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HEALTH ANALYTICS

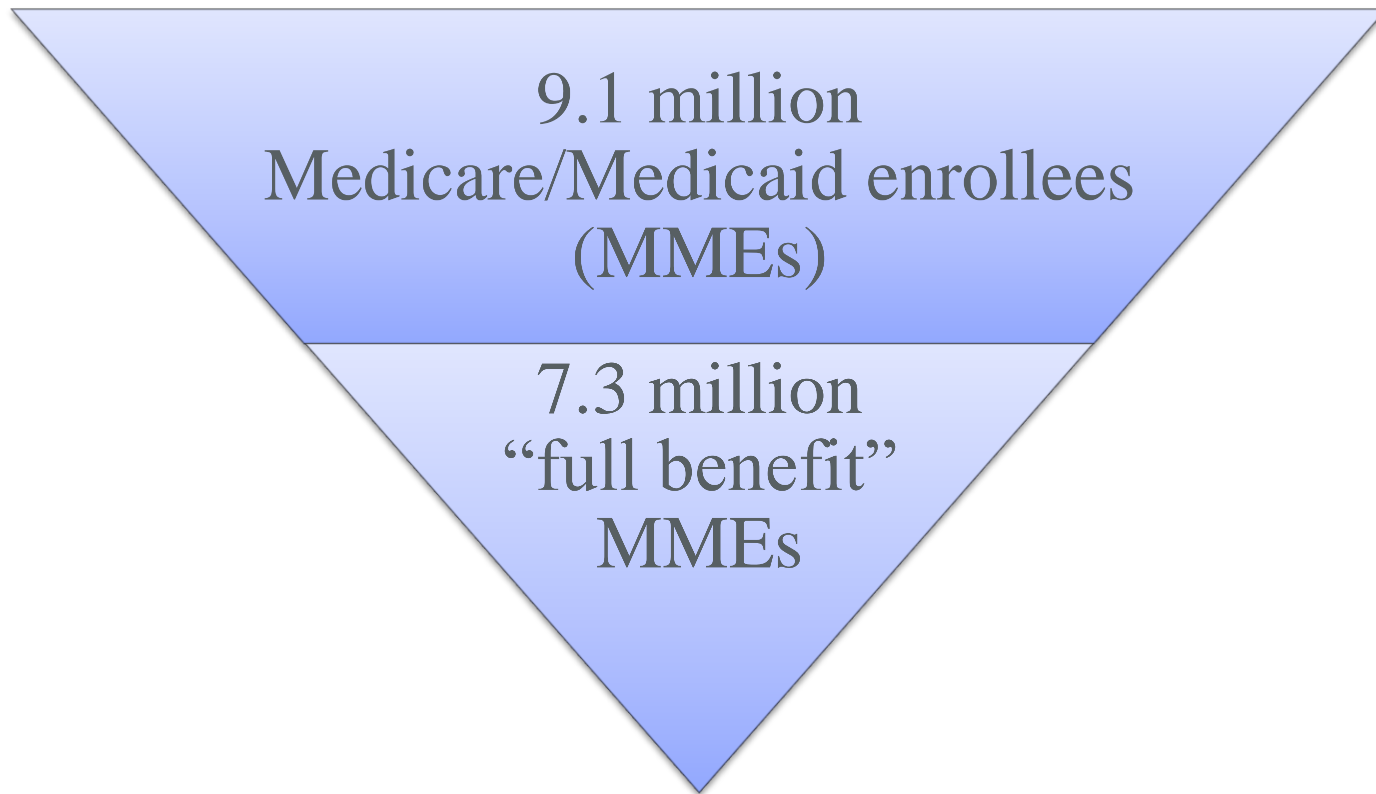
New England Fiscal Leaders Meeting

Opportunities for Budget Savings: Integrated Care Models for Dual Eligibles

Brian Burwell, Vice President
February 22, 2013

Who are Dual Eligibles?

Dual Eligibles are persons who are eligible for both Medicare and Medicaid.



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Why the Focus on MMEs?

- MMEs account for a high proportion of Medicare and Medicaid spending
  - About $300 billion in total Medicare/Medicaid spending in 2009
  - Average Medicare spending for MMEs is about double the average spent on non-MMEs
- Care is both high cost and low quality
- Care is fragmented across two programs
- Opportunities for program savings and better quality are considerable through improved approaches to care management
- Classic win-win opportunity

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- 61% Female
- 43% Non-White
- 55% limited in Activities of Daily Living
- 50% have less than high school education
- Only 16% live with a spouse
- High percentage have mental health issues and/or cognitive impairments
- High percentage do not use English as primary language
- Many persons become MMEs as a result of catastrophic life events

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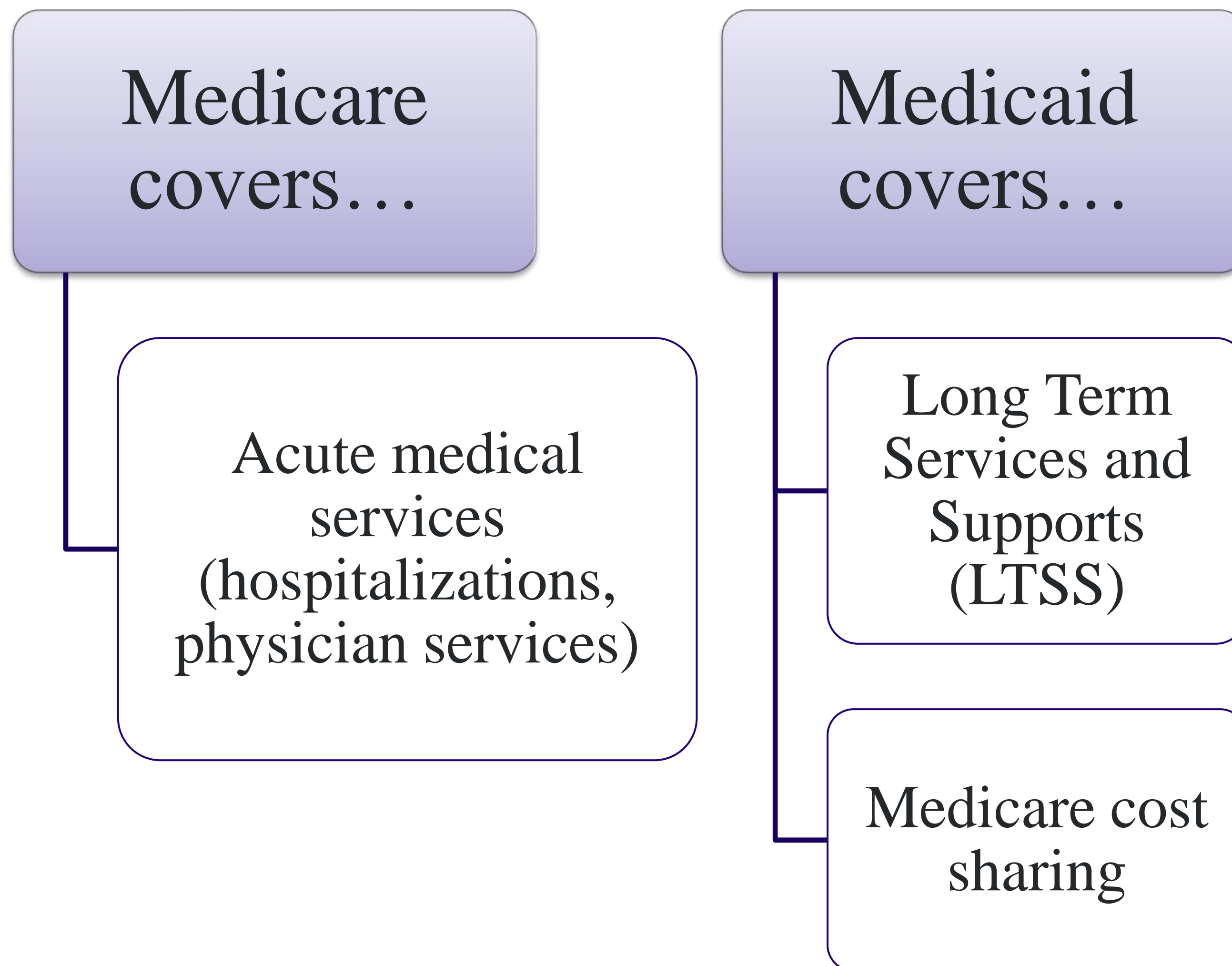
What do Medicare and Medicaid pay for?



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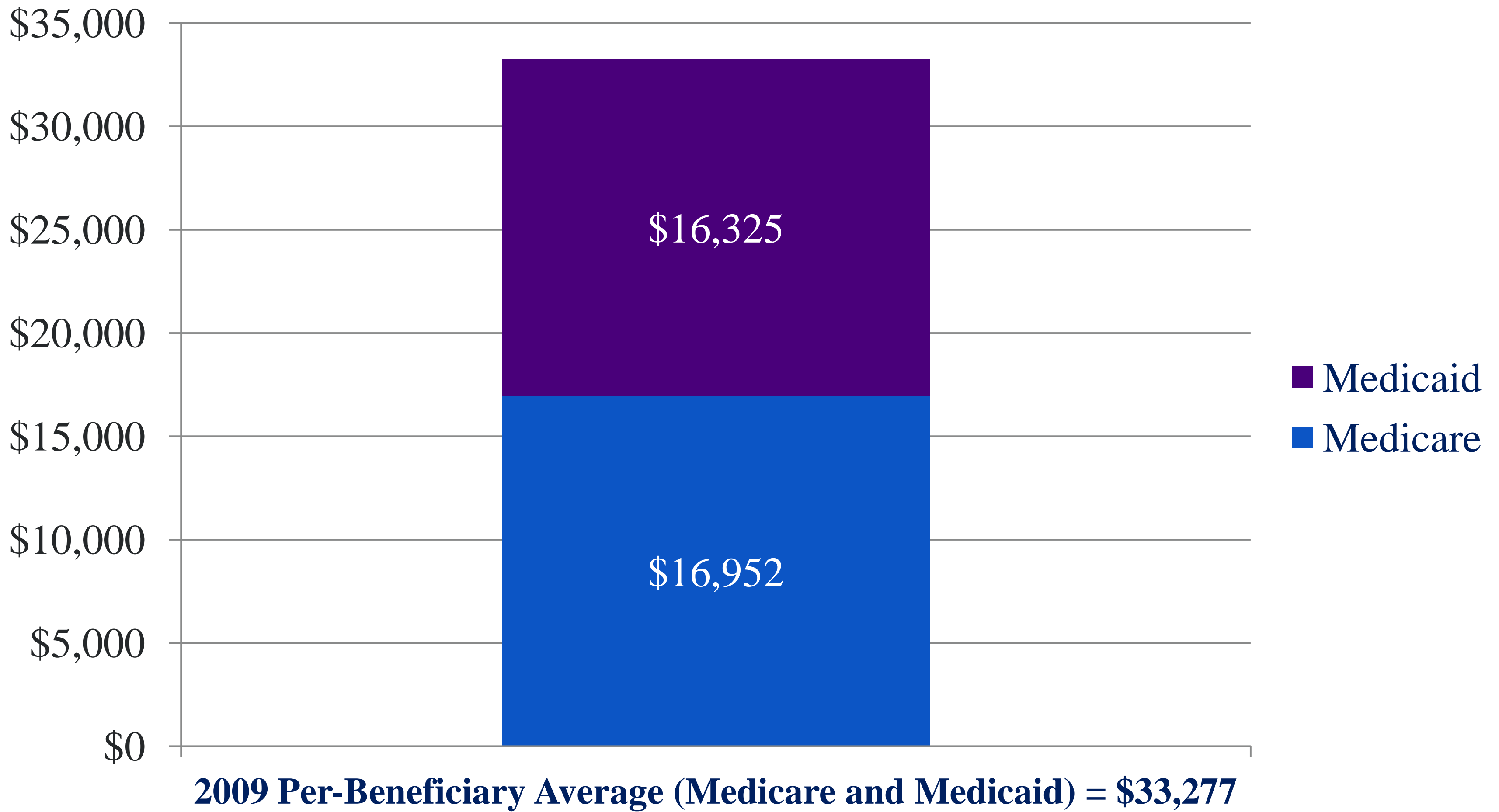
Estimated National Spending on Dual Eligibles in 2009



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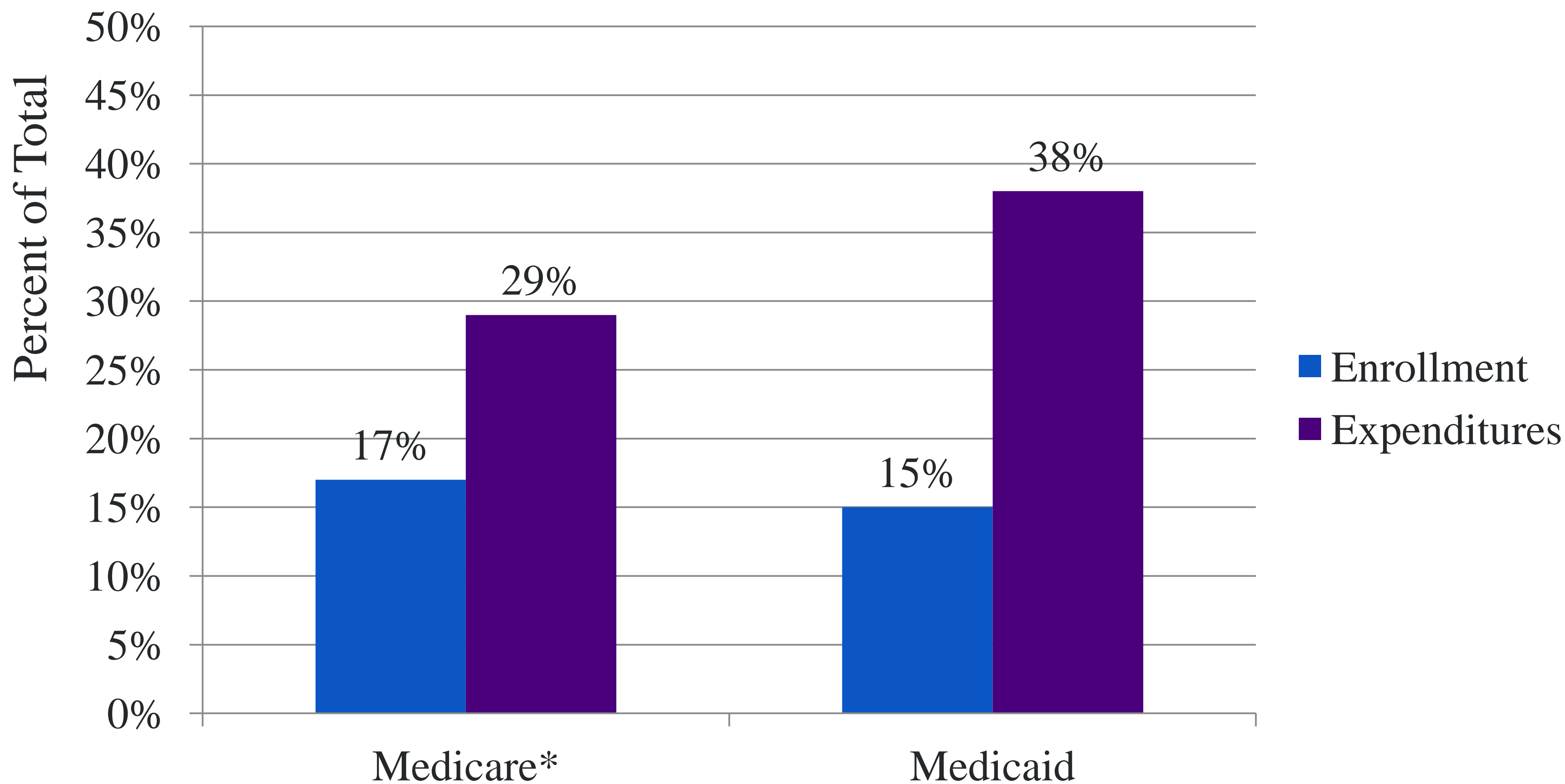
MME Expenditures are Large Relative to Enrollment



* Excludes Medicare manage care

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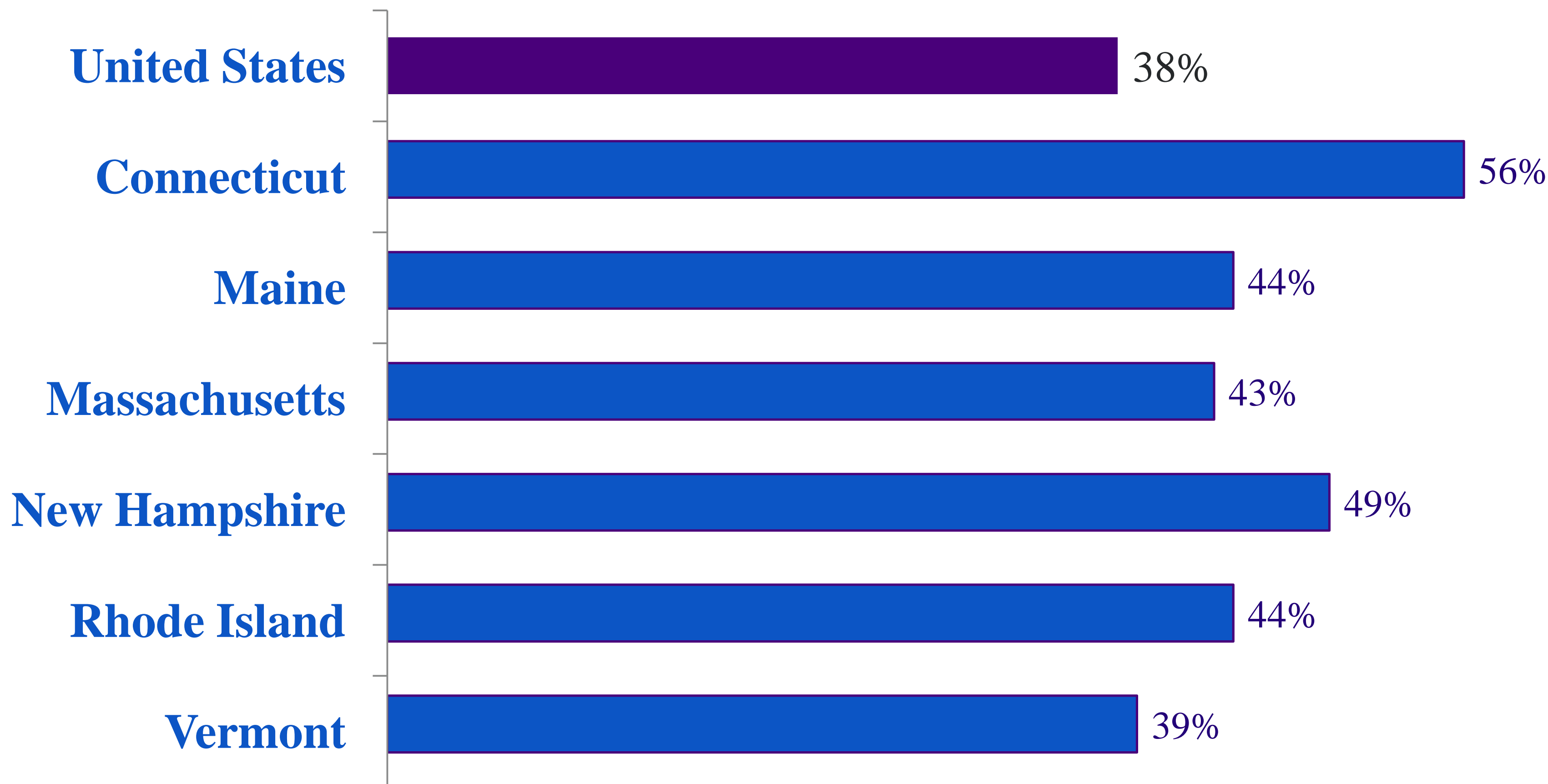
MMEs Share of Medicaid Spending in NE States, 2009



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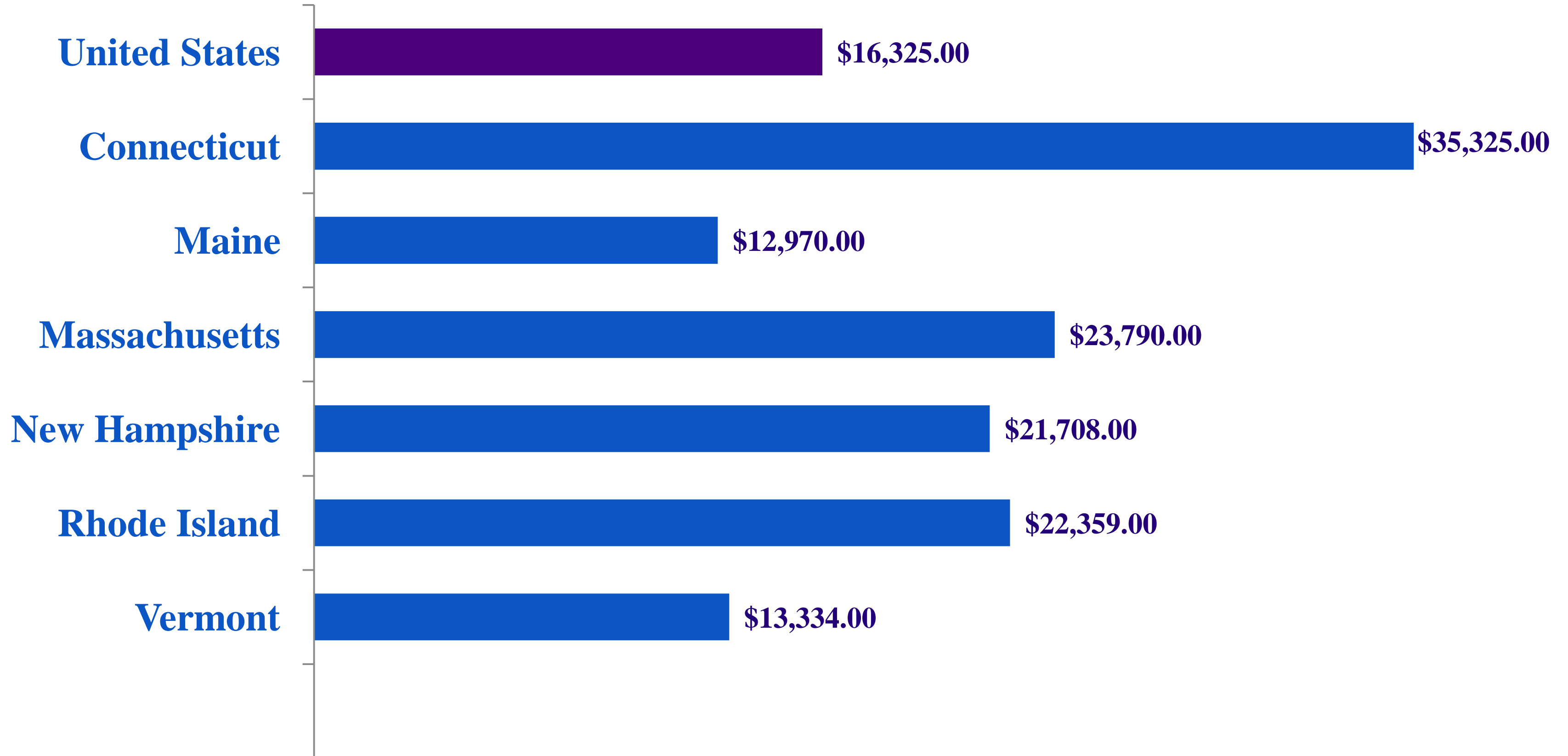
Medicaid Spending Per MME in NE States, 2009



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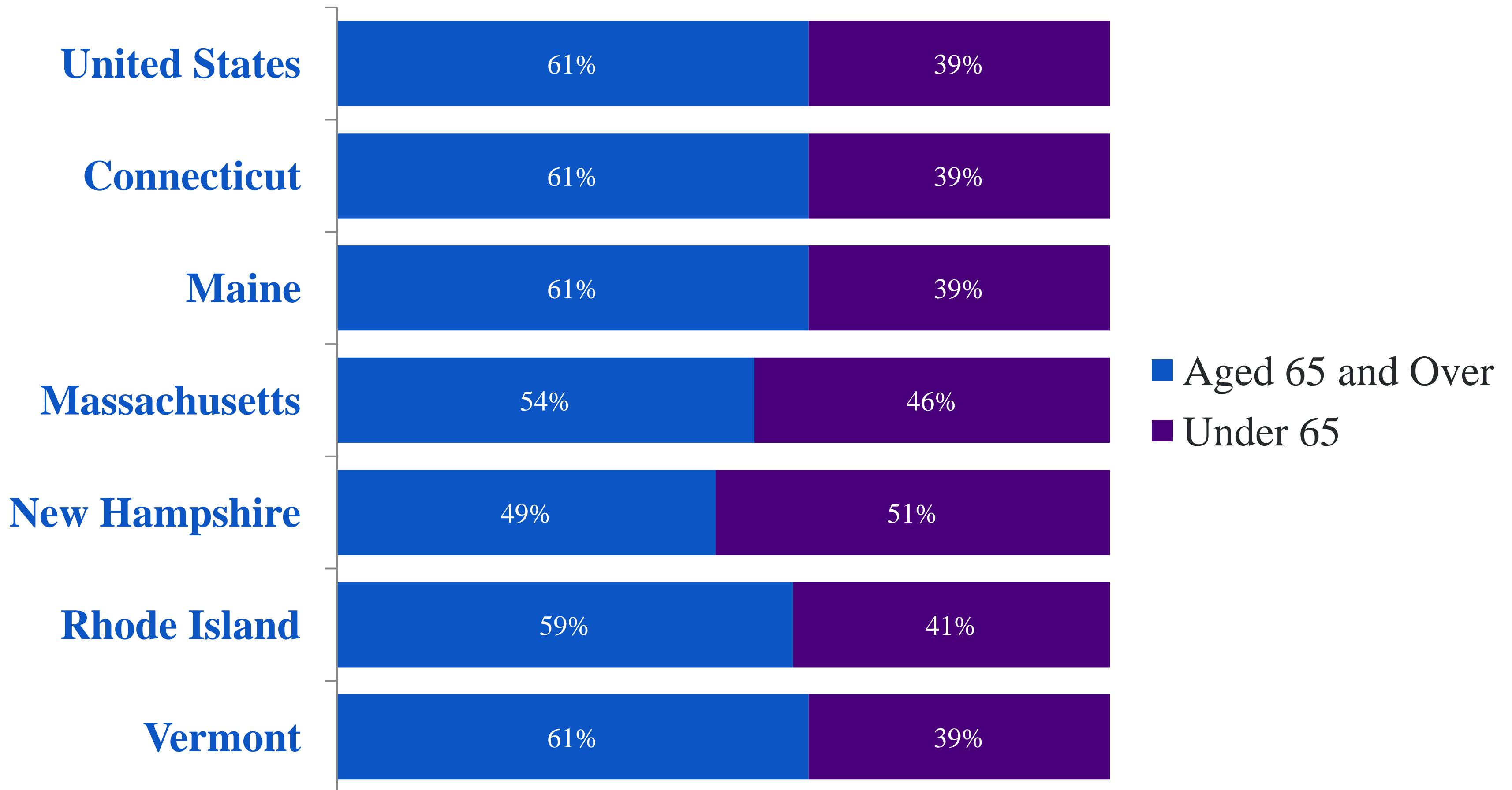
Age Distribution of MMEs in NE States, 2009



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ACA Includes Multiple Initiatives Focused on MMEs

- DUALS DEMONSTRATION
- Medicaid Health Homes
- Extension of Medicare SNP Program
- Community First Choice Option
- HCBS State Plan Options
- Balancing Incentive Payments Program
- Hospital Bundled Payment Demonstration
- Extension of Money Follows the Person Demonstration

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The Duals Demonstration Program

- Managed by the CMS Medicare-Medicaid Coordination Office
  - Melanie Bella, Director
- Demonstration Includes Two Different Financial Alignment Models
  - Fee-for-Service Model
  - Managed Care Capitation Model
- 26 States Have Submitted Proposals to CMS/MMCO for Demonstration
- 4 of 6 New England States Have Submitted Proposals
  - Connecticut
  - Massachusetts
  - Rhode Island
  - Vermont

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Theory Behind Capitated Financial Alignment Model

- Medicare and Medicaid make capitation payments to a single managed care entity
- Managed care entity is responsible for all Medicare and Medicaid-covered benefits for MME members
- Managed care entity has the flexibility and resources to implement new care management models for MMEs
- Medicare and Medicaid rules and requirements are “streamlined”
- Financial incentives are aligned between Medicare, Medicaid, and Managed Care Organizations (MCOs)
- Medicare, Medicaid, and MCOs divide savings from improved efficiencies
- Improved quality measurement is a key component of the demonstration

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Theory Behind Fee-for-Service Model

- States design and implement care management strategies for MMEs that do not involve capitated financing to MCOs
- For example, states develop new case management interventions to better coordinate Medicare and Medicaid-covered benefits
- States may use other ACA models (e.g. ACOs or Health Homes) in conjunction with the fee-for-service model
- States must define target MME population for demonstration
- Medicare and Medicaid savings measured retrospectively, and savings shared accordingly
- Most states using capitated model

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Massachusetts: First in Line

- **Timeline**
  - MOU signed August 2012 (Template for other states)
  - Voluntary enrollment begins July 1, 2013
  - Auto-assignments begin October 1, 2013
  - Enrollments completed by January 1, 2014
- **Six Integrated Care Organizations Selected in November 2012**
  - Blue Cross and Blue Shield of Massachusetts (BCBSMA)
  - Boston Medical Center HealthNet Plan (BMCHP)
  - Commonwealth Care Alliance (CCA)
  - Fallon Total Care (FTC)
  - Neighborhood Health Plan (NHP)
  - Network Health, LLC
- **Features**
  - Limited to MMEs under age 65
  - Medicare opt out
  - HCBS waiver services carved out of benefit package

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Connecticut: A Managed Fee-for-Service Model

- Connecticut has backed away from Medicaid managed care approaches in general
- Connecticut proposes two different care management approaches for MMEs
  - Administrative Service Organizations (ASOs)
  - Health Neighborhood model
- ASOs provide a variety of care management support services for Medicaid and CHIP including referrals, intensive case management, utilization management, and data analytics
- Health Neighborhoods are extended provider networks that focus on high-cost populations
- MOU with CMS still being negotiated

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Vermont: Taking on Medicare Risk

- Vermont approach to Duals Demonstration is unique in that the state itself intends to take on Medicare risk
- Vermont created a new public managed care entity to accept health care risk (Department of Vermont Health Access)
- Under Section 1115 wavier, DVHA accepts risk for most of the state's entire Medicaid program under a global budget authority
- Vermont plans to amend Section 1115 waiver to accept Medicare risk for MMEs
- DVHA will contract with Care Coordination Providers and Integrated Service Providers to manage Medicare and Medicaid services for MMEs
- Expected go live date of January 1, 2014

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Rhode Island: Using a Capitated Model

- Rhode Island will implement Duals Demonstration as extension of existing managed care programs:
  - Connect Care Choice (PCCM model) using primary care practice sites with enhanced care management services
  - Rhody Health Partners (traditional MCO model)
  - PACE model
- DD and SPMI populations excluded
- MOU still in negotiation
- Anticipated launch date of January 1, 2014

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New Hampshire: Pursuing Care Management Program

- New Hampshire not participating in Duals Demonstration at this time
- New Hampshire has embarked on Medicaid program initiative (Medicaid Care Management Program) to enroll all Medicaid recipients into managed care organizations in three phases.
- Three managed care contractors have been selected
- Phase I includes all acute care services for non-duals
- Phase II includes all LTSS services for non-duals
- Phase III includes MMEs
- Implementation of Phase I has been delayed beyond initial launch date of January 1, 2013

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Maine: Using an ACO Model to Integrate Care for MMEs

- Not participating in Duals Demonstration program at this time
- Yesterday, Maine received a $33 million State Innovation Model grant from CMS to develop multi-payer ACOs to integrate care for multiple populations, including the development of new payment models

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What Types of Care Management Approaches Work?

- Stronger affiliations with organized systems of care
- Team approach to care management – not physician-centric
- Culturally appropriate care
- Multiple touches and communication channels
- Care and support provided where the MME lives
- Strong behavioral healthcare component
- Appropriate end-of-life care
- Keep people functioning at the highest level possible
- Avoid unnecessary hospitalizations and nursing home placements

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What Are Some of the Major Outstanding Issues?

- How will savings be shared between CMS, States, and MCOs?
  - New guidance on rate setting process and shared savings was just released by CMS
- Will MME Demonstration Plans really get relief from conflicting and duplicative oversight requirements from Medicaid and Medicare?
- How will quality be assessed by CMS and states? Will quality measures be appropriate to MMEs and how they experience the health care system?
- Will participating plans be innovative in creating new care management models for MMEs?
- How will we learn from the experiences gained in the Demonstration?

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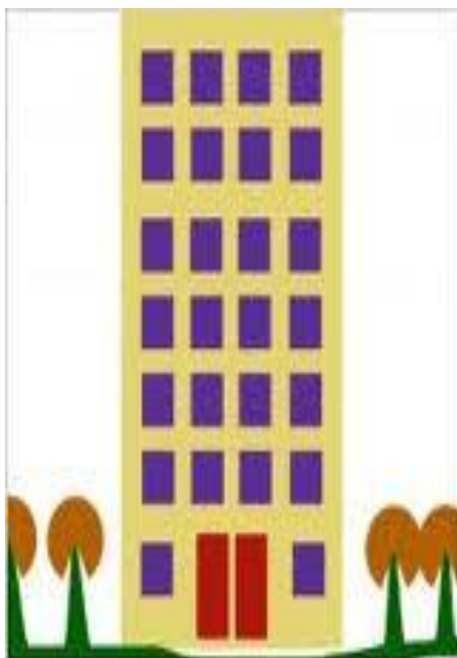
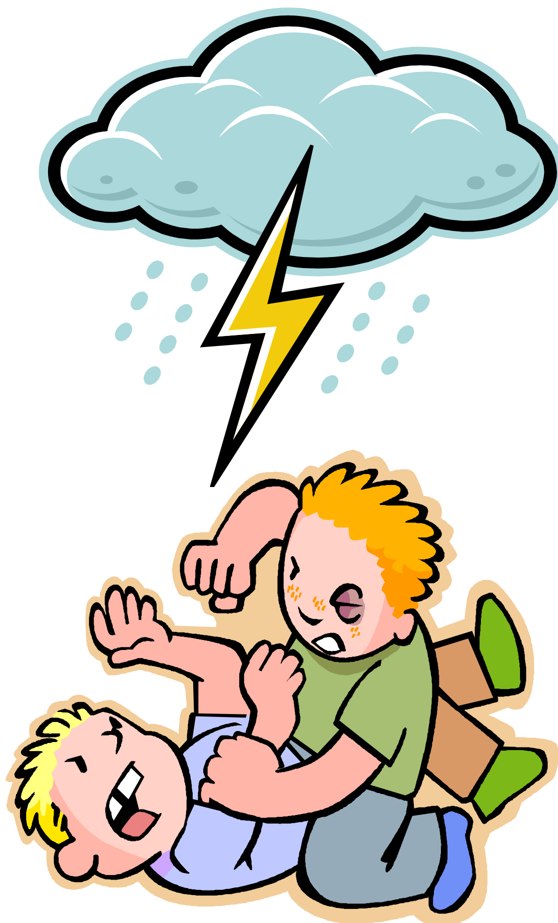
Medicare and Medicaid Don't Get Along

Medicaid





Medicare

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- Launch dates are likely to continue to be delayed beyond January 1, 2014 for many states.
- There is greater resistance from providers than from consumers – a lot of money on the table.
- Consumer and advocacy groups are surprisingly supportive.
- Which managed care companies will emerge as market leaders for integrated care plans?
- Is there a place for local non-profit plans?
- A few states have pulled out of the Demonstration (e.g. Tennessee) and more may do so in the future.

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Letter from Tennessee to CMS MMCO

"We are unable to resolve our concerns that demonstration plans will be paid less than existing Medicare Advantage plans serving the dual eligible population, but with higher expectations around quality and coordination of care."

December 21, 20012

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Concluding Observations

- Spending for MMEs accounts for a large percentage of Medicare and Medicaid spending. Current models of care are high cost and low quality.
- Aligning financial incentives across Medicare, Medicaid, and MCOs makes sense, at least in theory.
- States need to invest in strong management oversight of MME plans, and in IT systems.
- Integrated care plans need strong oversight, but also regulatory relief and the flexibility to be innovative.
- The vision of a seamless integrated health care system for MMEs is still a long ways away.

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Contact Information

Brian Burwell
Vice President
Truven Health Analytics
617-492-9302
brian.burwell@truvenhealth.com

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