Medicaid “Best Buys”: Improving Care for Medicare-Medicaid Enrollees

NCSL Legislative Summit
August 8, 2012

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Center for Health Care Strategies

www.chcs.org

CHCS Mission

To improve health care access and quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

Our Priorities

► Enhancing Access to Coverage and Services
► Improving Quality and Reducing Racial and Ethnic Disparities
► Integrating Care for People with Complex and Special Needs
► Building Medicaid Leadership and Capacity
Who are Medicare-Medicaid enrollees?

- Receive both Medicare and Medicaid coverage
- Focus on “Full Duals” in CMS’ demonstration
- 62% age 65 or older
- 38% under age 65

9.2M Americans are eligible for Medicare and Medicaid (known as Medicare-Medicaid enrollees or “dual eligibles”) & 7.1M are “full duals”

Who pays for what services?

**MEDICARE**
- Hospital care
- Physician & ancillary services
- Skilled nursing facility (SNF) care (up to 100 days)
- Home health care
- Hospice
- Prescription drugs
- Durable medical equipment

**MEDICAID**
- Medicare cost sharing
- Nursing home (once Medicare benefits exhausted)
- Home- and community-based services (HCBS)
- Hospital once Medicare benefits exhausted
- Optional services (vary by state): dental, vision, HCBS, personal care, and select home health care
- Some prescription drugs not covered by Medicare
- Durable medical equipment not covered by Medicare
What is wrong with how things are now?

**DISTINCT PROGRAMS, NOT DESIGNED TO WORK TOGETHER**
- Very confusing for beneficiaries
- Benefits are not aligned
- Program rules are not aligned
- Program financing promotes “cost shifting” between states and federal government
- Current financing arrangements limit financial innovation

**DESIGNED TO SUPPORT CARE IN FACILITIES VS. COMMUNITIES**
- Facility-based care is an “entitlement”
- HCBS often has waiting lists
- Limited coordination for HCBS participants across all service areas

What is integrated care?

- Creates **one accountable entity** to coordinate delivery of primary/preventive, acute, behavioral, and long-term services and supports
- Promotes the use of **home- and community-based** services
- Promotes and measures **improvements in quality of life and health outcomes**
- Blends/aligns services and financing to streamline care and eliminate cost shifting

**AND, most importantly…**
- Provides **high-quality, person-centered care**
Why is there so much federal and state interest?

- Integrated care saves money
- AZ Mercy Care Plan Study
  - Performed better than Medicare FFS
    - Access to preventive/ambulatory health services
    - Inpatient Utilization
    - ER utilization
    - Readmissions
- Outcomes for the Wisconsin Family Care Partnership
  - Focus on improved quality of life and better health outcomes
  - http://www.dhs.wisconsin.gov/LTCare/Reports/

New Medicare-Medicaid Coordination Office

- MMCO created by Section 2602 of the ACA
- Improve coordination between the Federal government and states for Medicare-Medicaid enrollees
- Focuses on:
  - Program alignment
  - Data and analytics
  - Models and demonstrations
- Developed two initial opportunities for states:
  - State Demonstrations and Financial Alignment Models
State Duals Demonstrations

MMCO partnered with the Center for Medicare and Medicaid Innovation (CMMI) to competitively select 15 states for $1M design contracts

15 State Design Contracts Awarded April 2011

<table>
<thead>
<tr>
<th>State</th>
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<tbody>
<tr>
<td>California</td>
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<td>North Carolina</td>
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Financial Alignment Models

- State Medicaid Director Letter, July 8, 2011
- Offers states two paths (aka “Financial Alignment Models”):
  - CAPITATED
  - MANAGED FEE-FOR-SERVICE
- Open to all states – but must pursue one of the two models
- State letter of intent was due October 1, 2011
- 38 states responded
Financial Alignment Model: **CAPITATED**

- Three-way contract (state, CMS, health plan)
- Prospective, blended payment with “aggressive savings” built in
- Single set of rules for appeals, marketing, and audits
- Joint procurement of “selected high-performing health plans”
- Voluntary Enrollment: passive enrollment but opt-out provisions
- **STATE EXAMPLES: AZ, CA, MA, MI, VA**

Financial Alignment Model: **MANAGED FEE-FOR-SERVICE**

- Improve coordination of care through fee-for-service providers, including Medicaid health homes or Accountable Care Organizations
- Must exceed quality thresholds and meet a target for savings
- Program will provide seamless integration and access to all necessary services based on an individual’s needs
- **STATE EXAMPLES: CO, CT, and OK**
State Participation (as of July 25, 2012)

<table>
<thead>
<tr>
<th>STATE</th>
<th>CMMI CONTRACT?</th>
<th>TARGET LAUNCH YEAR</th>
<th>MODEL</th>
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Next Steps for States

- Memorandum of Understanding development with CMS
- State-based procurement process
  - Massachusetts RFP: [http://www.mass.gov/masshealth/duals](http://www.mass.gov/masshealth/duals)
  - Illinois RFP: [http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx](http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx)
- Rate development with CMS
- Authority

State operational hurdles still exist

- Rates
  - Risk mitigation
  - Joint development process
- Benefits
  - Continuation of supplemental benefits
  - Carve-outs due to stakeholder resistance
- Outcome-Based Performance Measures
- Enrollment
The path has not been easy

National Leaders in Integrated Care – 1995 - 2012

<table>
<thead>
<tr>
<th>State</th>
<th>Name of Program</th>
<th>Type of Program</th>
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<tbody>
<tr>
<td>Arizona</td>
<td>ALTCS</td>
<td>Managed Long-Term Services (MLTS) with Special Needs Plan (SNP) enrollment option</td>
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<tr>
<td>Hawaii</td>
<td>QExA</td>
<td>MLTS with SNP enrollment option</td>
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<tr>
<td>Massachusetts</td>
<td>Senior Care Options</td>
<td>Fully integrated for long-term services and supports (LTSS) and Medicare</td>
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<tr>
<td>Minnesota</td>
<td>MN Senior Health Options</td>
<td>Fully integrated for LTSS and Medicare</td>
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<td>New Mexico</td>
<td>COLTs</td>
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<td>CHOICES</td>
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<tr>
<td>Texas</td>
<td>Star+PLUS</td>
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<tr>
<td>Wisconsin</td>
<td>Family Care Partnership</td>
<td>Fully integrated for LTSS and Medicare</td>
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Expansion has been slow

- Previous vehicles for integration have not achieved broad scale, full integration
- Administrative hurdles
- National debate – state-run vs. federal-run
- Lots of anecdotal evidence of improved care - limited funding for empirical research
States and CMS are working thoughtfully and carefully

- Ensure beneficiary protections guaranteed under the Medicare program
- Include quality standards and rigorous evaluations
- Show statistically meaningfully results
- Leverage experience of Medicaid agencies in:
  - Measuring the quality of services provided by health plans and other entities
  - Purchasing physical, behavioral, and long-term services and supports

States and CMS are working thoughtfully and carefully

- Engage stakeholders at every level in both design and implementation
- Build on existing relationships between state Medicaid agencies, providers and beneficiaries
- Incorporate payment strategies that encourage provider participation and offer potential savings for state and federal partners
Thank you!