Medicaid and Medicare Resource Use For Dual Eligibles in Maryland

November 9, 2011

Charles Milligan

NAMD Conference
The Hilltop Institute at UMBC conducted research on Medicare-Medicaid cross-payer effects in Maryland.

- Constructed and utilized a database that linked, at the individual level, Medicaid claims, Medicare claims, and MDS records

- One area of analysis: the cross-payer effects for dual eligibles who meet nursing facility level of care (NF LOC), regardless of setting (community or institution)

- One subgroup analysis: Maryland’s 1915(c) Older Adults Waiver (OAW), the largest NF LOC waiver in Maryland

- OAW beneficiaries were compared to two “control” groups using propensity score methods: (a) individuals in the community and not in the OAW and (b) individuals in institutions (CY 2006 used)

In the following slides, the “HCBS Waiver Group” means the OAW in Maryland in 2006.
Covariates used in the propensity score methodology

- Demographics (age, gender, race)
- CMS-HCC relative value
- 20 Chronic Condition Warehouse condition indicators (AMI, AD/dementia, COPD, diabetes, depression, hip fracture, stroke, etc.)
- Disability as reason for original Medicare enrollment
- Frailty indicator (diagnosis-based, Hopkins ACG system)
- ESRD indicator
- Months of full Medicaid coverage
HCBS Waiver Group Compared to Community Non-Waiver Group
Medicare payments were nearly identical for HCBS beneficiaries and the matched group in the community . . .

Although the overall costs were similar, the HCBS group had fewer hospital readmissions, fewer/shorter SNF stays, more home health, more DME, and fewer ER encounters, which suggests the HCBS recipients received better


Notes: Maryland OAW (treatment) and community (control) samples of 1,410 full-benefit duals aged 50 and older, enrolled for 12 months (with no group health coverage) in 2006.
... while Medicaid payments were far higher for the HCBS group than the community group ...

MEDICAID Benefit Payments, PMPM, by Service

<table>
<thead>
<tr>
<th>Service</th>
<th>OAW (Treatment)</th>
<th>Community (Control)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$2,778</td>
<td>$0</td>
</tr>
<tr>
<td>Hospital</td>
<td>$272</td>
<td>$0</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>$17</td>
<td>$0</td>
</tr>
<tr>
<td>Community Supports &amp; Services</td>
<td>$154</td>
<td>$0</td>
</tr>
<tr>
<td>Hospice</td>
<td>$11</td>
<td>$0</td>
</tr>
<tr>
<td>Physician/Outpatient</td>
<td>$9</td>
<td>$75</td>
</tr>
<tr>
<td>DME</td>
<td>$147</td>
<td>$15</td>
</tr>
</tbody>
</table>

Notes: Maryland OAW (treatment) and community (control) samples of 1,410 full-benefit duals aged 50 and older, enrolled for 12 months (with no group health coverage) in 2006. Medicare crossover payments paid by Medicaid not included.
... and as a result, the **HCBS group were far more expensive than the community group**, in total dollars.


Notes: Maryland OAW (treatment) and community (control) samples of 1,410 full-benefit duals aged 50 and older, enrolled for 12 months (with no group health coverage) in 2006. Medicare crossover payments paid by Medicaid not included.
HCBS Waiver Group Compared to Long-Term Nursing Facility (LT-NF) Group
Medicare payments were $441 higher PMPM for the HCBS group than the matched LT-NF group . . .


Notes: Maryland OAW (treatment) and community (control) samples of 1,731 full-benefit duals aged 50 and older, enrolled for 12 months (with no group health coverage) in 2006.
... while Medicaid payments were $2,055 PMPM higher for the LT-NF group, compared to the HCBS group ...
... and in total dollars, the **HCBS group was far less expensive than an LT-NF group.**


Notes: Maryland OAW (treatment) and community (control) samples of 1,731 full-benefit duals aged 50 and older, enrolled for 12 months (with no group health coverage) in 2006. Medicare crossover payments paid by Medicaid not included.
Conclusions
Key observations from the analysis

• Medicare and Medicaid financing do not align to promote home and community-based services; this is a barrier to HCBS. *Medicare saves $$ when a dual eligible is in a stable custodial LT-NF stay.*

• Medicaid’s HCBS program helped to promote better care and service utilization *in the Medicare program.*

• Because most extended NF admissions begin with a Medicare admission, *community integration for dual eligibles must engage Medicare*; engaging Medicare providers is crucial.

• The *HCBS waiver is cost-effective (at the individual level) for Medicaid when avoids a NF placement, but not for individuals who otherwise would remain in the community without a waiver.*
Contact Information

Charles Milligan, JD, MPH
Deputy Secretary, Health Care Financing
DHMH
410.767.5806
cmilligan@dhmh.state.md.us
Duals Integration: One State’s Perspective

John McCarthy, Medicaid Director
Office of Ohio Health Plans
Fall 2011 NAMD Conference
November 9, 2011
Washington, D.C.
Interaction with CMS

- Grant Awardees
- The State Medicaid Director Letter
- CMS Team
First Question: Why are we doing this?
A few high-cost cases account for most Medicaid spending

1% of the Medicaid population consumes 23% of total Medicaid spending

4% of the Medicaid population consumes 51% of total spending

Source: Ohio Department of Job and Family Services; SFY 2010 for all Medicaid populations and all medical (not administrative) costs
First Question:
Why are we doing this?

Ohio’s answer:

- To create an integrated care delivery system where the Medicaid contracts with one entity that is responsible for all services for the individual.
  - The entity must provide a single point of care coordination for the individual for all services both medical and social.
Second Question: Who will be Served?

- What is a Dual?
- What are dual likes?
- Individuals with Severe or Persistent Mental Illness (SPMI)
- Individuals that are Intellectually or Developmentally Disabled (IDD)
Delivery Models

- Fee for Service
- Managed Care
- Accountable Care Organization
- Something else???
Where Will This Happen?

- Geographic areas
- How large is the population?
- Are there providers?
- Are there Medicare Advantage Plans or SNPs?
How to Get Providers

- To RFP or Not To RFP and the three way contract
- Are there existing contracts?
- How many providers?
- Who can be a provider?
The Most Important Process: The Public Process

- How to engage individuals that will be enrolled and their advocacy groups
- What is the involvement of the Legislature?
- What is the involvement of sister state agencies and quasi-governmental agencies like AAA’s?
- What is the involvement of providers?
Federal Authorities

- What do you mean I need a waiver????
  - The CMMI
  - The 1915(b) (c) combo
  - The 1115
- What about my other waivers?
  - Interactions with existing 1915(c) waivers
Coordinating Care for Medicare-Medicaid Enrollees

Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
Melanie Bella, Director

November 2011
Medicare-Medicaid Coordination Office

Section 2602 of the Affordable Care Act

- **Purpose:** 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.
  - Eliminate financial **misalignments** that lead to poor quality and cost shifting.
Medicare-Medicaid Coordination Office
Major Areas of Work

The Medicare-Medicaid Coordination Office is working on a variety of initiatives to improve quality, coordination and cost of care for Medicare-Medicaid enrollees in the following areas:

- Program Alignment
- Data and Analytics
- Models and Demonstrations
Pursue opportunities to better align Medicare and Medicaid requirements to advance seamless, coordinated care for dual eligibles.

- **Alignment Initiative**: Initiative to identify and address conflicting requirements between the Medicare and Medicaid programs that are potential barriers to seamless and cost effective care.
  - Published as Notice for Public Comment May 16th
  - All comments are available through regulations.gov

- **Regional Listening Sessions held for**: New York, New Jersey, Puerto Rico, Virgin Islands, California, Arizona, Nevada, Kansas, Nebraska, Iowa, Missouri and other Territories.
“The existing enrollment processes present a significant number of challenges for multiple stakeholder including CMS itself, the States, Plans and, most importantly, beneficiaries. Streamlining the enrollment process by eliminating duplication and reconciling asymmetries will not only reduce costs, it will improve the quality of services rendered to dually eligible individuals. The most fundamental flaw of existing enrollment processes for dual eligibles is simply the fact that there are multiple enrollment “processes”. Dual eligibles must separately enroll in both Medicare and Medicaid; enrollment into a SNP (or other integrated arrangement) requires yet a third step. Moreover, to enroll, beneficiaries often must juggle and track varying enrollment periods and deadlines. This is a patently inefficient and burdensome process—particularly in light of the fact that many dual eligibles are sick and/or elderly or suffer from behavioral and cognitive issues.”

-UPMC Health Plan
“In the current fee-for-service (FFS) system, particularly when multiple payers are involved, providers face challenges communicating and collaborating with one another about a person’s care. Providers may not be aware of the different types and sources of care provided or available to the dual eligible individuals they serve. Further, neither the Medicare nor Medicaid programs can alone afford to invest in the full range of services and comprehensive care coordination necessary to meet the needs of dual eligible individuals. Even with such an investment, potential savings may accrue to the other program in the absence of a shared savings mechanism....CMS should consider how to provide resources or allow flexibility within current resources to support comprehensive care management or coordination. Providing states and providers the flexibility to share savings with Medicare would be a critically important tool to encourage and support this investment.”

-MassHealth
Data and Analytics

*Improve State access to Medicare data for care coordination.*

- To date, 22 States have expressed interest in obtaining timely Medicare data. We are working with all of these States to understand what their interest is and walk them through their data request.

- Create national and State profiles of the Medicare-Medicaid enrollee population.
- Analyze the impact of eligibility pathways to better understand the beneficiary experience.

<table>
<thead>
<tr>
<th>11 States actively seeking timely Medicare Parts A/B data</th>
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<tbody>
<tr>
<td>• Approved to Receive: 4 States</td>
</tr>
<tr>
<td>• Request in Process: 3 States</td>
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<tr>
<td>• Drafting Requests: 4 States</td>
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</tbody>
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<table>
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<tr>
<th>14 States actively seeking timely Medicare Part D Data</th>
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</thead>
<tbody>
<tr>
<td>• Approved and Received: 2 States</td>
</tr>
<tr>
<td>• Request in Process: 4 States</td>
</tr>
<tr>
<td>• Drafting Requests: 8 States</td>
</tr>
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</table>
State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees

Develop, test, and validate fully integrated delivery system and care coordination models that can be replicated in other States.

• 15 states selected receive up to $1 million to design new models for serving Medicare-Medicaid enrollees.

• **Participating States:** California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.
Financial Alignment Demonstrations to Support State Efforts to Integrate Care

- **Capitated Model:** Three-way contract among State, CMS and health plan to provide comprehensive, coordinated care in a more cost-effective way.

- **Managed FFS Model:** Agreement between State and CMS under which States would be eligible to benefit from savings resulting from initiatives to reduce costs in both Medicaid and Medicare.

- **37 States and the District of Columbia** submitted letters of intent to participate in these financial demonstrations. CMS will work with these States to further develop these approaches.

- States must meet established standards and conditions, including implementation by 2012.
New Models Expand and Promote State Partnerships
Financial Alignment Initiative

Financial Alignment Model Letters of Intent - State Map

KEY:
Submitted Letter of Intent
Integrated Care Resource Center (ICRC)

Support for All States

Assist States in delivering coordinated care to high-need, high-cost beneficiaries.

- Provides technical assistance to all States to better serve beneficiaries, improve quality and reduce costs.

- Examples of assistance available by the ICRC include:
  - Developing resources to support States' efforts to integrate care for Medicare-Medicaid enrollees.
  - Assisting States in implementing MIPPA 2013 requirements.
  - Working with States to develop and expand on health home models that build and enhance coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illness.

http://www.integratedcareresourcecenter.com
Demonstration to Reduce Avoidable Hospitalizations of Nursing Facility Residents

To reduce preventable inpatient hospitalizations among residents of nursing facilities by funding new entities to provide additional supports to treat these individuals without unnecessarily going to a hospital.

- Areas of Focus:
  - Reduce avoidable hospitalizations;
  - Support transitions between hospitals and nursing facilities; and
  - Implement best practices to prevent falls, pressure ulcers, urinary tract infections and other events that lead to poor health outcomes.

- Request for Proposals expected Fall 2011.
Questions & Suggestions:
MedicareMedicaidCoordination@cms.hhs.gov

For more information, visit:
http://www.cms.gov/medicare-medicaid-coordination/
From DC to LA: Seeking to Expand Integrated Care for Dual Eligibles

Peter Begans
SVP, SCAN Health Plan
National Association of Medicaid Directors
November 9, 2011
What is SCAN?

- Not-for-profit Medicare Advantage health plan and service provider
- Founded in 1977 in Long Beach by senior citizen activists frustrated by a lack of access to needed services
- Mission: To find innovative ways to enhance seniors’ ability to manage their health and control where/how they live
- Model of Care emphasizes prevention, early intervention, and providing the right care at the right time
- Two decades as Social HMO demonstration project participant
- Has successfully delayed or prevented 100,000 nursing home admissions in California
Current Operations

• Nation’s 4\textsuperscript{th} largest not-for-profit MA plan with 130,000 members in California and Arizona
• One of only three MA plans in California with 4 Stars
• Serves about 9,000 California and Arizona dual eligibles via FIDE-SNPs, an I-SNP, and several C-SNPs
• Manager of California’s largest Multi-purpose Senior Services Program site
• Closely allied with best-in-class geriatric care providers, such as Health Care Partners
• Aligns financial and quality incentives through a delegated model
Metrics

• More than 96% of SCAN members with six or more chronic conditions currently live at home.
• Less than 2% of SCAN’s Nursing Facility Level of Care (NFLOC) members are enrolled in LTC institutions.
• Nursing home eligible members average less than a 12% acute hospital readmission rate.
• SCAN Dual eligible patient satisfaction = 90+%
• HEDIS percentile scores for most SCAN duals = 75-90+
• A USC study found a 26% greater likelihood of discharge from a SNF to a home setting through SCAN Home and Community-Based Services, thereby avoiding conversion of a short-term stay to a long-term stay.
Do you know this man?

• Dr. Tim Schwab, M.D.
• Chief Medical Officer with SCAN for 22 years.
• More experience helping people with chronic conditions than almost anyone else in America.
• Lived through the rise and fall of the Social HMO demonstration.
SCAN’s Integrator Proposal

- Comprehensive model that integrates Medicare and Medi-Cal funding for covered services into a single, fully-capitated payment
- Regulatory streamlining to eliminate conflicting or duplicative administrative and reporting requirements across the Medicare and Medi-Cal programs
- Automatic enrollment of target population based on medical needs and current use of services, with an opportunity to “opt out”
- Patient-centered care delivery model that focuses on care improvement through an interdisciplinary team, member/caregiver/family education, CME, and use of information technology
- Transparent payment model to provide guaranteed savings to State and CMS, with the potential for additional shared savings
• Establishment of plan and member goals with regular reporting of metrics against an established benchmark
• Use of a sophisticated infrastructure assessment tool to improve the ability of provider groups to meet the specific needs of the duals population
• Incentive payments to providers based on performance measures
• Real time monitoring of quality and utilization, with transparent reporting of data to members, providers, and to the State
Why the Integrator makes sense

• Today, very few organizations can integrate care effectively, especially for vulnerable populations
• The Integrator is more effective than a straight ACO, which has little or no experience accepting risk
• The Integrator is better than most insurance plans that focus on UM, UR, and claims payment but not on the HCBS and behavioral health services that duals need
• The Integrator takes current best practices and “learnings” and expands them geographically to less than best-in-class providers
2011 Outreach

• SCAN proposed that the Integrator become a permanent option for states with sophisticated plans and provider groups

• Interest increased as the budget deficit situation in Washington deteriorated

• Briefings were provided for the following:
  – FCCO, CMMI, HHS
  – Ways and Means, Energy and Commerce, Finance
  – Congressional leadership and CBO
  – National Governors Association
  – California Department of Health Care Services
  – Arizona Health Care Cost Containment System
• The national model that FCCO and CMMI have created is very similar to the Integrator

• The Secretary has the authority through the ACA to make a successful demonstration permanent

• Not yet clear what kind of resistance may emerge from plans on reimbursement cuts and from patients on auto-enrollment

• Questions remain regarding expansion in rural states where coordinated care has not yet taken hold
Meanwhile, back in California...

• State has 1.1M Dual Eligibles – the most in the nation
• State budget deficit presents a huge problem, necessitating Medicaid program and provider cuts
• State has three different insurance models for Medicaid recipients
  – Single payer counties (e.g., Orange)
  – Two-plan counties (e.g., Los Angeles)
  – Geographic managed care counties (e.g., San Diego)
• Patient advocacy community is active and strong
California’s Duals Initiative

- Legislation passes to create four Duals pilots
- Goal is to enroll 150,000 Duals by end of 2012
- Ultimate goal is to enroll all 1.1 million by 2015
- State received CMMI $1M planning grant in April
- Receives 39 responses to RFI in June, including for-profit and not-for-profit health plans and hospital/physician groups
- State now saying initial pilot may be greater than 150,000
• Due to budget cuts, California is ending its Adult Day Health Care Center program, with 26,000 Duals losing benefits

• In August, the State began notifying the Duals about the transition to managed care plans

• Since enrollment began, however, about 60% have chosen to opt out of managed care and go back to fee-for-service

• That bodes ill for mandatory enrollment of Duals in pilot program, both for California and for the national CMMI program
It is clear that Duals will vote with their feet if they are unhappy with their choices.

Duals will only agree to give up fee-for-service if the integrated care offered is clearly superior to current care offerings.

This presents a problem, as many states do not have sophisticated partnerships upon which to build integrated care models.

States need to grow sophisticated partnerships by offering incentives, primarily auto-enrollment.
Gaining Patient Acceptance

• California has put forward three “frameworks for understanding” that would help define the program and reassure patient advocates

• Frameworks include:
  – Consumer Protections
  – Mental Health and Substance Use
  – Long-term Care Coordination

• Remains to be seen if patients and advocacy groups deem choice and quality safeguards sufficient
Key Questions

• Should there be a limited number of plan offerings, or should greater competition be encouraged?
• Should certain populations like the disabled be carved out, or should all Duals be included?
• Should beneficiaries be auto-assigned with an opportunity to opt-out, and how liberal should the opt-out provision be?
• Should the state adopt both the capitated and the managed FFS financial models put forward by CMMI, and how would the FFS model work?
Lessons Learned So Far

• As California goes, so goes the nation
• Get stakeholder buy-in
• Reach out to those with care experience
• Encourage partnerships that make sense for patients
• Insist on savings
• Stay flexible
• Keep moving forward because, from a budget standpoint, there is no alternative