CHCS
Center for
Health Care Strategies, Inc.

Innovative State Initiatives in Care Management for Dual Eligibles

National Medicaid Congress
Managing Current and New Dual Eligibles Preconference
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CHCS Mission

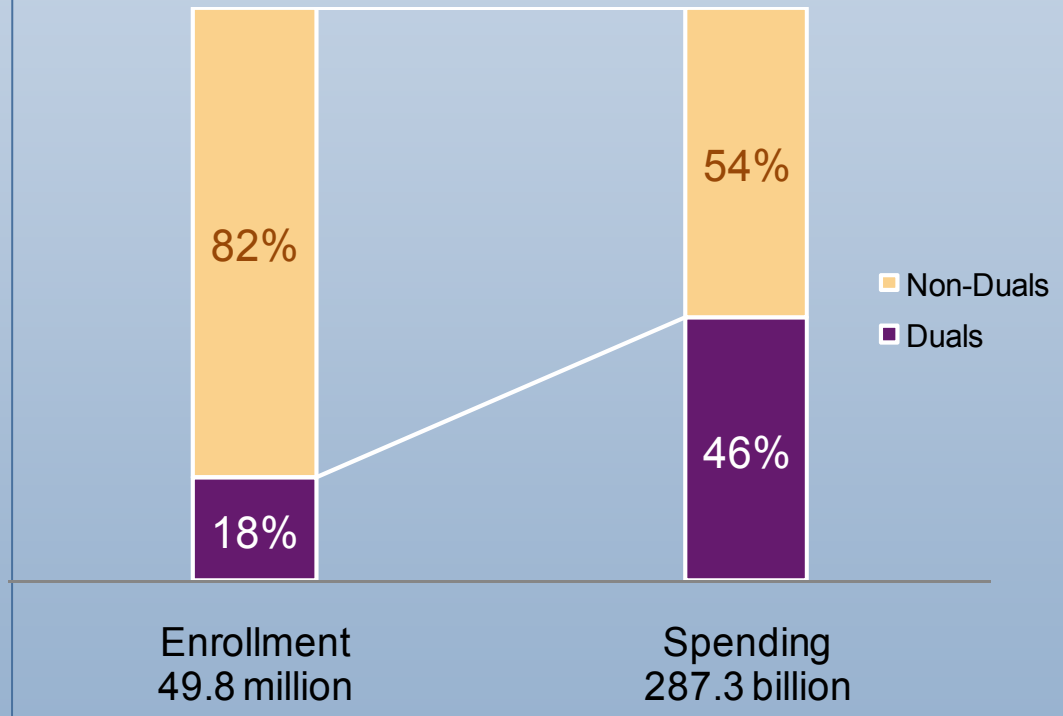
To improve health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

- **Our Priorities**
  - Improving Quality and Reducing Racial and Ethnic Disparities
  - Integrating Care for People with Complex and Special Needs
  - Building Medicaid Leadership and Capacity

Why Focus on Dual Eligibles?

- 8.8 million duals drive nearly half of Medicaid and one quarter of Medicare spending.
- 87% of duals have 1 or more chronic condition.
- 1.6 million duals with annual Medicaid costs of more than $25,000 account for more than 70% of all dual spending.
- Growing momentum at federal level with duals provisions included in health reform legislation.

Dual Eligibles' Share of Medicaid Enrollment and Spending, FFY 2005



Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2008

Benefits of Integration

- Creates a single point of accountability for the delivery, coordination and management of primary/preventive, acute, behavioral, and long-term care supports and services
- Promotes and measures improvements in health outcomes
- Promotes the use of home- and community-based long term-care supports and services
- Uses provider performance incentives to improve coordination of care
- Blends and 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

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
- Strong home and community based service options, including personal care services
- Adequate consumer protections
- Robust data-sharing and communications system
- Aligned financial incentives

Medicare and Medicaid Integration Options

1. Medicare Advantage Special Needs Plans
2. PACE Program
3. **Shared Savings Model**
4. **State as Integrated Entity**

Shared Savings Model

- *HOW IT WORKS*: Physician groups, integrated health systems, or regional coalitions create tailored alternative payment system to support integrated care for duals on a FFS basis
  - *Considerations:* Strength of provider network; overlap between Medicare and Medicaid providers; extent to which LTSS integrated; capacity/infrastructure
  - *Example*: North Carolina (only state to date)

Shared Savings Model

PROS

- Eliminates Medicaid disincentive to provide care management
- Supports better coordination than FFS
- Incremental step toward assuming more risk/blending of funds

CONS

- Maintains FFS system, which does not support quality of care vs. quantity
- Medicare/Medicaid funding is not fully blended
- Limited opportunity for state to share savings

State as Integrated Entity

- *HOW IT WORKS*: Emerging model that would allow state to act as integrator of Medicare and Medicaid covered benefits and blend the two funding streams
  - *Considerations:* State infrastructure/capacity; provider capacity; funding methodologies
  - *Examples*: Massachusetts & Vermont exploring this approach (no states have authority to date)

State as Integrated Entity

PROS

- Complete blending of funds
- More potential savings can accrue to state
- State can reinvest savings to better coordinate care
- Established care homes
- Better coordination than FFS
- Flexibility to provide state-specific options
- Increased accountability to improve care

CONS

- State bears Medicare risk
- Voluntary nature of program can influence rate uncertainty, adverse selection, etc.
- Potential health plan, provider, and/or consumer reluctance to lose direct Medicare relationship

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