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

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CMS Design Contract for Integration of Care for Individuals who are Dually Eligible  
Oregon Health Authority

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# Dually Eligible Individuals in Oregon

- There are approximately 59,000 dually eligible individuals in Oregon
  - 27,000 are eligible for Medicaid under Aid to the Blind and Disabled
  - 32,000 are eligible for Medicaid under Old Age Assistance
- Many are in managed care plans for Medicare or Medicaid
  - 61% are in fee-for-service for Medicare, Medicaid, or both
  - 47% are in managed Medicare
  - 61% are in managed Medicaid
- Approximately 24,000 (41%) of dually eligible individuals receive LTC services

# Medicare and Medicaid Spending for Dually Eligible Individuals

Estimated One-Year National Spending for Dual Eligible Beneficiaries, 2011

	<i>Without Medicaid LTC</i>	<i>Medicaid LTC costs</i>	<i>Total with Medicaid LTC</i>
<i>Medicare</i>	<i>\$175.7 (80%)</i>		<i>\$175.7 (55%)</i>
<i>Medicaid</i>	<i>\$43.1 (20%)</i>	<i>\$100.5</i>	<i>\$143.6 (45%)</i>
<i>Total</i>	<i>\$219 (100%)</i>		<i>\$319.5 (100%)</i>

- Medicaid spending in Oregon for dually eligible individuals was \$275 million in 2010, excluding LTC
- Medicare spending in Oregon for dually eligible individuals was estimated to be approximately \$1.7 billion in 2009

# Importance of Including Dual Eligible Medicare Funding in CCOs

Opportunity to :

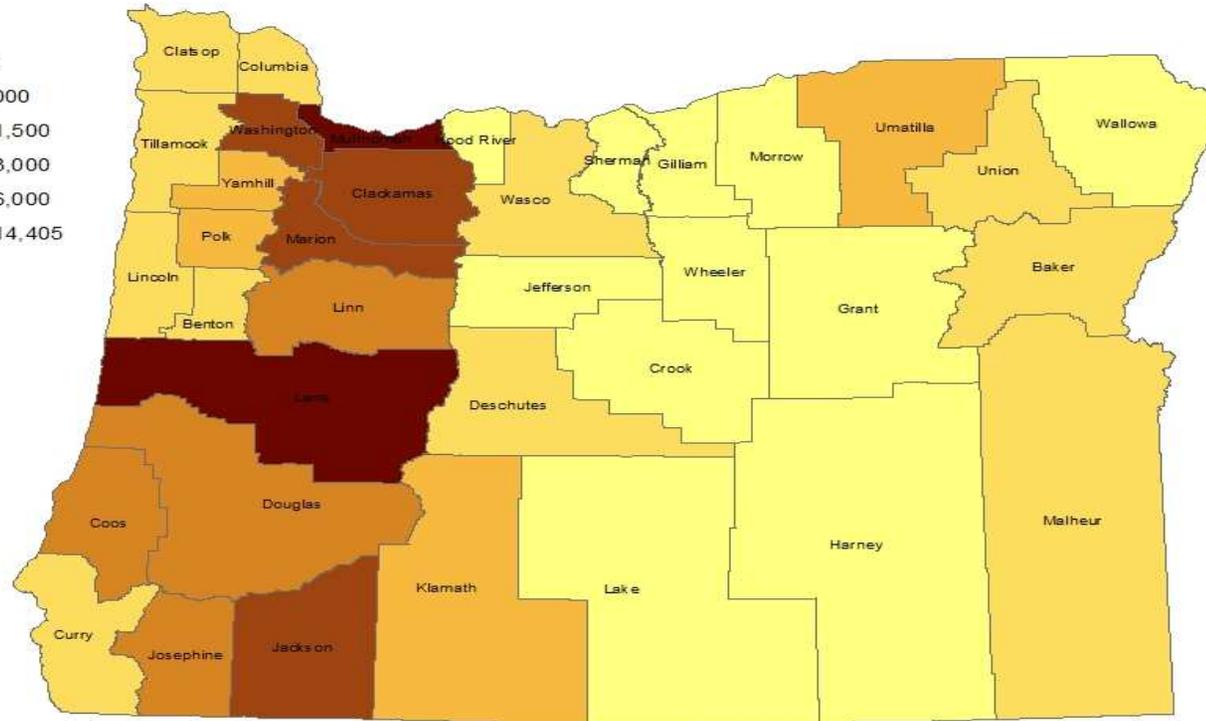
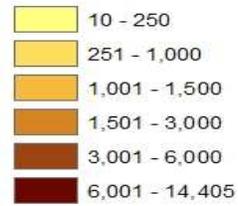
- Leverage larger pool of funding , economies of scope and scale
- Use funding streams more flexibly
- Better integrate care for dually eligible beneficiaries
  - Key to realizing Triple Aim
- Potential savings for this population from:
  - Reductions in avoidable hospitalizations, emergency room utilization, other acute care
  - Reductions in unnecessary or duplicative drug utilization
  - Administrative efficiencies from Medicare/Medicaid alignments

# CMS Process for Inclusion of Dual Eligible Medicare Funding

- OHA has a design contract with CMS
  - \$1 million in funding over 12 months to develop a proposal to integrate care for dually eligible individuals
- CMS has also offered all states new opportunity for 3-way contracts between health plans, state and CMS for blending Medicare and Medicaid funding for dual eligible beneficiaries
  - Oregon indicated intent to include this model in design contract proposal
- Design contract may also be opportunity to pursue other promising models
  - Housing with services
  - More flexible Program of All-Inclusive Care for the Elderly (PACE)

## 2010 Medicare-Medicaid Dually Eligible Counts by County

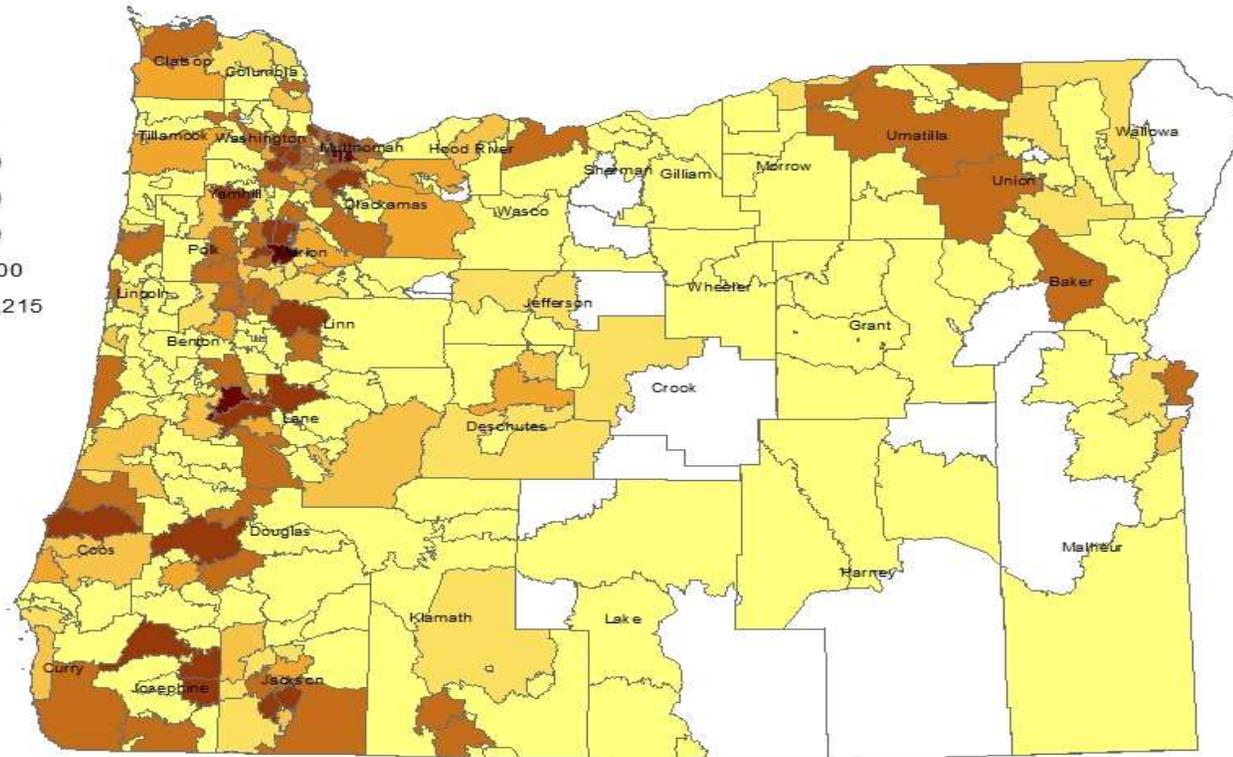
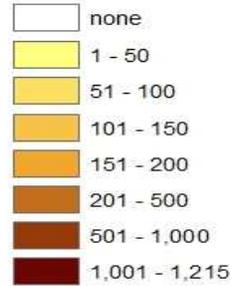
### Legend



Data Source: DMAP, 2010 Eligibility File. Point of time estimates for Jul 15, 2010.  
 Prepared by: Sata Hackenbruck, Oregon Health Policy and Research on 12/09/2011

## 2010 Medicare-Medicaid Dually Eligible Counts by Zip Code

### Legend

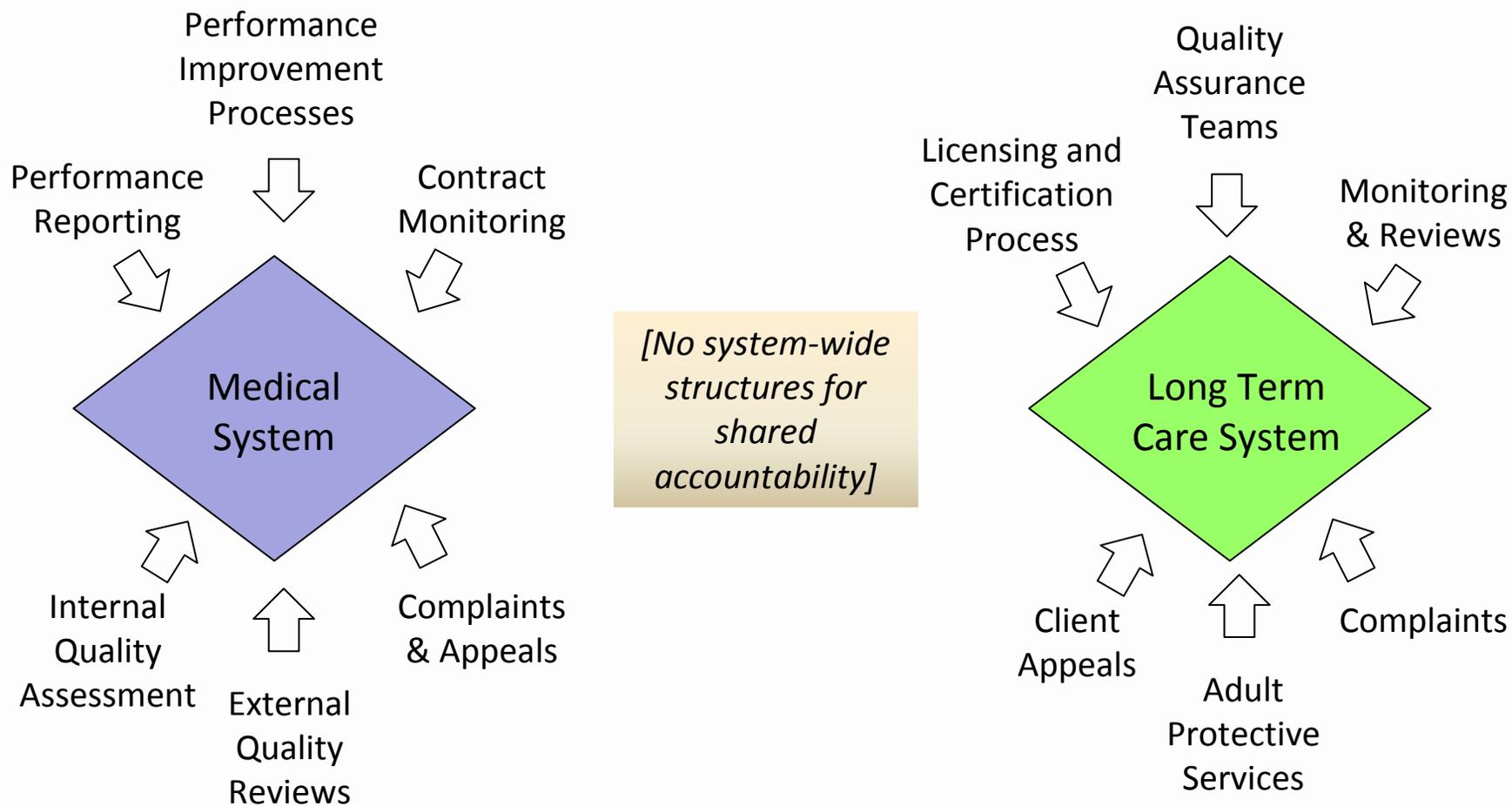


Data Source: DMAP, 2010 Eligibility File. Point of time estimates for Jul 15, 2010.  
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# Challenge of coordination between CCOs and Long Term Care system

- Medicaid-funded LTC services are legislatively excluded from CCO budgets
  - will continue to be paid directly by the Department of Human Services
- Creates challenge for coordination between two systems
- Potential for cost-shifting – examples:
  - Unnecessary ER visits and hospitalization due to inadequate care planning
  - Premature entry into LTC after deterioration in condition from inadequate access to behavioral health, durable medical equipment, other services
  - Overuse of Mental Health Drugs and increased acute care costs due to lack of capacity to care for behavioral health needs in LTC system
  - Failure of LTC placement in home and community based settings due to poor hospital discharge planning and poor post-acute care coordination
- Need to share accountability between two systems, including financially

## Current Accountability Structures\*

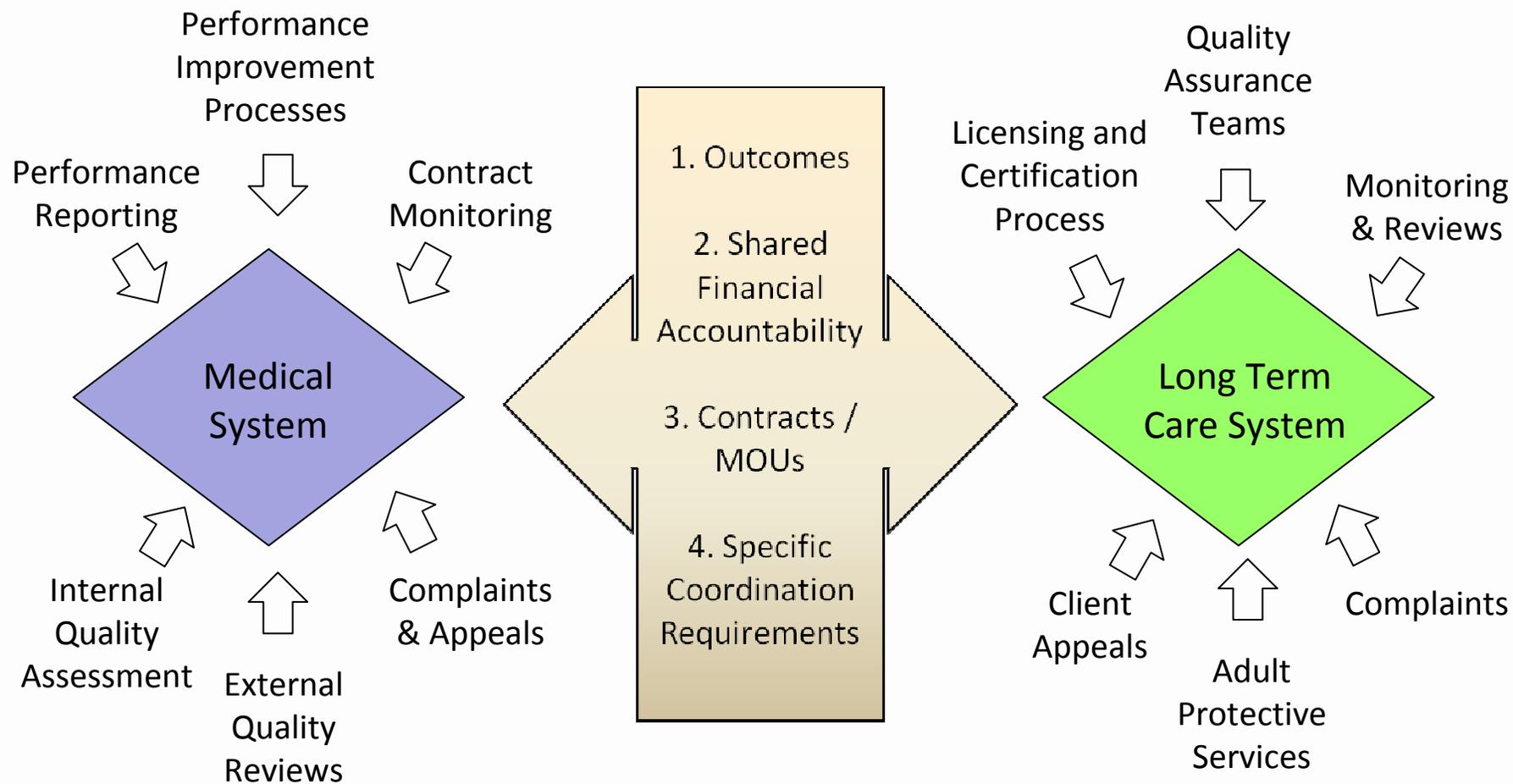


\*Examples, may not represent all current accountability structures

# Promising Coordination Models

- Promising models and pilots exist in Oregon for better coordinating care between the medical and LTC systems, including:
  - Co-location or team approaches
  - Services in congregate settings
  - Physician extender/home-based programs
  - Other care coordination models
- To achieve system-wide alignment, need to be brought to scale and supported by mechanisms to share accountability

## Four Proposed Shared Accountability Structures



# Stakeholder Feedback on Shared Accountability

- Feedback through
  - Medicare-Medicaid Integration of Care and Services Workgroup
  - Medicare-Medicaid Integration Sub Group – HB 5030 Budget Note
- Support for:
  - Focus on outcomes
  - Contract/Memorandum of Understanding (MOU) between two systems
  - Specific coordination requirements
- Open to financial accountability mechanisms
- Desire for local flexibility

# Initial Options for Shared Financial Accountability (11/17 meeting)

- Options were discussed for ensuring shared accountability between CCOs and the LTC system:
  1. Incentive payments and/or penalties based on performance metrics
  2. Shared costs and/or savings compared to a spending or caseload benchmark or target
  3. Ensuring correct allocation of costs between LTC system and CCOs (and specifically a modified Minnesota model).
- Meeting participants were most interested in further exploring options 1 and 2.
- Participants were generally not interested in pursuing option 3, although there was interest in ensuring that the 3-day hospital stay requirement could be waived for Skilled Nursing Facility stays and exploring whether this benefit could be offered in other LTC settings.

# Initial Options for Shared Financial Accountability

	Option	Example	Pros	Cons
1	Incentive Payments and/or Penalties Based on Performance Metrics	<ul style="list-style-type: none"> <li>For a CCO, performance metric might be % of LTC clients served in home/community setting vs. institution</li> <li>For LTC providers, performance metric might be hospital or ER utilization for patients in their care</li> </ul>	<ul style="list-style-type: none"> <li>Flexible in targeting incentives</li> <li>Could be combined with a larger CCO incentive structure</li> </ul>	<ul style="list-style-type: none"> <li>Funding may not be available for incentive payments</li> <li>Poorly chosen metrics could have unintended consequences</li> <li>Incentive/penalty amounts may not be enough to motivate change</li> </ul>
2	Shared Costs and/or Savings compared to a Spending or Caseload Benchmark	<ul style="list-style-type: none"> <li>For a CCO, this might be shared costs if Nursing Facility placements or costs are above projections, shared savings if they are below</li> </ul>	<ul style="list-style-type: none"> <li>Utilizes metrics that are already tracked</li> </ul>	<ul style="list-style-type: none"> <li>Funding may not be available for shared savings</li> <li>Cost/savings amounts may not be enough to motivate change</li> </ul>

# Initial Options for Shared Financial Accountability (continued)

	Option	Example	Pros	Cons
3	Ensuring correct allocation of costs between LTC system and CCO	<ul style="list-style-type: none"> <li>“Modified Minnesota model:” Transferring responsibility and funding for nursing home costs in first 180 days that are actually primarily medical in nature, not LTC, to CCO</li> </ul>	<ul style="list-style-type: none"> <li>Appropriately moves medical costs to CCO</li> <li>Gives CCO greater flexibility to care for patients in most appropriate setting</li> </ul>	<ul style="list-style-type: none"> <li>May be difficult to clearly define what is medical care vs. LTC</li> <li>Does not address cost-shifting and coordination with remaining LTC services</li> </ul>

# Further Stakeholder Feedback on Shared Financial Accountability

- 11/30 Meeting: Medicare-Medicaid Integration Sub Group – HB 5030 Budget Note
- Open to financial incentives, particularly:
  - Shared savings and
  - Incentive payments tied to outcomes
- Concerns about sharing risk/penalties
  - Particularly for smaller LTC providers
- Open to some penalties
  - Idea of not paying for duplicative, uncoordinated services

## Next Steps:

- 12/19 Final Meeting: Medicare-Medicaid Integration Sub Group – HB 5030 Budget Note
- December: Developing more specific models/strategies for the CMS Design Contract Proposal
- January: Review/input by Medicare-Medicaid Integration workgroup
- January: Request input from Oregon Health Policy Board
- February: Finalize Draft CMS Design Contract Proposal
- March: 30-day Public Comment Period
- April: Submit CMS Design Contract Proposal to Integrate Care for Dually Eligible to CMS