronic data exchange infrastructure sponsored by the North Carolina Department of Health and Human Services (DHHS). The Informatics Center provides a secure web portal and report distribution system to networks for patient, practice, and network level data. NC-CCN plans to link CMS claims data with data from Medicaid and providers to generate patient-level and provider-level quality reports, alerts, and reminders for participating providers.

In this model, the existing FFS Medicaid and Medicare systems are largely maintained as is. There is limited flexibility to tailor benefits as under capitated payment arrangements. However, there is also limited risk for the state, with an upside opportunity for the state to share in Medicare savings realized through improved care coordination for dual eligibles. In North Carolina, the section 646 Medicare waiver authority allows for sharing a portion of Medicare savings in the event the demonstration site reduces Medicare costs, with at least half of any shared savings payment made to NC-CCN will be contingent on achieving targets on a set of performance measures. The upside gain-sharing eliminates disincentives for Medicaid to invest in care management activities that reduce costs for Medicare acute care benefits for dual eligibles.



Key Lessons from Select States

As previously documented, there is a considerable body of knowledge related to long standing integrated care programs in Massachusetts, Minnesota and Wisconsin, as well as PACE. As part of this research process, PCG interviewed a number of states with lesser known and newer integrated care programs for dual eligibles to gain a better understanding of their experience and the lessons learned in developing such programs. These states included Florida, Oregon, Tennessee, and Washington. North Carolina's integrated care program was described previously. North Carolina was of particular interest because, unlike other programs, the initiative to improve care for dual eligibles was designed around a primary care case management system, not risk-based capitation arrangements.

Voluntary Enrollment Can Limit Programs Achieving Scale

It was not uncommon for states to limit attempts at integration to target specific populations or selected geographic areas. This was the case for Florida's Senior Care program and Washington's Medicare Medicaid Integration Project. Both sought to test integrated care by limiting program enrollment to older dual eligibles age 65 and older, and in designated areas of the state.

Florida applied for and received the necessary Medicaid waivers to begin a mandatory Medicaid enrollment program for dual eligibles in Florida Senior Care. The state received approval for a 1915 b/c combo, effective Nov 2006. Waiver authority expired in 2008 without the program being implemented. Initial plans included mandatory enrollment in the Florida Panhandle (voluntary in the more populous Central Florida area), but 2007 legislative changes made all enrollment voluntary. State agency staff viewed mandatory enrollment as fundamental to get to critical mass (particularly in less populated areas like the Panhandle), and this change was a significant reason why Florida Senior Care was not implemented.

Washington only targeted 500 enrollees. Enrollment numbers remained well below that target, which ultimately led to the decision by the state and the managed care plan to end the program in 2009. Oregon's integrated care pilot through CareOregon also reflects the difficulty of reaching critical mass in a completely voluntary enrollment environment. CareOregon serves almost





128,000 low-income Oregon residents, representing nearly one-third of the state's Medicaid enrollees. Duals are not mandatorily enrolled in Medicaid managed care under Oregon's 1115 waiver. While more than 6,000 dual-eligibles are enrolled in CareOregon's Medicare Advantage Special Needs Plan, only a fraction (c. 1%) is enrolled in the integrated care pilot.

Thus, an important lesson involves the Freedom of Choice requirements in the Medicaid statute (Title 19). States were cognizant that they would need a Medicaid waiver in order to do mandatory enrollment. Obtaining a waiver of Medicaid law can be an arduous process. As one state official shared, regarding mandatory enrollment of duals into integrated care "It is the right direction and we may do it sooner or later. It is a question of finding the time to do all the pieces for it. We simply t haven't had the time."

It is important to note that the discussion of Medicaid freedom of choice waivers does not even address freedom of choice requirements in the Medicare statute (Title 18). Medicare beneficiaries have the freedom to choose their providers and as a result cannot be required to enroll in a health plan. For dual eligibles, this means that Medicare gives patients the right not to enroll in a managed care plan that would integrate care. With respect to this issue, North Carolina's experience with enrollment was quite instructive.

North Carolina amended its state plan to include an "opt out" process for enrolling dual eligibles in its primary care case management (PCCM) program. Dual eligibles receive a letter informing them of the medical home to whom they will be assigned unless they contact the state to request an exemption within 30 days of receipt of the letter. The letter also provides notice to beneficiaries of their right to opt out (i.e. disenroll) at any time during their enrollment process. Technically, dual eligibles are still "optional" (i.e. non-mandatory) participants in the Community Care of North Carolina PCCM program, as they can disenroll from the program at any time. However, the shift opt-out mechanism resulted in a dramatic enrollment increase to over 80,000 of the total 200,000 dual eligible population.

The state indicated that obtaining federal approval for a State Plan Amendment, which is generally quicker and easier than obtaining a waiver, was not the challenge. Questions arose after





approval. In hindsight, CMS wanted "lots of freedom of choice explained" to Medicare beneficiaries. CMS requested specific changes in the PCCM member handbook, call center manuals, and program fact sheets to make a clear distinction between Medicaid (where the PCP can function as a gatekeeper) and Medicare rights (where there are no limitations on service).

The state is still working on how best to do address Medicare requirements in their Medicaid member material. In the state's view, they generally do not explain another agency's program. A key lesson shared along was to coordinate with CMS – both Medicaid and Medicare staff – ahead of time and share all member-related material in advance of program implementation of an integrated care program. There was a common refrain of advice to keep in close contact CMS regarding state plans/waivers as necessary.

Benefits Design Must Consider Behavioral Issues and Chronic Care

Most of the states interviewed were interested in integrated care for dual eligibles as an effort to integrate medical and long-term care services. Florida, Washington and Tennessee all sought, to some degree, to incorporate long-term care benefits in capitated integrated care programs. Those states utilizing a SNP model for integrated care also included Medicaid behavioral health services within the plans' benefits package. Care coordination was a critical benefit feature found across different states, regardless of integrated care model.

Tennessee has enrolled full benefit dual eligibles in a TennCare managed care plans since 2006. These plans offer primary care, acute care, and behavioral health care. Long-term care benefits were traditionally been carved out of managed care. Tennessee requested permission to integrate long-term care for elderly and disabled individuals through a change to its statewide managed care program operating under a Section 1115 waiver. The state began discussions with CMS about this program since in July 2008 following passage of the state's Long Term Care Community Choices Act of 2008. One year later, CMS approved an amendment to the TennCare waiver that will allow managed care organizations to coordinate all of the care a TennCare member needs. The new program, called CHOICES, will now include medical, behavioral and long-term care. The program was actually launched in August 2010.





Under the CHOICES program, TennCare enrollees who qualify for long-term care, including dual eligibles, enrolls with a single entity to manage access all of the different kinds of Medicaid benefits. These benefits include nursing facility services and more community-based options for home care services, in addition to medical and behavioral health services. The state intended to move away from a heavy reliance on the most costly long-term supports and services (98% of long-term care spending for Nursing Facility services) and spur the development of lower-cost community-based residential alternatives such as adult care homes and live-in companion care. The CHOICES program as an avenue to stretch existing funding further from the potential to nearly double the number of people receiving services in the home and community in the first year using existing state dollars.

Oregon is on the other end of the spectrum with respect to long-term supports and services. Oregon provides a broad array of Medicaid long-term care services, with roughly 80% of long-term supports and services provided in non-traditional settings. Despite the development of a robust long-term care system, service delivery across long-term care and acute services remained segregated. In attempting to use integrated care to improve acute care for beneficiaries receiving long-term care, the state realized that broader learning was needed to have the acute health care system learn about long-term supports and services. The state indicated the acute care system may have underestimated how developed the state's long-term care system really was – thinking of long-term care as nursing homes and not adequately understanding the concept of home and community-based services. A lesson learned is that efforts to bring both systems together are more complicated than most people who advocate the rapid development of an integrated system realize.

In addition to Washington's Medicare Medicaid Integration Project referenced above, the state began the Washington Medicaid Integration Partnership project in January 2005. This managed care model initially integrated medical and chemical dependency services. The state expanded to include mental health services later that year, and long-term care services were added to the project in 2006. Washington Medicaid Integration Partnership reflects an awareness of the behavioral health needs of dual eligibles.



In contrast to state like Washington that use risk-based capitation arrangements to integrate funding for Medicaid behavioral health services, North Carolina relies on collaborative strategy to integrate its Community Care of North Carolina PCCM program with mental health and substance abuse services. In 2005, North Carolina began providing Medicaid-funded services for mental health, substance abuse, and development disabilities on a capitation basis in a five-county area through a local behavioral health carve out plan. Care initiatives by the North Carolina Community Care networks include primary care screening for behavioral issues and linkage to access specialty mental health. The Medicaid agency also implemented new procedure codes that enable physician practices to provide behavioral health and substance abuse services.

In North Carolina, behavioral health integration also occurs through mental health provider colocation at primary care practice sites. North Carolina also has disease management initiatives in asthma, diabetes, heart disease and now palliative care across all Community Care of North Carolina networks. A large number of care managers are also located in the PCP practice and are part of the practices, where clinical team having access to the staff and the systems.

All MCOs in TennCare are required to offer 9 separate evidence-based disease management programs (diabetes, congestive heart failure, major depression, coronary artery disease, etc.). Care Coordination in Tennessee's CHOICES program is enhanced to provide an integrated model of coordination of care. Comprehensive, continuous, holistic, and person-centered coordination of care is designed to help the member maintain or improve physical or behavioral health status or functional abilities.

In the Washington Medicaid Integration Project, services are coordinated through a coordinated care team within the health plan comprised of: nurse case managers, social workers, care coordination specialists. Oregon has had a requirement for care coordinators since 1985 when the state began enrolling persons. This is a requirement at the plan level and plans have exceptional needs care coordinators (Care Coordination Workers) that can embed expertise in primary care. Dual eligibles have been a main focus of that requirement. For example, CareOregon also uses specialized care teams to address discrete, high-risk situations. This transitional care team focuses on dual-eligible patients who are transitioning from one care setting to another. This





team uses the evidence-based care transitions intervention developed by Eric Coleman, M.D., to reduce the risk of preventable readmissions.

Data Limitations Can Hinder Clinical Improvement and Rate Setting

States generally recognized the need to strengthen administrative and clinical health information systems to foster improved care integration. In 2006 CMS developed a model national contract, called the Coordination of Benefits Agreement (COBA), to facilitate the standardized exchange of eligibility and Medicare claims payment information. A COBA permits states to receive Medicare Parts A and B from CMS. Historically, the use of claims data received through a COBAs was restricted to only determining payment liability and coordinate payment for dual eligibles.

In 2008, CMS offered State Medicaid Agencies the opportunity to exist modified COBAs that permit the data to be used for quality improvement activities and to re-release the data for treatment and other purposes. Tennessee was one of the first states to receive CMS approval to use Medicare Parts A and B claims data for activities aimed at improving the quality of care for dual eligibles. In 2009 Tennessee also received approval to share the Part A and Part B claims data to MCOs in order to identify dual eligibles that are eligible for disease management programs and to better coordinate Medicaid and Medicare services for duals.

North Carolina Community Care Networks, Inc. (NC-CCN) Informatics Center hosts an electronic data exchange infrastructure maintained in connection with the state's Community Care of North Carolina PCCM program. NC-CCN is the non-profit entity comprised of and governed by its constituent 14 community-based PCCM networks. Networks utilize a web based information system containing claims information, diagnosis, procedure/drug information, cost, and utilization data to identify network enrollees who might benefit from care management services and to document interventions. NC-CCN actually negotiated the 646 Medicare waiver as part of the Medicare Health Care Quality Demonstration. NC-CCN is getting Medicare data from CMS, but only Part A and Part B data. North Carolina is working on integrating Medicare Part D pharmacy data, which is not been available at this time. State staff noted that filling in the missing data for duals has been their biggest challenge. For example CCNC implemented a





pharmacy management initiative called the Pharmacy Home Project. The project aggregated pharmacy claims and used automated processes to and translating the data into adherence calculations and clinical care alerts for network pharmacists, case managers and primary care providers. State staff was confident that quality improvements to eliminate medication errors were possible for dual eligibles if Part D data was available.

Washington is just venturing into getting Medicare data. State research staff is working with CMS to get the Medicare data through the COBA process. The state also experiences barriers in extracting data from its own Medicaid Management Information System (MMIS), and is now in process of procuring a new MMIS. Washington is looking to make use of its Integrated Client Database (ICDB) and Predicative Risk intelligence System (PRISM) to inform development of its integrated care program. ICDB and PRISM tools for risk stratification and clinical decision support. One of Washington's explicit goals is to improve capitation rate-setting for duals --including risk adjustment based on long-term care assessment.

Oregon receives Medicare cross-over data but has found the data of limited value for program planning and rate setting because of data gaps. The state has used crossover claims data recognizing that cross-over claims do not provide a complete profile of dual eligibles enrolled in traditional Medicare. Oregon agency staff supplements cross-over data with any national reports that they can get their hands on, with recognition that assuming that the state's actual experience is similar to national data may not be valid. Oregon has established an all-payer database that will soon maintain paid claims for Medicaid and Medicare Advantage plans. Medicare data is the missing element. The state is revising a COBA agreement to receive all Medicare Part A and B claims. Oregon views this as an important vehicle for decision support and rate setting.

Stakeholders Engagement and Buy-In is Essential

Oregon expressed reservations regarding including capitated long-term care, and home and community-based services and nursing facility care, in its approach to integrated care. The state elected to focus on medical acute care, including primary care and behavioral health services, for people in long term care. The idea not to cover the costs of their long term care services was in large part due to legislators' consideration of stakeholder objections.





Like Oregon, Washington cited difficulty for its integrated care plan in navigating LTC system. Also similar to Oregon, Washington push back from stakeholders was in part due to a suspicion of managed care. Dual eligible enrollment in the Washington Medicaid Integration Partnership is low, despite specific outreach efforts to increase enrollment; the voluntary program includes auto-enrollment of all but dual eligibles. A lesson learned was to start dialogue and meet with providers and community members regularly and expect to provide significant outreach to both providers and potential enrollees.

Florida undertook extensive process for stakeholder input in developing Florida Senior Care, yet still encountered opposition from providers and advocacy group for seniors. As noted previously, Florida's program was impacted by significant legislative changes to the initial program design. In addition to eliminating mandatory enrollment, one modification by the legislature essentially prohibited network building in response to strong lobbying by the nursing home industry. In contrast, Tennessee was able to gain buy-in from a wide variety of stakeholder groups through their open communication and collaboration with stakeholders in designing and implementing its CHOICES program. This buy in from stakeholders was supported by the unanimous passage of the Long-Term Care Community Choices Act of 2008 that integrated long term care services into the current capitated TennCare system under the TennCare managed care organizations.

North Carolina community-based networks have had long standing support. Physicians view the CCNC model as a positive alternative to the capitated arrangements with managed care plans that were being adopted by the Medicaid programs in many other states. North Carolina Community Care's interest in participating in the Medicare Health Care Quality Demonstration Program began in 2006 after the North Carolina General Assembly directed Community Care to extend its medical home and community-based care management system to aged, blind, disabled Medicaid beneficiaries, including dual-eligible. The legislature supported the effort to obtain the 646 waiver that allows the networks to share Medicare savings with CMS and has since passed legislation requiring a comprehensive plan to address shared savings budget models for the Medicaid enhanced PCCM system.

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