THIRD WAY

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Local Examples: Innovations in Care Coordination for the Most Vulnerable

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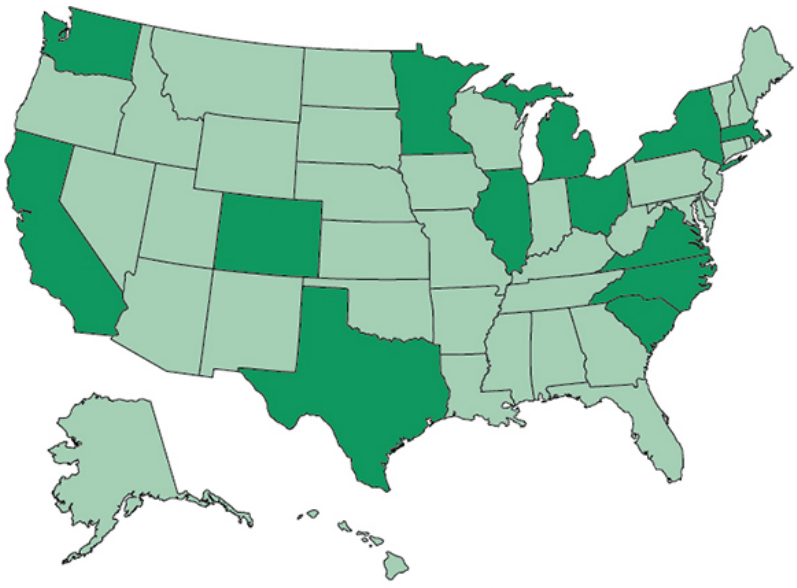
Americans dually eligible for both Medicare and Medicaid have lower incomes and more complex health conditions than those in either program alone. Instead of easing these challenges as intended, the programs' diverging financial and benefit structures lead patients to struggle to navigate various sources of coverage, cause replication of services and wasted spending, and impede care that could improve patient health and quality of life.



To address these issues, states and the Centers for Medicare & Medicaid Services have partnered to test models that coordinate care and financing for this population. These programs include the Program of All-Inclusive Care for the Elderly (PACE), Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP). In 2011, CMS launched the Financial Alignment Initiative with 12 states, which are currently in various stages of implementation.

California

After her remaining family passed away, Susan found herself living alone in a garage. She had the help of an in-home service to assist with the laundry, shopping and some household chores, but Susan still struggled with cleaning and cooking. Through Cal MediConnect, she was able to meet with a member advocate charged with engaging and assisting dual eligible beneficiaries in the community. Her advocate provided Susan with a phone and connected her with transportation services, as well as a social worker who helps Susan access assistance with food and utilities.

The Cal MediConnect duals demonstration expands the benefits of the state's existing Program of All-Inclusive Care for the Elderly (PACE). It aims to improve quality of care and reduce costs through coordinated services and integrated financing. Program health plans provide enrollees with medical, long-term, and behavioral health care as well as social supports, dental, vision, and non-emergency medical transportation benefits. Implementation of Cal MediConnect followed the recent transition of nearly all of California's Medicaid beneficiaries into mandatory managed care. Those dually eligible for both Medi-Cal, California's Medicaid program, and Medicare were passively enrolled into the program through a year-long process that began in April 2014, but may opt out of the integrated program and continue to receive Medicare benefits as they did before.

As with other states using the capitated model, California pays plans a monthly amount composed of both Medicare and Medi-Cal payments in exchange for providing enrollees with all their benefits. The state's Memorandum of Understanding with CMS specifies both minimum and maximum savings and requires plans to make incentive payments from quality withhold funds to county behavioral health agencies based on the achievement of certain service coordination measures. The demonstration will not continue if it does not become cost effective by January 2016.

Colorado

Michael struggled with Type 2 diabetes and found managing his insulin and blood sugar levels overwhelming. He frequently used the emergency room to get care, using an ambulance for his transport. When a care coordinator through his Regional Care Collaborative Organization (RCCO) reached out to intervene, she discovered that Michael's primary care provider had moved away. She connected him with a new provider, where he had access to diabetes education and a new glucometer. Since his care assessment, Michael has not returned to the ER and successfully kept all his appointments to see his doctor.

Colorado built on the infrastructure of its Medicaid health care delivery system, the Accountable Care Collaborative (ACC), in creating a managed care, fee-for-service demonstration model for individuals eligible for both Medicaid and Medicare. Under the ACC program, the state contracts with seven RCCOs to develop provider networks and coordinate physical, behavioral, and social services for beneficiaries. The state uses fee-for-service payments as a base, with additional payments tied to performance indicators such as emergency room visits and hospital readmission rates. If the dual-eligible demonstration achieves at least a two percent Medicare minimum savings rate, Colorado will be eligible for annual retrospective performance payments, based on the savings rate.

The seven-phase passive enrollment process for Medicare-Medicaid beneficiaries began on September 1, 2014. Beneficiaries were categorized into groups based on their location, delivery system and provider type and enrolled accordingly, starting with individuals who have the least complex conditions. The demonstration allows for beneficiaries to keep their network of providers and to opt out or disenroll at any time. Key elements of the program include a Service Coordination Plan (SCP), cross-provider communication agreements, disability competent care, and a beneficiary's rights and protections alliance.

In 2014, the ACC achieved net savings totaling $29 million to $33 million after administrative expenses and the state hopes to expand on these savings through the demonstration model for Medicare-Medicaid beneficiaries.

Illinois

Under the Illinois Medicare-Medicaid Alignment Initiative (MMAI), eight health plans contracted with the state and federal governments to coordinate care for dual eligible beneficiaries age 21 and up. A care manager integrates benefits from both programs, coordinates access to physical, behavioral, and long-term care and social supports, and acts as a single point of contact for both enrollees and providers. Enrollees each receive an individualized care plan based on the results of an initial assessment, and are stratified into one of three risk groups based on need. Each plan assumes the risk to provide all care and services to its members for a fixed monthly rate with a savings percentage and quality withhold applied upfront.

Starting in February 2014, beneficiaries had the opportunity to opt into MMAI and select a health plan before a phase of passive enrollment. Individuals can choose to opt out of the demonstration at any time and continue receiving Medicare benefits as they had before, but are still required to enroll in Medicaid managed care. As of May 2015, 55,672 individuals,

approximately 41% of the eligible population, were enrolled in the program.

Massachusetts

Before the launch of One Care: Mass Health plus Medicare, Boston resident Dennis Heaphy struggled to get coverage for a larger bed from either Medicare or Medicaid. A quadriplegic, Dennis knew both he and his care attendants would have an easier time with a bigger bed. After the launch of the demonstration program, Dennis got his bed in two days thanks to the efforts of his case manager. "I feel like I won the lottery," he said.

One Care focuses on full benefit dual eligible beneficiaries between the ages of 21 and 64 by providing comprehensive Medicare and Medicaid benefits through three available plans. Using a capitated model, the state, CMS, and health plans have a three-way contract under which the plans coordinate and are accountable for all services. In addition to voluntary enrollment by those eligible to participate, Massachusetts is conducting automatic assignment in a One Care plan in three rounds throughout the first year of implementation. Automatic assignment is restricted to four counties in which at least two One Care plans are available and excludes individuals enrolled in a Medicare Advantage plan or the PACE program. All beneficiaries retain the right to choose a different One Care plan or retain their prior Medicare and Medicaid options. As of August 1, 2015, 17,518 dual eligible beneficiaries were enrolled in one of three One Care plans. Approximately 115,000 full dual eligible adults age 21-64 are included in the target population. Despite a rocky start, One Care is seeing high satisfaction rates among participants.

Michigan

Sixty five-year-old Francine is overweight, suffers from cataracts, end stage renal disease, and depression. She often falls out of bed at night because it's too narrow, and must call 911 for paramedics to help her back into bed. Yet Medicare has

not approved an automatic bed that could be adjusted to the right height. Through the care coordination offered through MI Health Link, Michigan's dual eligible demonstration, Francine could receive help overcoming barriers to care.

Under the demonstration, health plans, called Integrated Care Organizations (ICOs), collaborate with established behavioral health organizations called Prepaid Inpatient Health Plans (PIHPs) to integrate care for Michigan's dual population. ICOs are responsible for physical health and long-term care supports and services, while PIHPs cover behavioral health supports and services for individuals with intellectual and developmental disabilities and substance abuse disorders. Coordination takes place through the "Care Bridge," a framework that includes both an electronic health record integrated across ICOs and PIHPs and a lead coordinator from either entity that is chosen by the beneficiary. ICOs and PIHPs contract with the state and CMS for capitated payments and negotiate reimbursement arrangements with their network of providers.

Voluntary opt-in enrollment began in January 2015, followed by phased-in passive enrollment in April 2015. Beneficiaries can switch health plans or opt out of MI Health Link at any time. Health plans also allow people to continue to see their current health care providers for at least 90 days after enrollment in order to provide more continuity of care through the transition.

Minnesota

In one year, Larry was hospitalized four times for dehydration due to his difficulty taking care of his every day needs and aversion to asking for help. His meals often included canned foods and soda. Once enrolled in Minnesota Senior Health Options (MSHO), Larry met with a care coordinator who arranged for Meals-on-Wheels to bring him a daily meal. A nurse now visits him every two weeks to help manage his diabetes and medication, and a home health aide assists with hygiene and personal care. The care coordinator also

arranged for homemaking services and regular doctor appointments. During the first six months of MSHO enrollment, Larry was not hospitalized once.

Since 1997, Minnesota has combined Medicare and Medicaid financing and acute and long-term care service delivery systems through MSHO. The state contracts with managed care plans for a single, combined monthly capitation payment based on the population mix enrolled in the plan for the month. Minnesota's current ongoing demonstration tests administration alignment within this existing financial structure. Health plans are responsible for care coordination between medical and social services and volunteer organizations and provide coverage for all services under Medicare A/B and Minnesota Medical Assistance, including behavioral health and the first 180 days of care in a skilled nursing facility for those participants who enrolled in the plan while living in the community.

Enrollment into MSHO is completely voluntary and can take place any time of year. The state prioritized flexibility for beneficiaries to retain or choose their own primary care physicians as an incentive for potential clients to select the program over other care options. As of July 2014, 70 percent of Minnesota's eligible population were enrolled in MSHO. Those in nursing homes in particular have experienced significantly fewer hospitalizations, emergency room services, and preventable emergency services since enrollment in MSHO, according to an evaluation of the program in 2004.

New York

Adults age 21 and older who are enrolled in Medicare and Medicaid and also require long term care can enroll in Fully Integrated Duals Advantage (FIDA), New York's dual eligible demonstration. Under the program, beneficiaries receive all Medicare and Medicaid services, including long term care, and work with an interdisciplinary team that develops a care plan and coordinates services.

Enrollment in some counties began in January 2015, with passive enrollment phased in starting in April 2015. FIDA-eligible patients receive three notices before their passive enrollment and receive the same services from existing providers for at least 90 days after the coverage start date or until a care plan has been completed. Beneficiaries can switch between plans or opt out of the program once a month.

North Carolina

The North Carolina Community Care Network (NC-CCN) provides coordinated care but without the financing integration. NC-CCN is a primary care case management model used by the state to provide care coordination for its Medicaid program. It was expanded to cover dual eligible beneficiaries under the Medicare Health Care Quality (MHCQ) demonstration program, authorized in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Under the program, NC-CCN assigns dual eligible beneficiaries to physician practices that are responsible for coordinating care and measuring outcomes. The state provides these practices with support, including community-based coordination services, and a host of data and analysis tools such as patient-level and provider-level quality reports. In addition, physicians are paid a monthly fee for providing care coordination services.

The state is eligible for shared savings under the MHCQ program upon achieving quality targets. Performance in the first year of the NC-CCN demonstration was based on 18 quality measures covering management of areas such as diabetes, heart failure, and transitional care. The number of quality measures will expand over time.

In the NC-CCN program, the state pays monthly case management fees to physicians up front which, absent the MHCQ demonstration, would not be reimbursable by Medicare. Yet, this investment by North Carolina Medicaid is making a marked difference in utilization of acute care

services by the dual eligible population. Hospital inpatient admissions for the elderly, blind, and disabled dual eligible NC-CCN population were 15-20% lower than for the un-enrolled population. For NC-CCN enrollees with two or more chronic conditions, emergency room visits were 19% lower than the control population. NC-CCN reduced Medicaid spending by about $1 billion over four years and slowed the Medicare cost growth rate relative to a comparison group.

Ohio

Dual eligibles in targeted areas of Ohio now receive care coordination across acute, long-term, behavioral, and social services through an integrated care delivery system called MyCare. The state launched its financial alignment demonstration at the same time it implemented mandatory Medicaid managed care, first enrolling beneficiaries into Medicaid plans, followed by Medicare plans eight months later. Individuals can opt out of the Medicare portion of the program and continue receiving those benefits through their current plan. As of January 2015, 72 percent of eligible individuals were enrolled in the integrated model.

One unique feature of MyCare is the requirement that plans work with Area Agencies on Aging (AAAs) and similar entities that have experience working with people with disabilities and have consequently built relationships with beneficiaries and providers over time.

South Carolina

Once enrolled in Healthy Connections Prime, dual eligible beneficiaries in South Carolina receive help from a care coordinator in determining what care they need and where to get it. Managed care organizations, called Coordinated and Integrated Care Organizations (CICOs), are paid a blended capitated rate of Medicaid and Medicare funds with a savings percentage applied upfront. In turn, they provide, arrange for, and coordinate a continuum of benefits including medical and behavioral health, preventive services, prescription

drugs, long-term services and supports, social supports, and palliative care for patients with serious, chronic illness.

The state began with a voluntary enrollment period during which beneficiaries could join the demonstration and select a health care plan. This was followed by a passive enrollment period when the remaining beneficiaries were automatically assigned to plans based on existing provider relationships and history with other managed care plans. CICOs must allow new enrollees to maintain their current providers and preauthorized services for 180 days from the date of initial enrollment. Individuals can opt out or disenroll from the program at any time, and continue receiving coverage through fee-for-service Medicaid and original Medicare or Medicare Advantage.

Texas

After Steve's motorcycle accident, his integrated Medicare-Medicaid health plan helped him live as independently as possible. With newly widened doors and a ramp to the backyard, Steve is able to stay mobile. Thanks to in-home care, his wife is able to go to work without worrying about her husband.

Under contract with the state of Texas, Amerigroup, a private health plan, provides long-term care services to dual eligible beneficiaries with coordinated care and integrated financing. It also has a Medicare Advantage Special Needs Plan that enrolls many of the same duals. Together, they have reduced hospital costs by 22%, and emergency room use has decreased by 40%. Compared with the traditional, fee-for-service care, the Texas program has generated savings of 15% for acute outpatient care and 10% for long-term services and support.

Virginia

One Virginia resident, who suffers from Alzheimer's, congestive heart failure, aphasia, and incontinence, was primarily cared for at home by her daughter before joining

Commonwealth Coordinated Care (CCC). During the patient's initial care assessment upon enrollment, the coordinator observed that the daughter was under great strain from her caregiving role and considering nursing home placement for her mother. After completing the assessment and discussing care options with the family, the coordinator facilitated the approval of increased hours for an in-home attendant. This additional support from both the coordinator and attendant enabled the patient to remain in her home while giving her daughter the relief she needed.

CCC offers primary, preventive, acute, behavioral and long-term services and supports to Virginia's dual eligibles through a single, integrated program under CMS' Financial Alignment Demonstration initiative. CCC health plans receive capitation payments combining funding from the state based on historical fee-for-service payments and from CMS for all Medicare Parts A, B, and D services, which are adjusted for a plan member's health status. Payments are reduced each year by an agreed upon percentage designed to capture the savings that should be achieved by coordination of services. A percentage of the capitation payments are also withheld, to be repaid to plans retrospectively if certain quality measures are met each year.

Initial enrollment took place in phases to allow the state to make improvements along the way, and began with voluntary enrollment followed by rounds of automatic enrollment. Beneficiaries can opt in or out of the program or switch plans at any time. Under program rules, automatic enrollment cannot take place in a region unless beneficiaries have a choice of plans. Although Medicare data was not available at the beginning of the program, CCC was designed to use an "intelligent assignment" process for automatic enrollment that takes each beneficiary's prior providers into account in order to promote continuity of care. Plans must allow new CCC enrollees to maintain their current providers and preauthorized services for 180 days from the date of initial enrollment. As of January 2015, 42 percent of the eligible population was enrolled in the CCC program and the state

projects $28 million in savings if enrollment reaches 50 percent.

Washington

Michael is an independent man who once enjoyed carving and woodworking. But his chronic obstructive pulmonary disease and insulin dependency began to limit his activity, requiring him to be on oxygen 24 hours a day. Once he enrolled in Washington's Health Home Program, Michael's care coordinator found that he would benefit from a walker. Unfortunately, his physician failed to complete the proper paperwork that would obtain it for Michael at no cost. His coordinator was able to advocate for him and follow through with the doctor so that Michael received his walker, which he is now using it for walks outside with his portable oxygen. Since then, Michael's depression scores have decreased, he's lost weight, and feels stronger and more independent.

Washington began its fee-for-service demonstration, called the Health Home Program, in July 2013 for both Medicaid only and dual eligible beneficiaries. Through in-home visits and phone conversations, enrollees develop relationships with coordinators who are responsible for managing services across primary, mental health and long-term care providers —who are paid on a fee-for-service basis. This system allows beneficiaries to participate in the program while maintaining their current choice of providers. Beneficiaries engage in the development of an individualized Health Action Plan, and may choose to include their families or caregivers as part of their Health Home team. They may also opt out of the Health Home services and continue to receive all other care through the existing fee-for-service system.

Demonstration savings are determined retrospectively and shared with the state if savings and quality targets are met. By December 2014, the state reported anecdotal improvement for engaged beneficiaries.