advance healthcare NETWORK | ExecutiveInsight

Managed Care for Dual Eligibles

Current status and how providers can respond now

Current status and how providers can respond now

By Jade Gong

In July 2011, the Center for Medicare and Medicaid Services (CMS) launched a demonstration that to give all states the opportunity to test models of care that integrate acute care, behavioral health and long term services and supports (LTSS) for dual eligible populations. Called the federal Financial Alignment Demonstration (FAD), this initiative is a joint effort of the Center for Medicare and Medicaid Innovation (CMMI) and the Medicare-Medicaid Coordination Office.

There were two different models available for states to integrate care:

1. Capitated Model
2. Managed Fee-for-Service (FFS) Model

The capitated model utilizes a 3 way contract between CMS, the state and the participating MCO to provide the full range of Medicare and Medicaid benefits. These MCOs in turn are responsible for developing the networks and contracting with the providers who will deliver the care, thus eliminating direct Medicaid FFS payment for providers. A key requirement is for Dual Eligible MCOs (MCOs) to undertake health risk assessments, apply risk stratified care management and develop person centered care plans.

At that time, CMS had established an ambitious goal of enrolling 1 to 2 million dual eligibles into this demonstration with 26 states initially expressing interest. We now begin 2015 with clearer picture of the scale of state participation in the demonstration. Although we still await direction from the Managed Care Organizations (MCOs) on their interest in meaningful partnerships with providers to achieve demonstration goals, we can predict their expectations so that long term supportive services (LTSS) providers can prepare to be selected as preferred providers.

Background Facts About the Dual Eligible Demonstration

This demonstration has unique features that align the incentives between Medicare, Medicaid and MCOs:

- The Medicare and Medicaid programs are guaranteed up front savings for plan enrollees as compared to baseline spending
- In addition to these guaranteed savings, MCOs have additional quality withholds from their capitation rates which they can earn back when specified quality metrics are achieved.
- States have an opportunity to share in the savings that are achieved through both Medicare and Medicaid spending reductions.
- Beneficiaries can be passively enrolled into their Medicare benefits with an "opt out" or disenrollment option
- Providers have to contract directly with MCOs and no

longer receive Medicaid FFS payments directly

Given the potential enrollment and the structure of the demonstration, there was interest and anxiety among LTSS providers about the incentives to shift utilization from institutions to home- and community-based care.

Who are the Duals Elgibiles?
Nearly 10 million people in the US are dually eligible for Medicare and Medicaid. These 10 million persons typically are among the highest need and highest cost populations, but often receive poorly coordinated care with poor outcomes. Dual eligible persons are a varied group. Their profile shown in Table 1 suggests that MCOs will seek LTSS providers who can furnish interventions to improve quality outcomes and reduce costs.

Who are the Dual Eligibles?
Medicare and Medicaid dual eligible are a diverse group with a range of medical, behavioral health and social services needs[1]

- 59 percent are age 65 and over and are eligible for Medicaid because they are both low income and needs LTSS
- 41 percent are under age 65 and most have chronic illnesses or disabilities
- Nearly 20 percent have 3 or more chronic conditions
- 30 percent have a mental illness
- 44 percent receive LTSS (either HCBS or institutional care)

Which States are Participating?
As of February 2015, there were 11 states active in this demonstration with a potential of 1.4 million enrolled lives. The majority of states began the demonstration in 2014.

State Implementation of Financial Alignment Demonstrations[2]

STATE	MODEL	START DATE
California	Capitated	April 2014
Colorado	Managed Fee-for-Service	Sept. 2014
Illinois	Capitated	March 2014
Massachusetts	Capitated	Oct. 2013
Michigan	Capitated	Feb. 2015
New York	Capitated	Jan. 2015
Ohio	Capitated	May 2014
South Carolina	Capitated	Feb. 2015
Texas	Capitated	March 2015
Virginia	Capitated	April 2014
Washington	Managed Fee-for-Service	July 2013

Over the coming year, 3 additional states (Connecticut, Oklahoma and Rhode Island) are expected to receive CMS approval and will have a potential enrollment of 200,000 beneficiaries.

What Are the Components of the Demonstration that will Drive MCO Practices?
A deeper understanding of the components of the demonstration will provide insight into the areas where MCOs will focus in order to achieve demonstration goals. As will be seen below, LTSS providers should expect impact on current patterns of service delivery and should be considering new partnership models to achieve mutual goals.

Guaranteed Savings

LTSS providers should be aware that MCOs have guaranteed savings to CMS and states should expect focused efforts to bend the cost curve in these settings. CMS and states have reduced payments to MCOs according to a negotiated schedule thus guaranteeing state and federal savings of 1-4% annually.

Example:
Ohio: Savings percentages applied to Medicare and Medicaid portions of the baseline capitated rates are 1 percent in the first year, 2 percent in the second year and 4 percent in the third year of the demonstration.

Quality Withholds
LTSS providers should be aware that MCOs will be keenly focused on achieving their quality metrics. In addition to the required up front savings, MCOs face "quality withholds" that an MCO can earn back if they meet specific federal and state quality measures. Providers should pay particular attention to how they can help MCOs achieve these quality metrics. The following are selected measures from Ohio and New York that are relevant to LTSS providers:

- Long term care overall balance measure = reporting of the number of enrollees who reside in a nursing facility as a proportion of the total number of enrollees in a plan
- Long term care rebalancing measure = reporting of the number of enrollees who were discharged to a community setting from a nursing facility and who did not return to the nursing facility during the current measurement year as a proportion of the number of enrollees who resided in a nursing facility during the previous year

Example:
In most states, including Ohio and California, quality withhold percentages of 1 percent in the first year, 2 percent in the second year and 3 percent in the third year are withheld from the capitation and can be earned back when federal and state-specified quality benchmarks are met.

All MCOs will be keenly focused on ensuring that the cost of care is reduced from the current levels and that they earn back the quality withhold.
Care Management and Risk Stratification - LTSS providers should expect MCOs to contract with providers that utilize evidence based approaches to reduce the costs of care to high risk segment enrollees. MCOs are required to perform in person assessments of high risk enrollees. Long term care providers, in particular, should determine how they can help the care managers to provide preventative care in nursing facilities and manage care in situ without a hospital admission.

Example:
Ohio has five stratification levels (Intensive, High, Medium, Low and Monitoring) with associated assessment timeframes and care management staffing levels.

Where are MCOs in their Start Up and What is the Experience of LTSS Providers to Date?
The startup of these demonstrations has been more challenging than anticipated from the negotiation of the three-way agreements through initial implementation. Consequently, MCOs have had very short timelines to start these programs from the time that approvals have been secured, rates have been provided and readiness reviews have been completed. The initial implementation of these demonstration has been tumultuous with beneficiary "opt out rates" much higher than expected. In addition, MCOs have been challenged to find and enroll eligible beneficiaries.

As such, MCOs have been focused on start-up operational issues including the development of adequate networks for LTSS providers. To date, there has been little focus on new types of partnerships. We are aware of one relationship that is emerging between MCOs and housing providers to provide care management to dual eligible living in low income senior housing. This is an example of a win-win partnership to achieve population health goals with a trusted provider in the community.

However, once these MCOs go beyond the first year of operations, they are likely to turn to LTSS

providers for partnership to achieve population health goals and to maximize the provision of HCBS to enrollees as part of their care plans.

How Can You Become a Valued Partner to a Dual Eligible MCO?
Although all payers are increasingly seeking value from providers, Dual Eligible MCOs have full risk and responsibility for meeting the needs of high risk and high cost populations and will become robust population health managers. Their goal is to provide high quality, person centered and cost effective care to eligible beneficiaries in the setting of their choice, which is usually the home.

LTSS providers should anticipate that over time, MCOs will turn their attention to the development of meaningful partnerships that meet the social and medical needs of their enrollees to deliver care in the setting of their choice, which is usually the home.

If you are operating in a demonstration state but the demonstration is not in your county, the program may expand to your county at the end of the third year of the demonstration. CMMI has the authority to expand the demonstration if this expansion would not increase net spending for Medicare and Medicaid and if the Secretary of Health and Human Services certifies that the program would provide the same or better quality than is currently provided.

Even if you are operating in a market that is not part of the FAD, other payers including Medicare Advantage Plans, Medicare ACOs and Medicare bundlers are driving providers towards fee for value in every market. LTSS provider should begin now to prepare for fee for value environment and consider these steps:
Know what is happening in your market: Although we are universally moving towards a value based payment system, markets are moving at different rates of change. Look to see what payment models are active in your community and which payers and players are driving change in your market.

Follow the evidence: Evidence practices should drive clinical decision making. SNFs should manage to best clinical evidence about length of stay and optimal discharge destinations. Available tools such as Interact 3.0 should be fully deployed.

Be better than yourself: All providers should think about their services as part of a continuum and consider transitions and outcomes of care from upstream and downs stream referral sources. For example, have you considered the performance of the downstream HHA where you refer your patients?

Find your best partners. In thinking about the range of needs of a dual eligible individual, possible partnerships include a wide range of community agencies such as area agencies on aging (AAAs) or low income housing providers. Physician groups are increasingly bearing risk as ACO developers and bundlers.

Patient outcomes reign supreme: As LTSS providers, you should be working to improve the efficiency of care and reduce any unnecessary costs without compromising outcomes. Meeting or exceeding outcome and quality metrics are of paramount importance.

Prepare now to actively manage the care of your patients and the enrollees of accountable care payers including Dual Eligible MCOs and become a valued strategic partner and population heath manager. Your future sustainability may depend on it.

References:

1. Center for Health Care Strategies, Update on Medicare-Medicaid Integration, February 2015.

2. Medicare-Medicaid Coordination Office Financial Alignment Website.

Jade Gong is the Principal of Jade Gong and Associates, providing strategic advisory services to C Suite executives in hospitals, post-acute organizations, associations and health technology