

# The Value of Integrated Plans: What We Know and What It Means

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HCBS Conference  
August 29, 2019

Medical  
Utilization  
In Plans that  
Integrate LTSS

In partnership with:

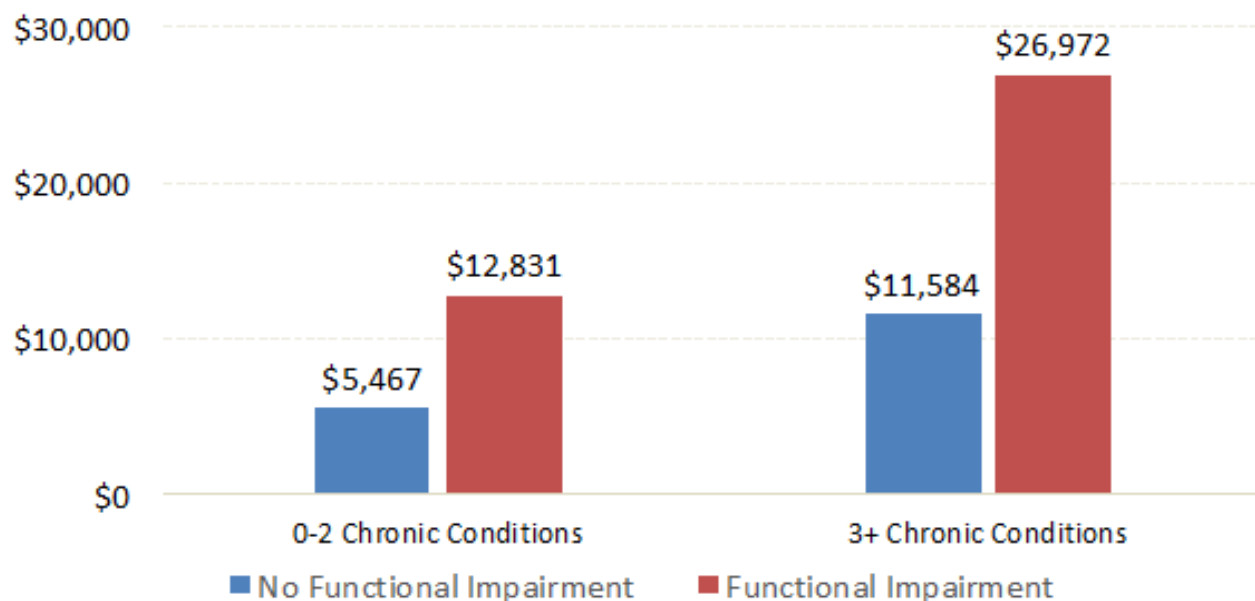
*Roger C. Lipitz Center for Integrated Health Care  
Johns Hopkins Bloomberg School of Public Health*

And support from:



## Functional Impairment Associated with High Medical Costs

*Per Capita Medicare Spending, 2015*



## Previous Work on Integrated Care

- What does comprehensive, integrated LTSS look like:
  - *Taxonomy of LTSS Integration*
  - *Key Components of Successful Integration* (10 case studies).
    - Identifying key elements for successful LTSS integration.
    - Addressing service delivery, legislative and regulatory barriers to success.
    - Replicating the advantages of LTSS integration in a variety of organizational and financing contexts.
- Roundtable – *Developing an Agenda to Advance Integrated Approaches*

# Developing Evidence of Medical Utilization in Plans that Integrate LTSS

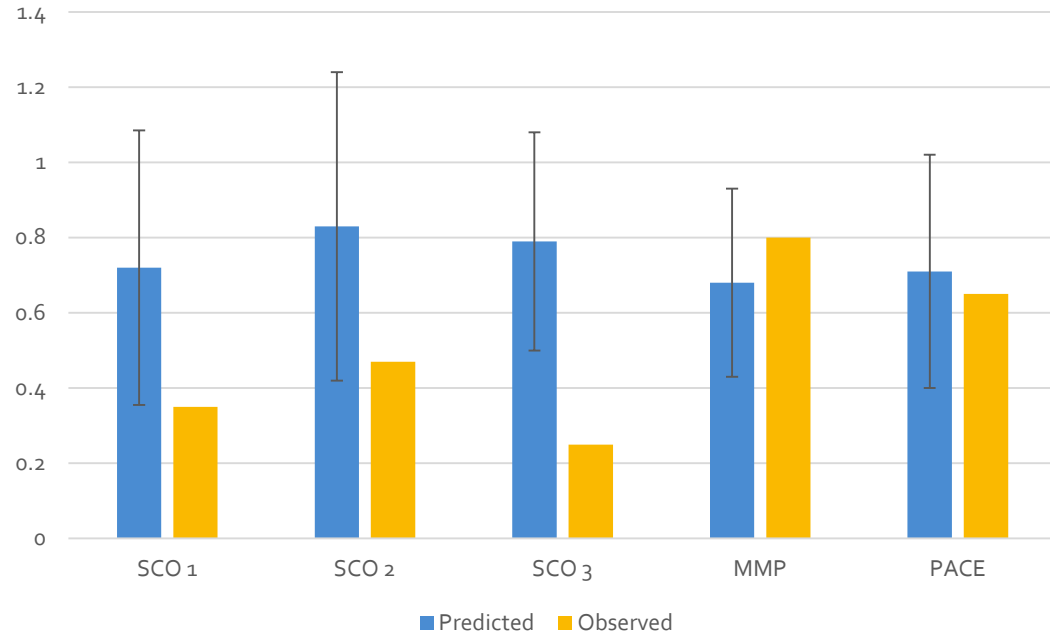
- The study compares results for five integrated plans -- three Senior Care Options (SCO) plans, a Medicare-Medicaid Plan (MMP), and a PACE program.
- Compared with a population having a similar level of functional impairment but enrolled in traditional Medicare.

## Overall Findings

- LTQA found generally lower medical utilization rates for enrollees with functional limitations in integrated plans than predicted for a similar population in traditional Medicare.
- Plans had some rates that were lower, but no plan had lower rates across the board and the rates that were lower varied by type of plan.

# Results

## Hospitalization Rate



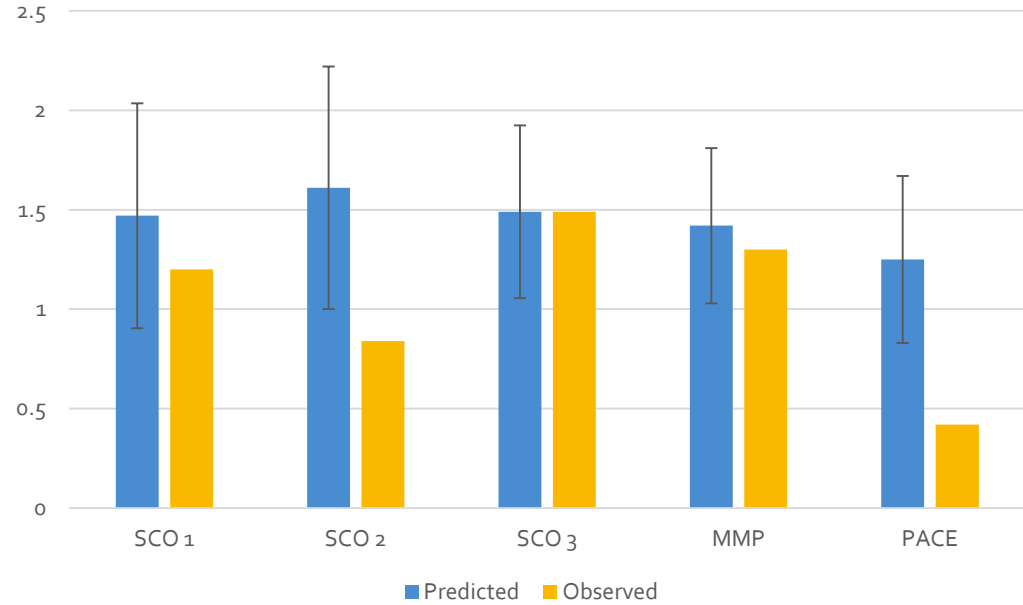
Error bars represent the 95% confidence interval for Predicted results. Significant Observed results lie outside this range.

SCO – Senior Care Option Plans MMP – Medicare-Medicaid Plan PACE – Program of All-inclusive Care for the Elderly

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# Results

## ED Visit Rate



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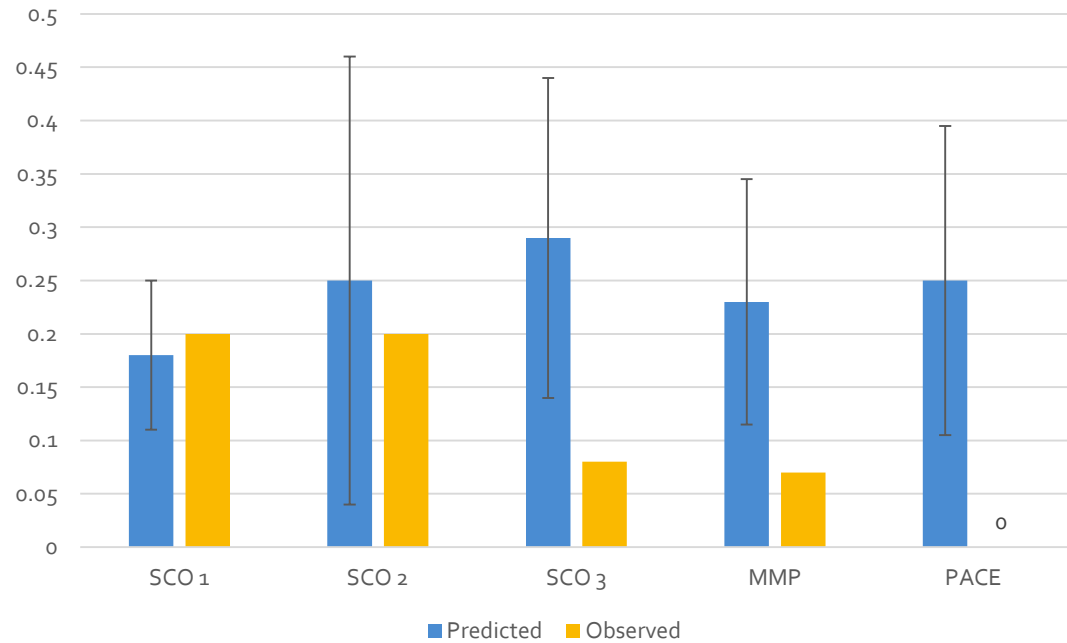
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# Results

## SNF Events



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# The SCO Program: Integrated Care and Medical Utilization

- 3 SCO Plans Participated
  - United HealthCare
  - Commonwealth Care Alliance
  - Fallon Navicare
- SCO Program Overview
- SCO Plan Case Studies
- Quantitative Results

## SCO Program Value

- One of the original integrated programs for individuals with dual eligibility with 14 years of operating experience.
- The SCO model has many features (e.g., intensive, person-centered, care management and interdisciplinary care teams) viewed as having a significant effect on members ability to remain in their homes as they age and their use of intensive medical treatment and institutional care.
- While SCO is an attractive prototype for integrated duals plans, it lacks two features needed to gain wide-scale adoption:
  - broad enrollment of its target population in Massachusetts,
  - evidence base needed to measure and communicate its value.

# SCO and Medical Utilization

- Hospitalization:
  - SCO model associated with hospitalization rates 40 to 70% lower than were predicted
  - one result was significant at 95% confidence interval, and two were at the lower edge of the margin of error.
- ED Visits:
  - The difference varied by SCO.
  - One plan had a substantially (50%) lower observed rate of ED visits - statistically significant.
  - The other two plans had the same or slightly (20%) lower rate, but neither of these results were significant at the 95 percent level.
- SNF admissions:
  - Mixed results.
  - One plan had a much (70%) lower SNF admission rate than predicted, which was a statistically significant difference.
  - Two SCO plans had SNF rates matching the rate predicted for their members had they been enrolled in traditional.

# Resources

- [Research Brief](#)
- [Final Report](#)
- [Technical Appendix](#)

## Related Media:

- Forbes: [Can Managed Care Plans Reduce Health Care Costs By Providing Social Supports?](#)



# **The Medicare-Medicaid Financial Alignment Initiative** *And Other Opportunities to Better Serve Dually Eligible Beneficiaries*

Lauren Gavin • CMS Medicare-Medicaid Coordination Office  
NASUAD HCBS Conference • August 29, 2019



# Dually eligible beneficiaries

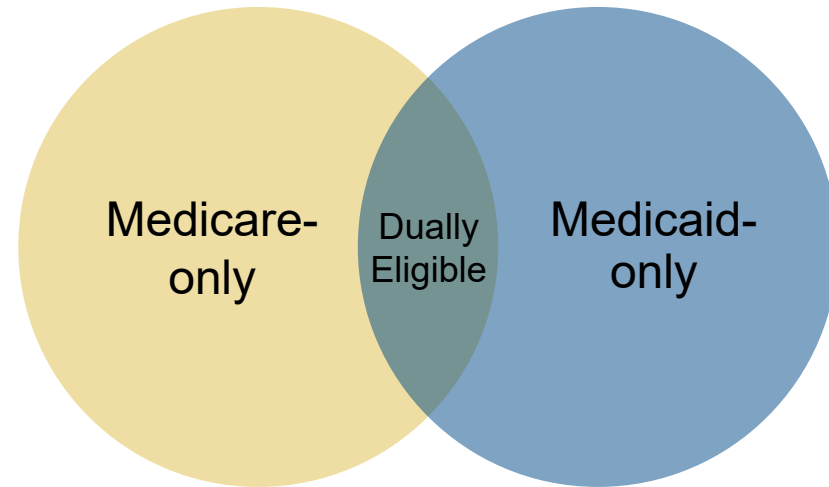
## The dually eligible population

- Higher incidence of chronic conditions, disability:
  - 41% have at least one mental health dx
  - 41% eligible for Medicare due to disability (vs. 8% for non-dual Medicare beneficiaries)
  - About half use long term services and supports
  - 19% have Alzheimer's or related dementia

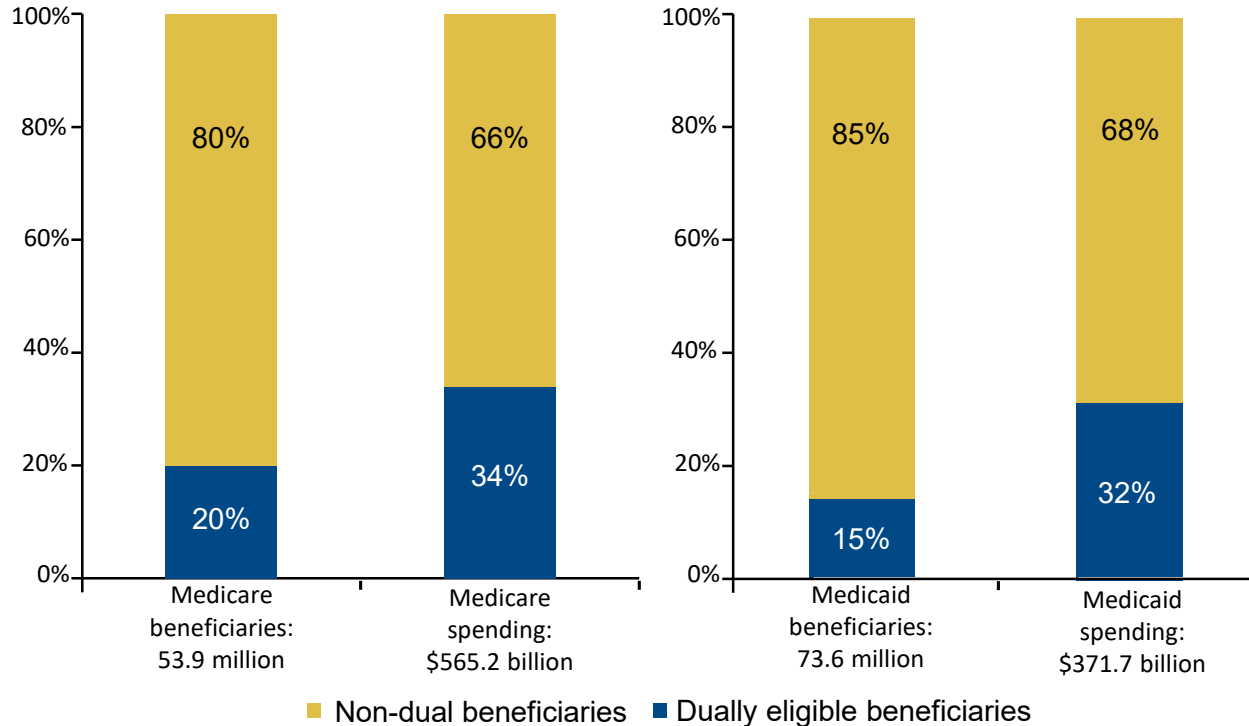
## How it works

- Duals navigate two separate programs:
  - Medicare for the coverage of most preventive, primary, and acute health care services and drugs
  - Medicaid for the coverage of long-term care supports and services, certain behavioral health services, and for help with Medicare premiums and cost-sharing
  - Where benefits overlap, Medicare is primary payer

12 million individuals are simultaneously enrolled in Medicare and Medicaid



# Dually eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending



**Note:** Data are from CY 2013. Charts include all dually eligible beneficiaries (FFS, managed care, and ESRD). Medicaid spending amounts exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Source: MedPAC-MACPAC Data Book 2018



# Dual eligibility correlates to poorer outcomes in Medicare programs

Program	ASPE findings for dually-enrolled vs. non-dually-enrolled beneficiaries
Hospital Readmissions Reduction Program	- 10-31% higher risk-adjusted odds of readmission
Hospital-Acquired Conditions Reduction Program	- Higher safety event rates for 4/8 individual events; lower for 2/8
Hospital Value-Based Purchasing Program	- 5-14% lower risk-adjusted odds of mortality - 4% higher risk-adjusted spending per episode
Medicare Advantage	- Performance worse on 17/20 quality measures
Medicare Shared Savings Program	- 18% higher risk-adjusted odds of readmission - 16% higher age/gender-adjusted odds of COPD admission - 14% lower age/gender-adjusted odds of HF admission
Physician Value-Based Payment Modifier	- 11-20% higher risk-adjusted odds of readmission - 80-230% higher risk-adjusted odds of preventable admission - \$725-\$2,979 higher risk-adjusted costs
ESRD Quality Incentive Program	- Performance worse on 5/5 quality measures
Skilled Nursing Facility Readmissions	- 4% lower risk-adjusted odds of readmission
Home Health Readmissions and ED Use	- 9% higher risk-adjusted readmission rates - 18% higher risk-adjusted ED use rates

ASPE Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. December 2016.  
<https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>.

# CMS' Better Care for Dual Eligible Individuals Strategic Initiative

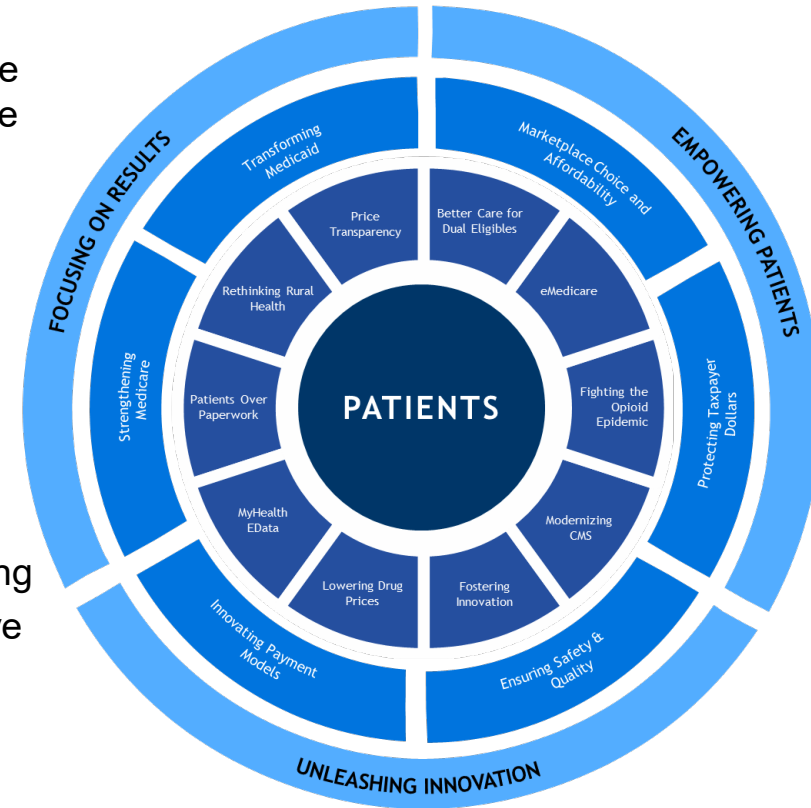
**Initiative Goal:** Improve quality, reduce costs, and improve the customer experience for people dually eligible for the Medicare and Medicaid programs.

## Modernizing the Medicare Savings Programs (MSPs)

- CMS–state data exchange
- Crossover payments
- Reducing burden in eligibility processes

## Promoting integrated care to achieve better outcomes

- Strengthening Medicare Advantage and Medicaid alignment in the final 2020 Medicare Advantage rulemaking
- Modernizing requirements for the Programs of All-Inclusive Care for the Elderly
- Inviting states to partner to test approaches in serving dually eligible individuals that work best for the unique needs of their state



# Overview of the Financial Alignment Initiative

## Background

- A longstanding barrier to coordinating care for the dually eligible population is the financial misalignment between Medicare and Medicaid. That is, investments or disinvestments in one program may result in savings or costs to the other program.
- CMS is testing models to integrate the service delivery and financing of both Medicare and Medicaid through federal-state demonstrations to better serve the population.

## Goals

- Reduce expenditures while preserving or enhancing quality of care.
- Increase access to quality, seamlessly integrated services for the dually eligible population.

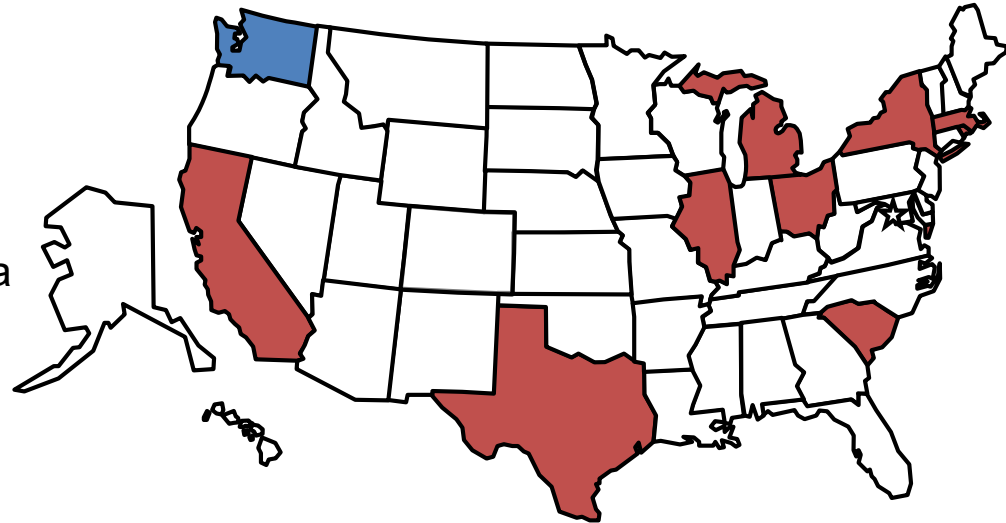
# FAI demonstration models

## Capitated Model

- Three-way contracts among states, CMS, and health plans (Medicare-Medicaid Plans) to provide comprehensive, coordinated care in a more cost-effective way

## Managed Fee-for-Service (FFS) Model

- Agreements between states and CMS under which states would be eligible to benefit from savings resulting from initiatives to reduce costs in both Medicaid and Medicare



- Capitated financial alignment demonstration (9 states)
- Managed FFS financial alignment demonstration (1 state)

Note: CMS and NY operate two separate capitated demonstrations, both in the New York City area.

# The capitated model

- Enrollment assistance and options counseling
- Integrated set of enrollee materials and single ID card
- Person-centered care planning
- Care coordination and assistance with care transitions
- Continuity of care provisions
- Passive enrollment into participating MMPs
- Single contract between state, CMS, and MMP
- Customized Medicare network adequacy standards
- Integrated grievances and appeals process
- Opportunity for the state to share in savings

# FAI independent evaluation

- CMS contracted with RTI International to evaluate the demonstrations under the Financial Alignment Initiative.
- The mixed methods evaluation includes qualitative components (e.g., site visits, beneficiary focus groups) and quantitative components (e.g., analyses on measures of quality, utilization, access to care, and costs).
- To date, evaluation reports are available for the CA, IL, MA, OH, TX, and WA demonstrations. Additional evaluation reports are expected over the next several months.

# Results from FAI evaluation reports

Early FAI evaluation results show promise on key cost, utilization, and quality metrics:

Cumulative results for evaluation reports released to date			
	Statistically significant reductions (desired effect)	Results not statistically significant (suggesting no effect)	Statistically significant increases (undesired effect)
Inpatient	3	0	1
SNF	3	1	0
Long-stay NF	3	0	1
Medicare costs	3	3	0
Medicaid costs	TBD	TBD	TBD

# Other quality results for the capitated model

- CAHPS survey results indicate that MMP enrollees have high levels of satisfaction with their health plan
  - 90% of respondents rated their health plan a 7 or higher in 2018 (scale of 0-10)
  - 65% of respondents rated their health plan a 9 or 10 in 2018 (up from 59% in 2016)
- Strong MMP performance on HEDIS measures of particular interest, such as the Care for Older Adults measures and certain behavioral health measures
  - For example, overall MMP performance on the Care for Older Adults measures increased by an average of 14% from HEDIS 2017 to HEDIS 2018
- Substantial MMP improvement on key measures of care coordination
  - Overall assessment completion rate improved from 69% in 2014 to 90% in 2018
  - Overall care plan completion rate improved from 47% in 2014 to 72% in 2018



# Opportunities for states

CMS released two recent State Medicaid Director Letters outlining opportunities for states to improve care for dually eligible individuals:

- December 19, 2018: describes 10 opportunities that do not require complex waivers or demonstrations
  - <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf>
- April 24, 2019: invites states to partner with CMS to test innovative approaches to better serve those who are dually eligible for Medicare and Medicaid
  - <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19002.pdf>

# D-SNP integration opportunities

- The Bipartisan Budget Act of 2018 requires a minimum level of Medicare-Medicaid integration for all D-SNPs beginning CY 2021
- CMS-4185-F requires that D-SNPs meet at least one of the following criteria by CY 2021:
  - Be a FIDE SNP
  - Be a HIDE SNP
  - Notify state/designee(s) of hospital and SNF inpatient admissions for some high-risk enrollees

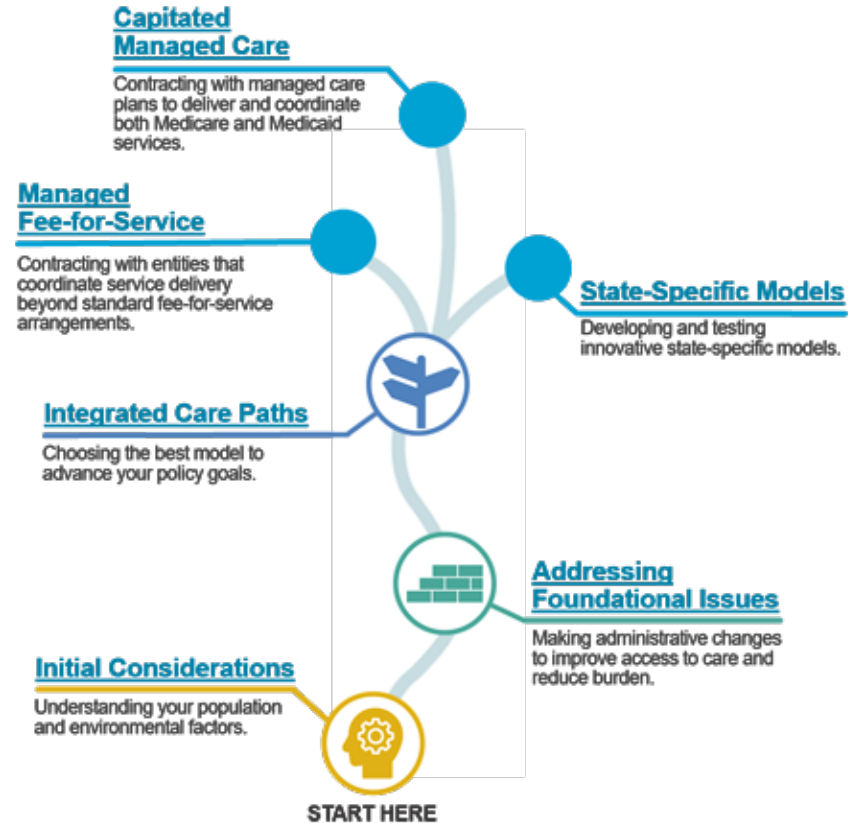
# Demonstration opportunities

- Integrating care through the capitated financial alignment model
  - Extensions of time and geographic scope available for existing states
  - Option for new states to participate in model test
- Integrating care through managed FFS financial alignment model
  - Option for new states to participate in model test
- States may also propose other state-specific models

# Resources for states: where to start

- The Integrated Care Resource Center (ICRC) developed a State Pathways to Integrated Care tool
- States can use the tool to explore their options, which include both demonstration and non-demonstration opportunities
- MMCO and ICRC are available to help walk through various options and considerations in more detail

[https://www.integratedcareresourcecenter.com/sites/default/files/pdfs/ICRC\\_Pathways\\_to\\_Integration\\_04.15.19.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/pdfs/ICRC_Pathways_to_Integration_04.15.19.pdf)



# Other resources for states

- ICRC has a number of other FAI related resources, including:
  - WA Managed FFS Model Case Study:  
<https://www.integratedcareresourcecenter.com/resource/using-health-homes-integrate-care-dually-eligible-individuals-washington-state's>
  - Ohio Capitated Model Case Study:  
<https://www.integratedcareresourcecenter.com/resource/mycare-ohio-demonstration-early-successes-and-stakeholder-insights-integrating-care-dually>
  - A variety of TA tools, issue briefs, and tip sheets related to capitated model demonstrations: <https://www.integratedcareresourcecenter.com/>
- The MMCO website includes links to a variety of FAI foundational documents including MOUs, three-way contracts, rate-setting FAQs, etc.
  - <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/CapitatedModel.html>

# The Value of Integrated Plans: What We Know and What It Means

## *The Ohio Demonstration Experience*

Karla Warren, Integrated Care Manager, Ohio Medicaid

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614-752-2195

# MyCare Ohio

- About 125,000 individuals enrolled in MyCare Ohio, making it the 2nd largest demo.
- Nearly 70% elect for plan to coordinate both Medicare & Medicaid benefits, highest “opt-in rate” among dual demos.
- Medicaid not optional.
- Launched May 2014; current end Dec. 2022.
- Specific role for AAAs.



Demonstration Region	Managed Care Plans Available
Northwest	Aetna   Buckeye
Southwest	Aetna   Molina
West Central	Buckeye   Molina
Central	Aetna   Molina
East Central	CareSource   United
Northeast Central	CareSource   United
Northeast	Buckeye   CareSource   United

# MyCare Ohio Population

- Individual must be:
  - » Eligible for *all parts* of Medicare (Part A, B and D);
  - » Over the age of 18; and
  - » Reside in one of the demonstration counties.
- Eligible individuals include:
  - » Individuals in a nursing facility
  - » Individuals in some home and community-based setting programs (PASSPORT, Ohio Home Care, and Assisted Living)
  - » Individuals in the community not receiving LTSS who are dually eligible.





## What is MyCare Ohio trying to Achieve?

- Goals of MyCare Ohio:
  - » One point of accountability and contact for enrollees
  - » Person-centered care, seamless across services and care settings
  - » Easy to navigate for enrollees and providers
  - » Focus on wellness, prevention and coordination of services
  - » Integrated approach to care coordination to integrate services into one benefit package

**Every member has a care manager.**



# RTI MyCare Ohio Evaluation

## Evaluation Findings:

- Data sources: interviews, beneficiary focus groups, CAHPS survey, Medicare claims data, the Minimum Data Set nursing facility assessments and MMP encounter data.
- Medicare – neither increased spending or reduced savings in early analysis, but plans reported savings. Medicaid analysis not yet avail.
- Care managers overwhelmed initially, struggled to meet deadlines, and members unaware of care manager.
- Ombudsman – very positive experience for members.
- Plans retained most providers after transition of care periods.
- Plans lacks of experience with LTSS and BH systems was a significant challenge early on, incl. payment delays.

## Evaluation Findings – the numbers

- 21.3% reduction in inpatient admissions.
- 14.3% reduction in the probability of ambulatory care sensitive condition (overall) admissions.
- 13.2% reduction in the probability of ambulatory care sensitive condition (chronic) admissions.
- 15.3% reduction in skilled nursing facility admissions.
- However preventable emergency room visits increased by 10.3 percent increase.



# Looking beyond RTI report

## Other measurements of success

Care Management Survey

Care Management  
Comprehensive Reviews

Healthcare Effectiveness Data  
and Information Set (HEDIS)

Consumer Assessment of  
Healthcare Providers and  
Systems Survey (CAHPS)

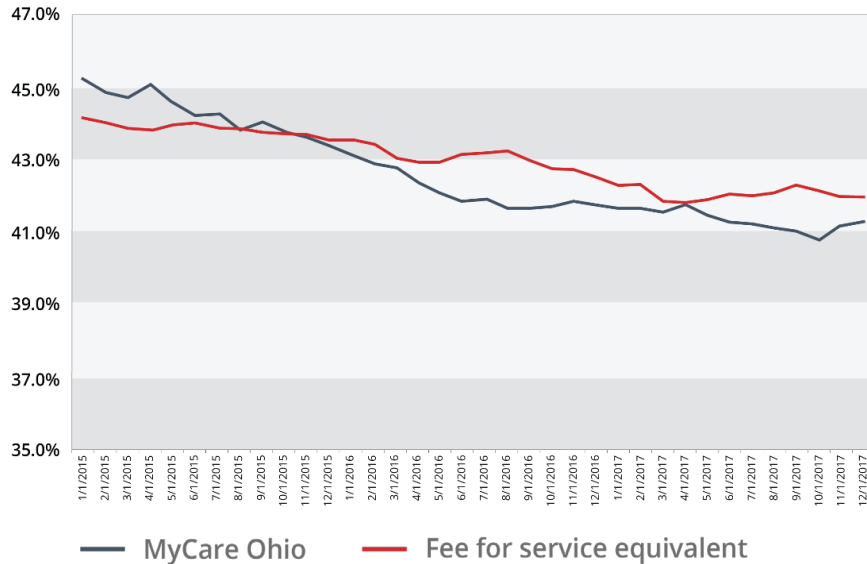
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# MyCare Ohio Enrollment Rebalancing

## Enrollment Rebalancing

Percent of NFLOC Members in an Institutional Setting

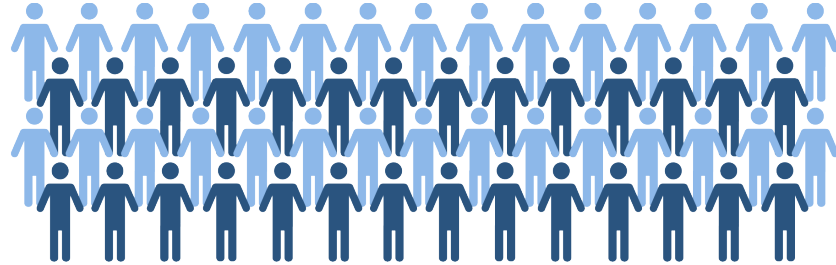


- This chart illustrates the percentage of NFLOC members in a nursing facility (NF) between the MyCare program and a FFS Equivalent population.
- Enrollment rebalancing in MyCare outpaced the FFS Equivalent population.
- This implies that the MyCare program resulted in a 2.0% increase in the number of members transitioning to the community.

***Saving Ohio approximately \$30 million annually above what would have been achieved under the traditional Medicaid fee for service program.***

## Improve Member Safety

**385**  
**residents**



Have been safely moved from 14 poor-performing nursing facilities that have closed since 2015.

MyCare Ohio plans have been involved in these closures and assisted with safely moving the residents.



## Improvements based on demo experiences

- Care management changes – less prescriptive, more flexibility
- Communication, collaboration, communication, collaboration and REPEAT!
- More closely monitoring of provider payments
- Reduction of provider burden
  - » Required initiative to reduce burden for LTC Providers, such as streamlined pre-authorization processes and improvement in the accuracy and timeliness of Provider payments
- Value-based requirements

# The unknowns and challenges

- Medicaid savings
- Experiences of members and providers
- Data analysis and RTI analysis is not a fast process
- Provider influence
- Medicare and Medicaid still has significant separations

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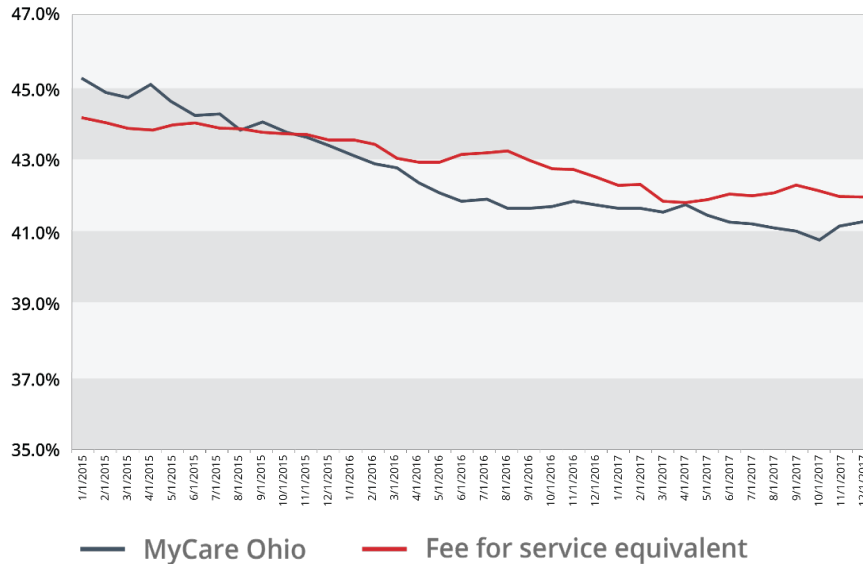
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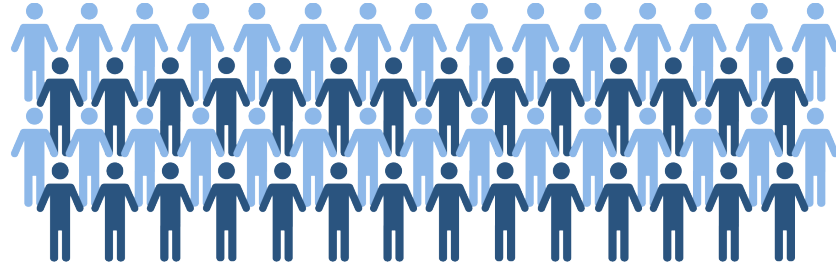


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# Discussion/Q&A

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