CHCS
Center for
Health Care Strategies, Inc.

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

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Alice Lind

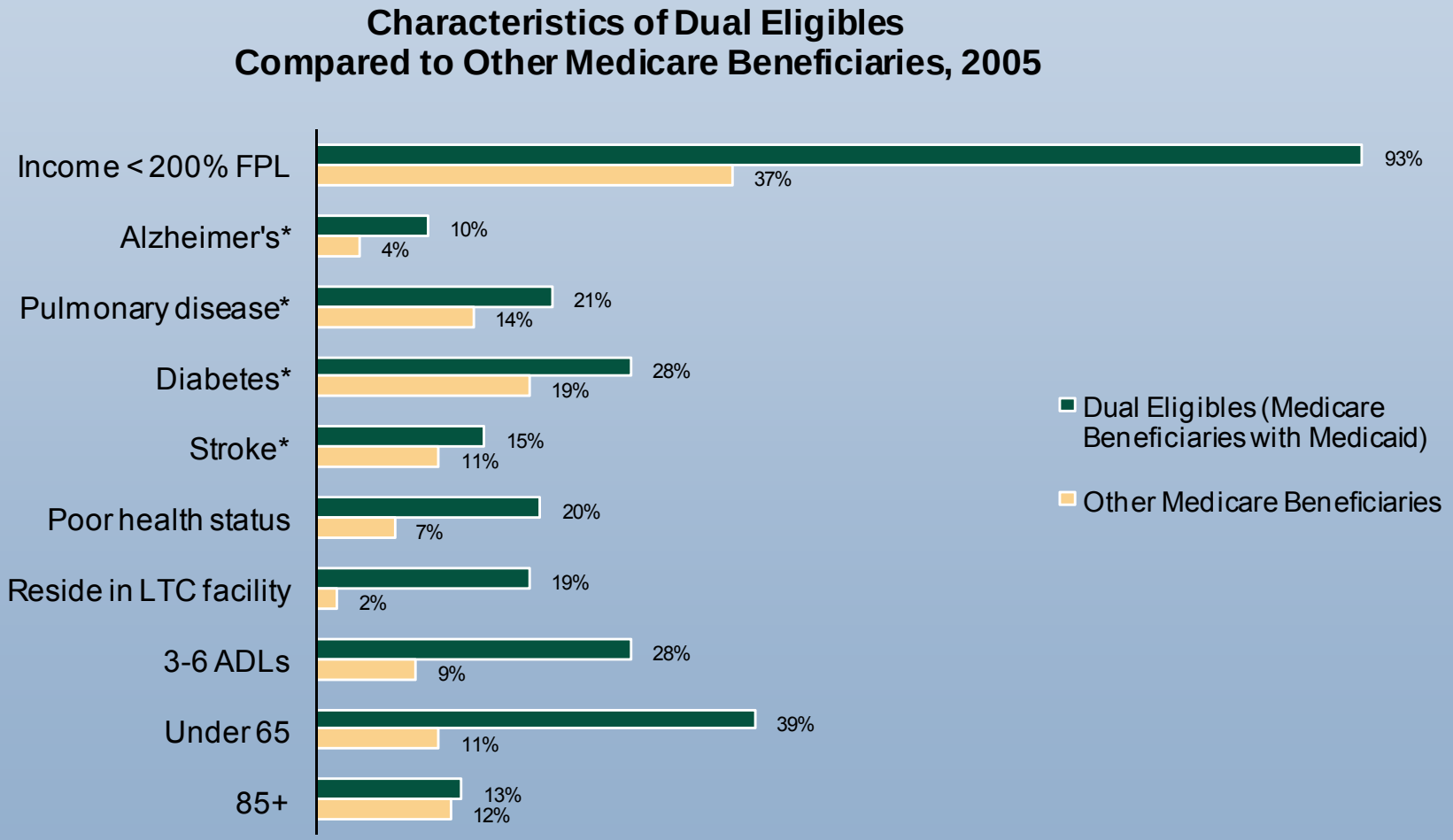
Senior Clinical Officer and Director,
Long Term Supports and Services,
Center for Health Care Strategies

Why Focus on Dual Eligibles?

- 9.2 M Americans are eligible for Medicare and Medicaid
- 3x more likely than others on Medicare to have multiple chronic illnesses and long-term care needs
- Represent 15% of Medicaid enrollees but 39% of Medicaid spending
- Few are served by coordinated care and even fewer are in integrated programs that align Medicare and Medicaid services

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

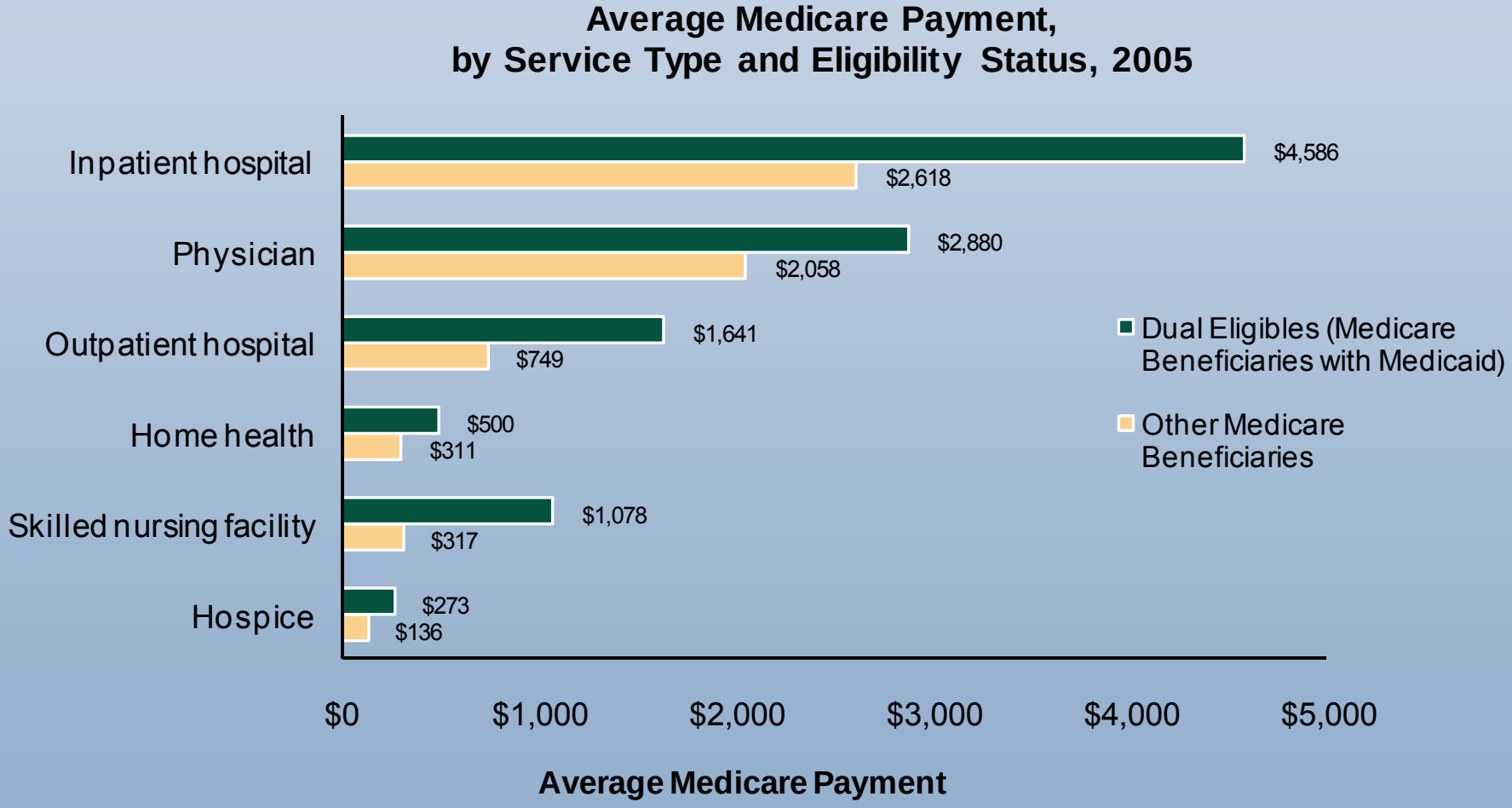
Duals are sicker and more functionally impaired than other Medicare beneficiaries



Source: Hilltop Institute -- MedPac, June 2008; based on data from the 2005 MCBS Cost and Use file

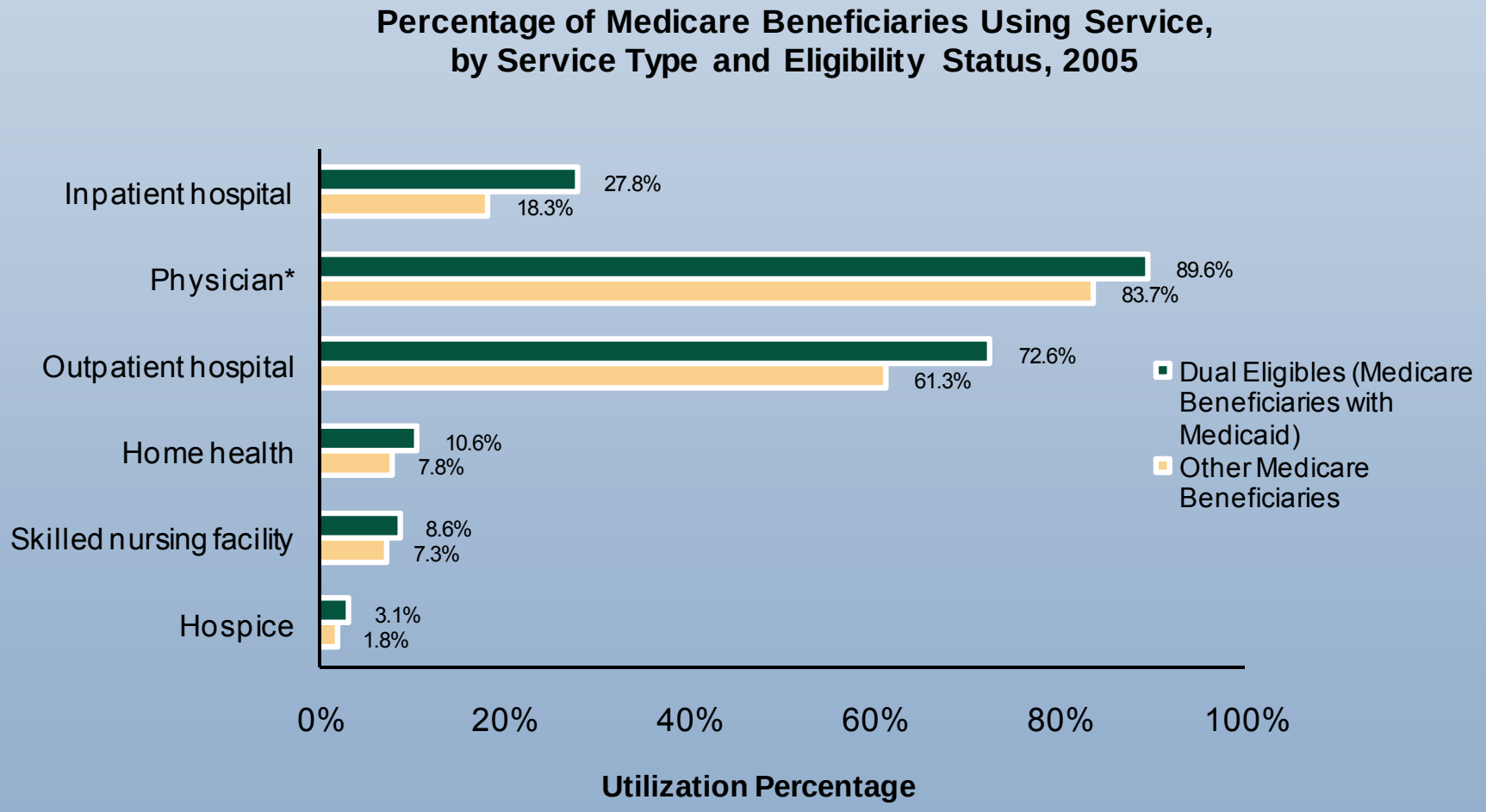
*Data from 2003 MCBS http://www.cms.hhs.gov/MCBS/Downloads/CNP_2003_dhsec8.pdf

Costs are higher for duals than non-dual Medicare beneficiaries across all major services . . .



Source: Hilltop Institute -- MedPac, June 2008

. . . and dual eligibles also use all services at a higher rate.



Source: Hilltop Institute -- MedPac, June 2008

Who pays for what services?

MEDICARE

- Hospital care
- Physician & ancillary services
- Skilled nursing facility (SNF) care
- Home health care
- Hospice
- Rx drugs
- Durable medical equipment

MEDICAID

- Medicare cost sharing
- Nursing home
- Hospital and SNF once Medicare benefits exhausted
- Optional services (vary by state): dental, vision, home- and community- based services, personal care, and select home health care.
- Some Rx not covered by Medicare
- Durable medical equipment not covered by Medicare

What does care look like now?

<u>WITHOUT</u> INTEGRATED CARE INDIVIDUALS MAY HAVE:
x Three ID cards: Medicare, Medicaid, and prescription drugs
x Three different sets of benefits
x Multiple providers who rarely communicate
x Health care decisions uncoordinated and not made from the patient-centered perspective
x Serious consideration for nursing home placement; Medicare/Medicaid only pays for very limited home health aide services

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

Why Focus on Dual Eligibles *Now*?

- Health reform (ACA) established the Medicare-Medicaid Coordination Office, which is helping states to design integrated care programs for duals.
- Federal $1M design contracts awarded to 15 states to develop integrated care programs for duals.
- Consumers are beginning to see the benefits of integrated care.
- States are looking for ways to improve the cost-effectiveness of budget-strapped programs by improving care for high-cost patients

The Value of Integration

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

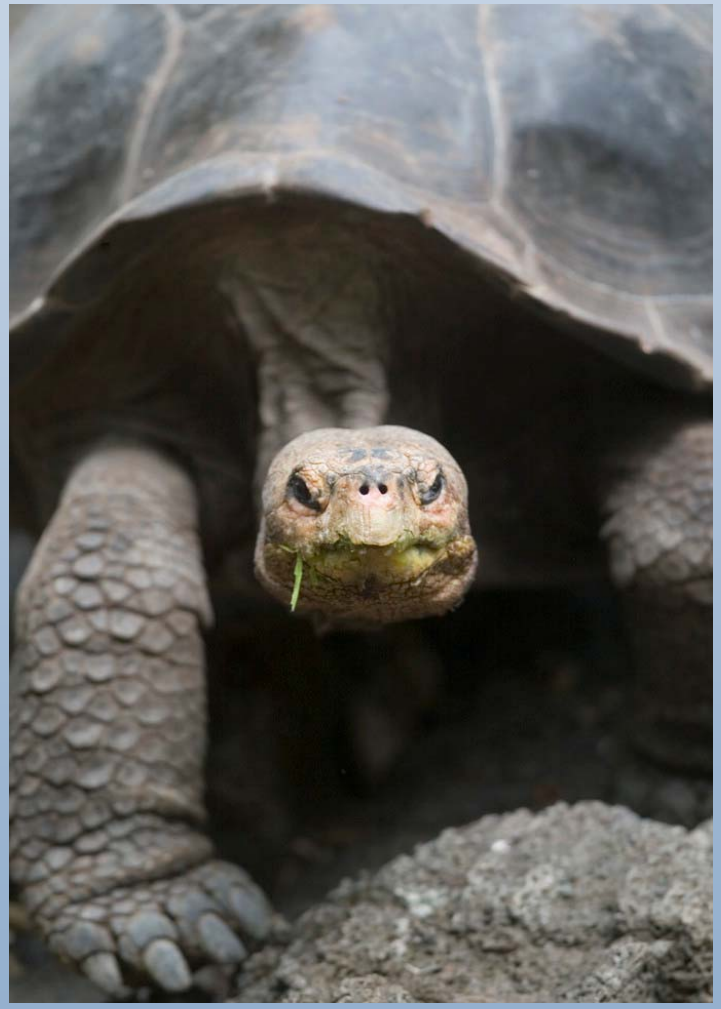
AND, most importantly…

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

What Ideal Care *CAN* Look Like

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

But Change has been Slow



- Significant administrative hurdles
- Substantial stakeholder (advocates/providers) resistance
- States' reluctance to invest in upfront costs
- Existing vehicles for integration have not achieved broad scale, full integration, or anticipated budget savings

The Stars Have Aligned...

- Significant interest by states in improving delivery of LTSS and care for dual eligibles
- Affordable Care Act potentially allows significant innovations in this area
- Federal funding is available to support state infrastructure development
- Beneficiaries and advocates are beginning to see that they have a lot to gain from streamlined care

New Federal Support to Integrate Medicare and Medicaid

- The ACA expands CMS' authority to approve new models of care.
- CMS is working with states to develop models that:
  - Adopt a person-centered model of care
  - Align the full range of Medicare and Medicaid covered services including:
    - medical,
    - behavioral health, and
    - long-term supports and services
  - Improve the actual care experience and lives of dual eligible beneficiaries.

New Federal Support for States:
Removing Obstacles to Existing Models

Examples of obstacles that states would like to revise include:

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

New Financial Models to Support States

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

New Financial Model: Capitated Model

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

New Financial Model: Managed Fee for Service

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

Requirements and benefits for all states outlined in SMD Letter

States must:

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

States may:

- Request technical assistance and Medicare data

Core Elements of Integrated Care Models

Integrated care models arrange for all Medicaid and Medicare services (including long-term supports and services). Core elements include:

- Strong primary care base
- Multidisciplinary care team
- Personalized plan of care
- Comprehensive provider network
- Robust data-sharing and communications system
- Adequate consumer protections
- Aligned financial incentives

Three Strategies for Integration

STRATEGY 1:

- States that have a strong managed care system for medical services, but lack a robust long-term supports and services (LTSS) program, should consider building on their existing managed care system to serve dual eligibles.

STRATEGY 2:

- States that have a strong system for LTSS, but lack a strong managed care system for medical services, should consider broadening their LTSS system to include managed medical services for dual eligibles.

STRATEGY 3:

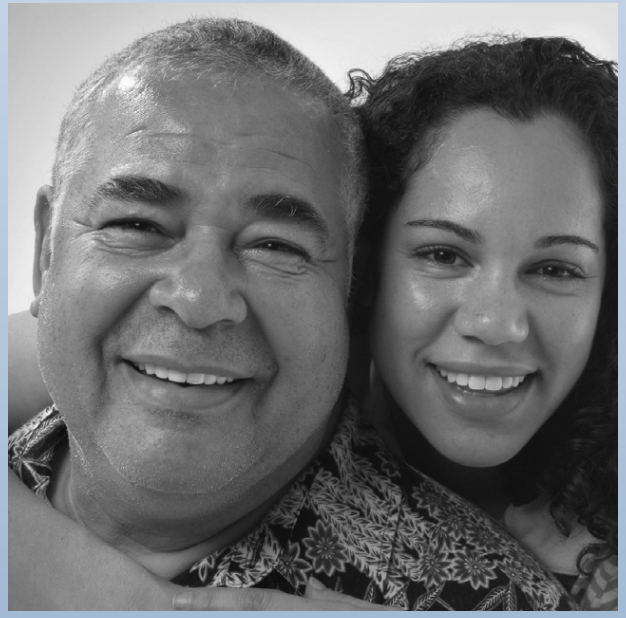
- States with both a strong medical care system and a strong LTSS program should consider bridging these systems to integrate services.

Washington's Success in LTSS!

- Number 2 overall on new Scorecard of Long Term Supports and Services Programs comparing 50 states
- Number 2 on choice of setting and provider
- Number 2 on support for family caregivers
- Number 6 on affordability and access
- Number 18 on quality of life and quality of care (room for improvement in new model?)

(Ref. The SCAN Foundation and AARP, "Raising Expectations", http://www.longtermscorecard.org/)

Thank you!



Questions?

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