Health Systems Transformation and Long Term Care for Individuals Dually Eligible for Medicare and Medicaid

Importance of Inclusion in CCOs of Individuals Dually Eligible for Medicare and Medicaid

In HB 3650, the legislature directed OHA to seek Federal waivers and permissions necessary to allow CCOs to provide Medicare and Medicaid services to dually eligible individuals. Inclusion of dually eligible enrollees in the CCOs, and of the associated Medicare funding in the global budget, is important for a number of reasons. Medicare spending covers the majority of the costs for individuals who are dually eligible, and the vast majority of costs not associated with Long Term Care (LTC) (see table below). Medicare is the primary payer for dual eligible beneficiaries, and therefore covers the bulk of medical services. Including the Medicare funding in the global budget creates a larger pool of funding to leverage and will allow CCOs to find economies of scope and scale. Including the Medicare funding also will provide a significant opportunity to use these funding streams more flexibly and integrate care more effectively.

Estimated One-Year National Spending on Dual Eligible Beneficiaries, 2011[i] (billions)

	Without Medicaid LTC	*Medicaid LTC costs*	*Total with Medicaid LTC*
Medicare	*$175.7 (80%)*		*$175.7 (55%)*
Medicaid	*$43.1 (20%)*	*$100.5*	*$143.6 (45%)*
Total	*$219 (100%)*		*$319.5 (100%)*

In Oregon, Medicaid spending for dual eligible beneficiaries, excluding LTC, was $275 million in 2010.[ii] Total Oregon Medicare spending in 2009 was $4.7 billion, and applying national proportions, we estimate that spending for dual eligible beneficiaries was approximately $1.7 billion.[iii]

Inclusion of the Medicare funding for dually eligible individuals in global budgets will be key to realizing Oregon's triple aim of better health, better health care, and lower costs. Dually eligible beneficiaries are a disproportionately high cost population, making up 15 percent of the Medicaid population nationally, but accounting for 39 percent of the costs.[iv] In Oregon, dually eligible beneficiaries make up 17 percent of the Medicaid population, but 40 percent of the costs (including LTC). Similarly, dually eligible beneficiaries make up 21 percent of the Medicare population nationally (15 percent in Oregon), but account for 36 percent of the costs.[v] There are approximately 59,000 dually eligible individuals in Oregon, about 47 percent of whom are in managed Medicare and 61 percent are in managed Medicaid; 61 percent are in fee-for-service Medicare or Medicaid (or both), and even for those who are in managed care for both, they may not be in plans managed by the same entity.

Better coordination of care for Oregon's dually eligible population holds promise for better health, better health care, and lower costs, for both Medicare and Medicaid spending. CCO savings for this population could come from:

- Reductions in avoidable hospitalizations, emergency room utilization and other acute care;
- Reductions in unnecessary or duplicative drug utilization; and
- Administrative efficiencies from new flexibilities to align Medicare and Medicaid regulatory and administrative requirements.

Inclusion of Medicare funding for dually eligible beneficiaries in CCO global budgets will be subject to CMS approval. The OHA is preparing a formal proposal to integrate care for dually eligible beneficiaries under a CMS initiative—called the "design contract"—to partner with states to integrate care for individuals who are dually eligible for Medicare and Medicaid.[vi] In addition, CMS has offered all states the previously unavailable opportunity to pursue three-way contracts between health plans, the state, and CMS for blended Medicare and Medicaid payment to plans, set at a level to target savings that can be shared. This is a significant opportunity for Oregon to capture a share of the Medicare savings we produce through our health system transformation. Oregon has submitted a Letter of Intent indicating that we will be including this blended capitation approach in our design contract proposal to CMS. However, as a design contract state, Oregon is not limited to proposing this model, and as such the proposal to CMS may also be an opportunity to pursue other promising models, such as housing with services and a more flexible Program of All-Inclusive Care for the Elderly (PACE) program.

Oregon will work with CMS to negotiate the terms and program structure for the dual eligible population to ensure that our proposal meets Oregon's requirements and CMS standards and conditions for including Medicare funding for dual eligible beneficiaries. After signing of a Memorandum of Understanding (MOU) between the state and CMS, CMS will participate in the contracting process as relevant for the Medicare funding, leading to the signing of three-way contracts among CMS, the state, and CCOs.

Shared Accountability with Long Term Care

Medicaid-funded Long Term Care (LTC) services are legislatively excluded from CCO budgets and will continue to be paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services. Approximately 24,000 dually eligible beneficiaries in Oregon (41 percent) receive Medicaid-funded long term care (LTC) services.

The medical system and long-term care system have parallel service delivery systems, leading to fragmented care for beneficiaries. Without coordination and alignment between the two systems, some services are duplicated, while others are denied in one system because they don't meet its criteria, even if the service would improve outcomes or reduce costs in the other system. The maintenance of two separate systems will continue to produce misaligned incentives, cost-shifting between the CCOs and the LTC system, and poor outcomes for beneficiaries. Examples of the types of cost-shifts that may occur include:

- Unnecessary emergency room visits and hospitalization due to inadequate care planning;
- Premature entry into LTC after deterioration in condition due to lack of access to behavioral health, durable medical equipment, or other needed services;
- Overuse of mental health drugs and increased acute care costs due to lack of capacity to care for individuals with mental/behavioral health needs in the LTC system;
- Failure of LTC placement in home and community based setting due to poor hospital discharge planning and poor post-acute care coordination.

In order to reduce cost-shifting and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to coordinate care and share accountability, including financial accountability. In addition, CMS has made it clear that it is their policy that for Oregon's design contract proposal to be approved, and thus for Medicare funding to be included and any shared savings to be realized, there must be this kind of coordination and shared accountability between CCOs and the LTC system.

Current Accountability Structures

In thinking about how to build systems for shared accountability, it is important to understand what structures are currently in place, and how they either work or do not work to hold the two systems jointly accountable for the best outcomes for beneficiaries. In the current system:

- Medical System Accountability – Managed Care Organizations (MCOs)[vii] are held accountable for the delivery and quality of physical and behavioral health services, based on standards that are set federally and by the state. They are held accountable through a variety of mechanisms, including performance reporting, contract monitoring, external quality reviews, internal quality assessment and performance improvement processes, and complaints/appeals.
    - The MCOs and their contracted providers are not held accountable for coordination with or the delivery of LTC services.

- LTC System Accountability - Both LTC providers and the local LTC office[viii] are held accountable for the quality of the LTC services that they provide based on standards that are set federally and by the state. They are held accountable through a variety of mechanisms, including quality assurance teams, monitoring and reviews, the licensing and certification process, adult protective services and complaints, and client appeals.
    - Providers in the LTC system are largely not held accountable for coordination with or delivery of health services, except in limited situations where the provider is involved in medical care, such as medication administration, or the nursing services provided in Nursing Facilities.

- Joint Medical/LTC System Accountability - Overall, accountability for the two systems largely treats them as separate silos and does not reflect the coordination across the two systems that is required to produce the best outcomes for beneficiaries.

- There are not system-wide structures in place to facilitate coordination between the two systems, and neither system is held accountable for ensuring coordination and interface across the two systems;
- Incentives are not aligned across the two systems, creating the potential for cost-shifts;
- As such, communication and coordination where they do happen are due to efforts of individual systems to overcome these structural barriers.

Promising Coordination Models

Promising models and pilot projects exist in Oregon for better coordinating care between the medical and LTC systems. Practices that are used in these projects are described below. These practices are not exclusive and can be combined.

- Co-Location or Team Approaches- These models include co-location of staff such as LTC case managers in medical settings (hospitals or primary care), care coordination positions jointly funded by the LTC and medical systems, or team approaches such as a multi-disciplinary care team including LTC representation.
- Services in Congregate Settings - Includes models where a range of LTC and medical services are provided in congregate settings such as licensed settings, apartment complexes, or day centers to a group of common beneficiaries. Services can be limited to one type of service such as 'in home' personal care services provided in an apartment complex or can be a comprehensive model such as the PACE program where all LTC and medical services are capitated and delivered by an eight-member interdisciplinary team with a merged social center and clinic setting.
- Physician Extender/Home-Based Programs- These include increased use of Nurse Practioners, Physican Assistants or Registered Nurses who perform assessments, plan treatments, and provide interventions to the person in their home, community-based, or nursing facility setting.
- Care Coordination- This is an essential component in all of the above projects but can be a stand alone model. While the actual practices vary, care coordination models use defined protocols and reexamination of staff roles to promote person-centered care, improve sharing of information and alignment of critical assessment, care planning and service interventions.

Proposed Accountability Structures

Although the models outlined above are promising, to achieve system-wide alignment, models such as these need to be brought to scale and supported by mechanisms to share accountability, including financially. There are a number of options and levers that are available to create a system of shared accountability. Implementation of these options could be achieved through the CCO criteria; OHA/DHS rules; contracts including the CCO contracts, LTC provider contracts, and the DHS LTC contracts with AAAs. The state should also consider alignment of state rules and regulation to reduce any barriers to coordination. Options under consideration for shared accountability include:

- Metrics/performance measures for CCOs and LTC providers, related to better coordination between the two systems

- Incentives/penalties based on performance
- Requirement for contract or MOU between the CCO and LTC systems delineating roles and responsibilities
- Specific requirements for coordination between the two systems, such as:
    - Specifying members of the Multi-Disciplinary Team
    - Requiring shared assessments or care plans
    - Requiring communication and data-sharing

As with the rest of the CCO development process, in developing these structures for shared accountability it will be important to balance prescriptiveness and local flexibility. The general approach for CCOs has been to ask them to describe how they will meet goals, and allow for variation in local approaches (and capacity). The same approach should apply to the relationship between the CCO and the LTC system, although there will be some areas where uniformity may be called for, in order to ensure mitigation risks of cost-shifting and uncoordinated care that can result in fragmented care and poor outcomes for beneficiaries.

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[i] Urban Institute. (October 2011). *Refocusing Responsibility for Dual Eligibles: Why Medicare Should Take the Lead:* Feder, Judy, Clemans-Cope, Lisa, Coughlin, Teresa, Holahan, John, Waidmann, Timothy. http://www.urban.org/uploadedpdf/412418-Refocusing-Responsibility-For-Dual-Eligibles.pdf. National Medicaid LTC costs extrapolated based on national estimates that 70% of Medicaid costs for individuals who are dually eligible are for LTC.

[ii] Oregon Health Authority, MMIS Data, Calendar Year 2010, analysis compiled October 2011.

[iii] Total Medicare cost for Oregon dual eligible individuals estimated based on reported Medicare cost for all Oregon beneficiaries (National Health Expenditures Data, CMS Office of the Actuary 2011), and estimated share of Medicare spending for dual eligible individuals (Kaiser Family Foundation, *Role of Medicare for the People Dually Eligible for Medicare and Medicaid*).

[iv] 2007 data - The Kaiser Family Foundation Program on Medicare Policy. (January 2011). *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid*. Menlo Park. CA: Jacobson, Gretchen, Neuman, Tricia, Damico, Anthony, Lyons, Barbara. http://www.kff.org/medicare/upload/8138.pdf Oregon specific data: Kaiser Family Foundation, State Health Facts (2007 data). www.statehealthfacts.org

[v] Ibid.

[vi] In April 2011, Oregon was one of 15 states selected to receive a $1 million design contract from CMS for a 12 month planning process to develop a proposal to integrate care individuals who are dually eligible for Medicare and Medicaid.

[vii] MCOs include Fully Capitated Health Plans, Physician Care Organizations, and Mental Health Organizations.

[viii] May be a local office of the state office for Seniors and People with Disabilities within the Department of Human Services, or may be a local Area Agency on Aging (AAA).