CHCS Center for Health Care Strategies, Inc.

Profiles of State Innovation:
Roadmap for Improving Systems of Care for Dual Eligibles

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Profiles of State Innovation: Roadmap for Improving Systems of Care for Dual Eligibles

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The **Center for Health Care Strategies** is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries.

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Foreword

T he Affordable Care Act of 2010 presents national policymakers and state leadership across the country with the opportunity to improve quality outcomes for low-income adults receiving long-term supports and services (LTSS). Even prior to its passage, a number of states had developed successful long-term care models, particularly in the home- and community-based service area. The SCAN Foundation wanted to create an opportunity for all states not only to learn about these various model programs, but also to provide a specific roadmap for states interested in implementing similar programs. Key issues include what concrete steps state officials need to consider within their own state as well as how to best interface with the Centers for Medicare & Medicaid Services to implement these options.

To this end, the Center for Health Care Strategies (CHCS) has developed three *Profiles of State Innovation* roadmaps to help states explore and understand emerging options, best practices, and proven models of success in three areas: (1) rebalancing LTSS care options to support home- and community-based services; (2) the development and implementation of a managed LTSS program; and (3) integrating care for adults who are dually eligible for Medicaid and Medicare.

The mission of The SCAN Foundation is to advance the development of a sustainable continuum of quality care for seniors. The *Profiles of State Innovation* roadmaps outline ways to achieve a more balanced, integrated, and efficient LTSS system. The information included in each roadmap has the potential to ensure that older adults and people with disabilities can age with dignity, choice, and independence while remaining in their homes or in the environment they prefer.

We thank all of those who have contributed to this series, especially the state and program innovators profiled, and members of the project's National Advisory Group, who gave so generously of their time and expertise. We also acknowledge the dedication and hard work of the CHCS staff: Stephen A. Somers, Alice Lind, Lindsay Barnette, Suzanne Gore, and Lorie Martin.

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The SCAN Foundation

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This roadmap outlines three core decision points to help states decide what direction to choose for designing integrated programs for dual eligibles based on current state strengths and capacities.

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▶ **STRATEGY 2:** States that have a strong system for LTSS, but lack a strong managed care system for medical services, should consider broadening their LTSS system to include managed medical services for dual eligibles.

▶ **STRATEGY 3:** States with both a strong medical care system and a strong LTSS program should consider bridging these systems to integrate services.

Introduction

Individuals dually eligible for both Medicare and Medicaid are among the most vulnerable, highest-need, and highest-cost beneficiaries in the U.S. health care system. The Urban Institute estimates that caring for these roughly nine million dual eligibles costs federal and state governments nearly $350 billion annually[1] -- more than 35 percent of combined Medicaid and Medicare spending.   One of the most challenging aspects of providing care for this population is that responsibility for administration, oversight, and financing for their services is split between the federal and state governments. This has resulted in a system of care that is difficult to navigate, inefficient, and costly.

Over the last 30 years, states have looked for ways to improve service delivery and financing for this population. To date, however, states have experienced limited success and promising programs have proved difficult to expand or replicate. The passage of the Patient Protection and Affordable Care Act (ACA) represents a significant shift in the federal government's interest in dual eligibles. It establishes the first legislation in decades to bring together Medicare and Medicaid and includes numerous provisions designed to improve service delivery and financing for this population.

Most notably, the ACA creates new offices within the Centers for Medicare and Medicaid Services (CMS) to support

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> This roadmap culls from state best practices across the country to offer guideposts for improved integration of services for dual eligible beneficiaries with the goal of high-quality, consumer-focused, and cost-effective care.

advancements in care for those dually eligible: the Federal Coordinated Health Care Office ("Office of the Duals") and the Center for Medicare and Medicaid Innovation. The ACA also includes provisions that improve states' ability to coordinate waiver applications and renewals, and increases flexibility in the development of accountable care organizations (ACOs), a promising new entity for integrated care.

Indeed, the ACA is the most purposeful federal effort to improve care for dual eligibles to date; however, in some ways it is just another step in the evolution of care for this population. In 1979, On Lok Senior Health Services of San Francisco received authority to blend Medicare and Medicaid financing for a small number of low-income adults at risk of institutionalization. The On Lok model spread across the country as the Program of All-inclusive Care for the Elderly, known as the PACE program, and many stakeholders believed that a scaleable solution for dual eligibles was just around the corner.[2] Many dual eligibles greatly benefit from PACE. Thirty years later, however, PACE still serves fewer than 18,000 adults nationwide.[3] In the late 1990s, stakeholders had high expectations for a series of Medicare-

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[1] J. Holahan presentation, "The Next Steps in Policy Towards Dual Eligibles," at Fifth National Medicaid Congress, June 7, 2010. Kaiser and Urban Institute analysis of MSIS-MCBS 2003 linked file, projected to 2010 using the CBO March 2010 Medicaid baseline and the CBO March 2009 Medicare baselines.

[2] On Lok is Cantonese for "peaceful, happy abode." For more information on the On Lok model, visit http://www.onlok.org/SeniorHealth/content.asp?catid=240000182&scatid=240000192

[3] PACE in the States, effective January 2009. National PACE Association. See http://www.npaonline.org/website/article.asp?id=12.

Medicaid demonstrations in Massachusetts, Minnesota, and Wisconsin. Each of these state efforts provide many valuable policy and programmatic lessons; however, due to ongoing regulatory barriers, to date none of these programs have delivered the broad solution to the fragmented and misaligned system experienced by most dual eligibles.

In 2003, the Medicare Modernization Act (MMA) authorized special needs plans (SNPs). SNPs are specialized Medicare Advantage plans that target services to specific populations, including dual eligibles. Initially, SNPs seemed to offer a breakthrough opportunity to expand enrollment in integrated care programs for dual eligibles. In 2005, the Center for Health Care Strategies (CHCS) began working with a group of states interested in capitalizing on this new authority. In this initiative and in a subsequent multi-state effort, CHCS brought competitively selected, highly motivated states together with federal Medicare and Medicaid officials to work through regulatory and administrative hurdles that blocked fuller integration of care for this population.[4] At first, "virtual integration" through parallel Medicare and state Medicaid contracting with SNPs seemed to be the most promising route. However, states' inability to mandate enrollment on the Medicare

> ### From 1979 to Present: Building a Better System for Dual Eligibles
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> ► **1979** – On Lok received authority to integrate care and financing for dual eligibles. This put integrated care on the nation's public policy agenda and provided the basis for the development of PACE programs across the country.
> ► **Late 1980s-early 2000s** – Statutory, regulatory, and administrative barriers between Medicare and Medicaid precluded broad replication of appealing models of integrated care.
> ► **2003** – The Medicare Modernization Act made scaleable integration more viable through the creation of SNPs. Administrative barriers and other challenges, however, have limited the expansion of these programs.
> ► **2010** – The Patient Protection and Affordable Care Act provides further impetus for scaleable integrated care programs for dual eligibles and state innovations in long-term supports and services. The ACA establishes new federal offices for innovation and includes provisions that are designed to improve service delivery and financing for this population.

side combined with dual eligibles' ability to choose fee-for-service or other options for their Medicare coverage limited the effectiveness of fully integrated care through SNPs. In contrast, most successful Medicaid managed care programs rely on the states' policy of mandatory enrollment into managed care organizations.

Medicare covers basic health care services for dual eligibles, including physician and hospital care, however; many dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing, and to cover necessary long-term supports and services. Long-term supports and services (LTSS) for dual eligibles represent a significant financial outlay for state Medicaid programs and most designs for integrated care for dual eligibles include the provision of LTSS. A number of states have developed strong contractual relationships with managed care plans to accept capitation for all LTSS. While managed LTSS by itself can offer significant advantages to consumers and states alike,[5] its benefits fall short of those that could be achieved through fuller integration of Medicaid and Medicare services and financing.

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[4] For more information about these two Commonwealth Fund-supported initiatives -- the *Integrated Care Program* and *Transforming Care for Dual Eligibles* -- visit www.chcs.org.

[5] For more information on managed LTSS, see a companion paper to this document: *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*, available at www.chcs.org.

In light of ongoing barriers to full integration through SNPs and the fact that many geographic areas exist that are of limited interest to managed care organizations (MCOs), a number of states are considering the advantages of the state serving as the entity to integrate Medicare and Medicaid financing. These states are receiving growing attention from policymakers and CHCS is pleased to have worked with the states at the forefront of this trailblazing effort.

This *Profiles of State Innovation* roadmap draws from interviews with seven states – Arizona, Hawaii, New Mexico, Oregon, Tennessee, Texas, and Vermont – as well as lessons from additional states to offer guideposts for improved integration of care for dual eligibles. The recommendations herein are proffered with the acknowledgement that our understanding is evolving and the expectation that the new Federal "Office of the Duals" will provide further guidance in the near term.

Background

People who are eligible for both Medicare and Medicaid tend to need more services from the health care and social services systems, and can have very confusing experiences trying to navigate the sea of rules, eligibility requirements, and benefit coverage. Dual eligible beneficiaries, who are often among the most chronically ill segments of both the Medicare and Medicaid population, typically require a complex array of services from a variety of providers.

Although Medicare covers basic health care services, including physician and hospital care, dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing and to cover necessary long-term supports and services. All too often, the fragmentation arising from separate payment and delivery systems results in unnecessary, duplicative, or missed services and avoidable exacerbations of illness leading to expensive hospitalizations and institutional stays. Fully integrated care, in which one entity manages Medicare-covered services as well as Medicaid services, cost sharing, and long-term supports and services, offers a significant opportunity for providing a seamless set of benefits and providers for dual eligibles, therefore improving care and controlling costs for both programs. Theoretically, this objective could be achieved through a variety of approaches, including medical/behavioral/LTSS homes, accountable care organizations, or SNPs that fully integrate Medicaid and Medicare services and financing.

As states grapple with increasingly limited financial and staff resources -- in particular state personnel to design, implement, and oversee new programs for dual eligibles -- the following key questions arise about which path to pursue:

- Should states focus on improving and rebalancing the LTSS system first, ensuring that there are program options available that support people to remain in or transition to community settings?
- Should states proceed immediately toward creating an integrated system for dual eligibles that includes both Medicare- and Medicaid-covered services – including LTSS?
- What impact will key stakeholders' support for or dissatisfaction with the current service delivery system have on program design options and the state's likelihood for success?

In our site visits with innovative programs, states were mindful of the large number of dual eligibles using LTSS and planning for a future where greater integration would be possible through an array of approaches. This roadmap for creating systems of care for dual eligibles reviews these alternative pathways, and gives examples of states that have started down a path and reached the finish line, or in a couple of cases, retraced their steps to reassure themselves that they are on the right track.

Elements of Integration

While programs that integrate care for dual eligibles vary by state and target population(s), core elements found in most fully integrated models include:

- Comprehensive assessment to determine needs, including screening for cognitive impairment/dementia;
- Personalized (person-centered) plan of care, including a flexible range of benefits;
- Multidisciplinary care teams that put the individual beneficiary at the center;
- Involvement of the family caregiver, including an assessment of his or her needs and competency;
- Comprehensive provider networks, including a strong primary care base;
- Strong home- and community-based service options, including personal care services;
- Adequate consumer protections, including an ombudsman;
- Robust data-sharing and communications system; and
- Aligned financial incentives.

By assessing elements that are already in place and conducting an inventory of system strengths, states can build on existing attributes to choose the best path for integrated care. For example, some states have a strong existing LTSS infrastructure for individuals who meet the institutional level of care, including a wide range of HCBS options. These states may already use a comprehensive assessment tool to evaluate health and LTSS needs. In best practice states, the care plan emerges from an automated comprehensive assessment system. Such states could build upon their assessment processes by adding a screening tool for behavioral health issues, thus making the assessment more appropriate to use with the dual eligible population. If a state has a strong infrastructure in place for beneficiaries who meet the institutional level of care, it may be possible to put these same tools in place for a broader population, such as all dual eligibles, even before they meet the institutional level of care requirements.

In other states, the Medicaid managed care system may have a robust provider network that meets the medical needs of Medicaid-only seniors and people with disabilities. In addition, state managed care programs may offer complex care management to enrollees who meet criteria for more intensive support from a multidisciplinary care team. Many MCOs have already built information systems to support data exchange and communication across provider types and with beneficiaries. If a state has a mandatory managed care system for Medicaid-only seniors and people with disabilities that is well-received by beneficiaries, it may be a natural transition to also include dual eligibles and LTSS.

On the other hand, the decision about which path to take may be driven by the critical absence of those needed elements. Many states, for example, still serve the majority of beneficiaries who need LTSS in institutional settings. Many do not offer innovative approaches such as paid family caregivers. And frequently, home- and community-based (HCBS) programs operate in their own silos (often in different state agencies), making it incredibly difficult to navigate HCBS (and easier to just use nursing facility care). A critical first step, in such states, may be a concerted effort to rebalance LTSS toward community-based options.[6] One approach used by best practice LTSS states, such as New Mexico and Tennessee, is to use a capitated managed LTSS program as a vehicle for improving the focus on and access to community-based care. Both of these states built upon a robust managed acute care program serving all of their beneficiaries, including those with disabilities in the Medicaid-only population. New

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[6] For rebalancing best practices, see a companion paper to this document: *Profiles of State Innovation: Roadmap for Rebalancing Long-Term Supports and Services,* available at www.chcs.org.

Mexico also used this program to reign in skyrocketing expenditures for state plan personal care. While it can be very difficult for a managed care organization to take over responsibility for LTSS ("a heavy lift" as one plan referred to it), the managed care system may bring more structure and focus to LTSS programs and better serve the needs of dual eligibles.

In states that do not have integrated Medicaid and Medicare programs for dual eligibles, Medicaid and Medicare providers operate largely in separate contracting silos. To begin to bridge those gaps, states can include dual eligibles in Medicaid managed care programs for their Medicaid cost sharing and/or LTSS and then build linkages to SNPs or other Medicare managed care entities through contracts or other arrangements that create a more integrated system of care.

While implementing a program that includes the abovementioned core elements poses numerous challenges, the ACA does include new provisions to support states in achieving fully integrated care (see Table 1). Nonetheless, states and interested stakeholders will not truly know the benefit and breadth of these provisions until CMS issues further guidance and proposed regulations.

Table 1: Health Reform Provisions Supporting Enhanced Care for Dual Eligibles

Affordable Care Act Provisions	Applicable Core Elements
§2401 - The Community First Choice Option enables states to cover self-directed attendant care and transition services (e.g., first month's rent and utility deposits) through a state plan amendment.	• Comprehensive needs assessment • Personalized (person-centered) plan of care • Strong HCBS options, e.g., personal care
§2402 - The Removal of Barriers to Providing Home- and Community-Based Services provision amends the §1915(i) State Plan Option by expanding certain eligibility requirements and allowing states to target services to populations. The ACA expands the §1915(i) State Plan Option in some areas, but eliminates states' flexibility in others.	• Personalized (person-centered) plan of care • Strong HCBS options, e.g., personal care
§2403 - The Money Follows the Person (MFP) Rebalancing Demonstration provision extends MFP through 2016 and alters the required length of stay rules for individuals in facilities.	• Comprehensive needs assessment • Personalized (person-centered) plan of care • Strong HCBS options, e.g., personal care
§2602 - The Federal Coordinated Health Care Office provision establishes an office within the Centers for Medicare & Medicaid Services (CMS) to connect the Medicare and Medicaid programs to more effectively integrate benefits and improve coordination for dual eligibles.	• Guidance from this office is expected to indicate its support for many of the core elements of integration.
§2701 - The Adult Health Quality Measures provision directs the Secretary to release an initial set of quality measures for Medicaid-enrolled adults by January 1, 2011, and to work with states to develop a standardized format for reporting information based on the selected quality measures by January 1, 2013. This provision does not include LTSS-focused measures; however, this may provide a good opportunity for states to help develop national benchmarks for LTSS.	• Adequate consumer protections, including an ombudsperson • Robust data-sharing and communications system
§2703 - The State Option to Provide Health Homes for Enrollees with Chronic Conditions provision provides states with the ability to establish provider-based health homes for individuals with chronic conditions through a state plan amendment. Many dual eligibles would benefit from improved chronic condition management.	• Comprehensive primary and specialty provider networks • Multidisciplinary care teams
§3021 - This provision establishes the Center for Medicare and Medicaid Innovation (CMMI) to test innovative payment and service delivery models. This provision includes specific models that CMMI can fund. Options include delivery models that promote care coordination and fully integrated care for dual eligibles.	• Aligned financial incentives • Robust data-sharing and communications system
§6703 - The Elder Justice Act of 2009 establishes numerous safeguards to protect frail elders from abuse and neglect. This provision includes grants and training to support the Long-Term Care Ombudsman program.	• Adequate consumer protections, including an ombudsperson
§10202 - The Incentives for States to Offer HCBS as an Alternative to Nursing Homes provision offers certain states an increase in federal match (FMAP) for HCBS services if the state meets specified requirements. To qualify for this provision, states must adopt a "no wrong door" enrollment process, conflict-free case management, and a standardized assessment instrument.	• Comprehensive needs assessment • Personalized (person-centered) plan of care • Strong HCBS options, e.g., personal care

Recommendations from States with Innovative Programs for Dual Eligibles

The following section draws from existing state experiences to outline three core strategies for designing programs for dual eligibles based on current state strengths and capacities.

STRATEGY 1: **States that have a strong managed care system for medical services, but lack a robust long-term supports and services (LTSS) program, should consider building on their existing managed care system to serve dual eligibles.**

If the state has contracts with managed care organizations for Medicaid populations that include seniors and people with disabilities, it may want to prepare managed care plans, beneficiaries, and stakeholders for an integrated set of medical/LTSS benefits. Depending on the state's approach, all or some of the HCBS waiver services can be made available through the managed care plans, which have additional flexibility to leverage cost-savings on the medical care side for Medicaid-only beneficiaries. The health plans can use their existing systems of care management and assessment, but may need technical assistance from state agency staff to expand these systems to incorporate LTSS. Recommendations from states that have begun tapping managed care expertise to provide LTSS benefits include:

- **Offer options to existing contractors.** For example, all Arizona Long Term Care System (ALTCS) contractors must either be certified as a SNP or have a connection to a SNP to ensure coordination with Medicare for dual eligibles. Currently about half of the ALTCS plans also operate as SNPs. In Hawaii, contractors with the QUEST Expanded Access (QExA) program either have SNP agreements in place or are ready to start the agreement process, and the fact that dual eligibles are mandatorily enrolled in the program on the Medicaid side offers an opportunity to coordinate benefits more easily.

- **Require contractors in expansion counties to become SNPs.** New Mexico requires that its contractors become SNPs in as many counties as possible to help coordinate care between both programs. Although it is not a state requirement in Texas, all of the current STAR+PLUS contractors also serve as SNPs, making it possible for the plans to provide some coordination between Medicare and Medicaid services for individuals who choose to receive their care from the same plan. In Texas, this side-by-side model of integration will soon become more streamlined given that the state is now requiring that plans participating in the new STAR+PLUS expansion area (in Dallas/Ft. Worth) must also be designated as a SNP. As such, the state will hold these plans responsible for proactively integrating Medicare and Medicaid services. The state has also gone a step further, developing contracts around Medicare cost-sharing and coordination of care with all SNPs in the state, even those operating outside the STAR+PLUS program. SNPs are required to promptly notify the state when a dual eligible beneficiary enters into a nursing home. This notification will allow the state to ensure that discharge planning can take place as quickly as possible so that the individual has the option to return to the community if possible.

- **Take advantage of stakeholders' push for improvements in the LTSS program.** A lesson learned in Washington was that a strong LTSS system may be a barrier to creating integrated programs for duals. Beneficiaries and stakeholders in Washington have historically held the LTSS program in high esteem. The system offers a wide range of HCBS alternatives for beneficiaries, and once the care plan has been established, beneficiaries are loathe to switch into

an unknown managed care environment. So, enrollment in integrated managed care programs has been low for dual eligibles and users of LTSS, and the state LTSS administrators were not eager to create an opt-out or mandatory enrollment in the absence of proven success. States that have a weaker LTSS system, and a push from stakeholders to rebalance their system toward home and community settings, may find a receptive climate if MCOs offer new choices and supports.

- **Obtain Medicare data to identify the needs of dual eligibles and build a program off the state's existing managed care platform.** Tennessee, which has integrated managed care in place for seniors and people with disabilities through its CHOICES program, hopes to pursue full integration with Medicare. Tennessee's first step toward full integration is to access Medicare data for dual eligibles to obtain a more complete picture of this population's needs. To do this, Tennessee is one of the first states to use CMS' Coordination of Benefits Agreement. The state hopes to use this agreement to obtain Medicare data and utilize it to identify opportunities to improve care for dual eligibles. Among other things, the state is providing this information to Medicaid MCO care managers to improve care coordination. In addition, two of the three MCOs participating in CHOICES have SNPs. Local Area Agencies on Aging (AAAs) serve as the LTSS point of entry in Tennessee. To support understanding about the benefits of SNP enrollment, the state is educating the AAAs about SNPs and the potential for care coordination through SNP enrollment.

- **If the state did not make an early investment in community options, building the infrastructure for home-based care may be the best opportunity to improve care for dual eligibles.** The Oregon LTC director said that in the early days of their HCBS waiver (1980s) when the state budget was on firmer footing, they had the luxury of reinvesting saved dollars in the program. Therefore, they were able to invest money in new facilities, converting nursing home beds and creating adult family homes. He said he doubted most "unbalanced" states would be able to do that now, and instead they would be better off focusing on keeping people in their own homes. An executive from Amerigroup in Texas also emphasized that beneficiaries do not consider adult family homes and other community facilities to be "non-institutional" -- they want to stay in their *own* homes. One way Texas has helped address this need is to invest in a federally funded Money Follows the Person program that works in concert with health plans. Health plans in states with a greater proportion of LTSS beneficiaries in nursing facilities may be able to augment state efforts to create safe, effective care plans for beneficiaries who want to remain at home.

Managed care options for dual eligibles are not viable for all states. For example, Wisconsin has a robust, locally-based managed care system, however, even in this situation a health plan stated that it would be very difficult for a "home-grown model" to enter the SNP market now because the SNP regulations have become very burdensome. In order to launch a SNP in a new state, health plans need the deeper pockets that a national health plan provides. It is not uncommon for integrated medical/LTSS health plans to lose money in the first year or two of operation. States do not have the resources to protect small health plans from losses, and do not want to invest their own staff time in a program that may not be successful. The combination of these factors resulted in the closure of one integrated plan in Washington, the Medicaid-Medicare Integration Program, despite the investment of a large national company over several years.

STRATEGY 2: States that have a strong system for LTSS, but lack a strong managed care system for medical services, should consider broadening their LTSS system to include managed medical services for dual eligibles.

In some states, MCOs do not participate in the delivery system for Medicaid-only seniors and people with disabilities, so it would be a stretch for these states to build a managed care program from the ground up for this population. But even in states with managed care for the SPD population, the state may not be ready for integration. In that case, strong coordination systems can be put into place. States can start by sharing data or coordinating care with the MCOs and providers. The ACA has created a platform for states to consider new models of integration, and MCOs may not be the best approach in every state.

- **States with successful LTSS programs may want the state to serve as the integrating entity.** Vermont has built a high-performing LTSS program and made progress on its goal of having a greater number of beneficiaries served in home and community settings rather than in institutional care. Vermont is proposing a program where the state would serve as the entity that administers care for dual eligibles. Vermont seeks to combine Medicare and Medicaid funding streams and integrate the full range of Medicare and Medicaid services for this population; including primary, acute, behavioral health, and LTSS. Vermont hopes to combine its existing Medicaid 1115 waiver with Medicare authority and funding and implement a program where the state would administer all services for dual eligibles. Vermont would enroll beneficiaries automatically, but individuals would have the ability to opt-out. Vermont also seeks to construct the financing arrangement to allow for shared savings and authority to operate under one set of rules and regulations.

- **States with strong LTSS programs may want to include these best practices in their MCO's integrated system for dual eligibles.**   Washington has a pilot program in one county that offers a potential best practice of full integration for dual eligibles. The Washington Medicaid Integration Partnership (WMIP) provides integrated medical, LTSS, and behavioral health services through an MCO to more than 4,000 dual and non-dual eligible enrollees. Dual eligibles are offered voluntary enrollment as an option to traditional fragmented fee-for-service. Although voluntary enrollment has resulted in low initial program uptake, over several years of operation the proportion of duals in WMIP is gradually increasing as beneficiaries become eligible for Medicare. The MCO offers all of the HCBS options provided by the state, and uses an interdisciplinary team approach to ensure that beneficiaries receive necessary services. The state is considering possible expansion and modifications to WMIP to enhance the delivery of LTSS, hoping to make enrollment more attractive to this population.

STRATEGY 3: States with both a strong medical care system and a strong LTSS program should consider bridging these systems to integrate services.

A small number of states have the luxury of robust systems of managed medical care and LTSS for Medicaid-only seniors and people with disabilities, but have not integrated the two systems. In the absence of that last step, one approach is to create linkages between LTSS and the entities that manage the medical services. This can be done whether the state has arranged for medical care through MCOs, primary care case management (PCCM) systems, or is thinking about the new accountable care organization approach.

- **Build a system off the PCCM base.** North Carolina, for example, has a robust PCCM program called "Community Care" that has enrolled Medicaid-only seniors and people with disabilities for several years. Starting in January 2010, the state began auto-assigning the dually eligible population residing in counties participating in the state's Medicare 646 "shared savings" demonstration. The program covers roughly one-third of the state's geographic area.

  To assist in enrolling the dually eligible, the state expects to receive Medicare claims data from CMS to identify patterns of service use (where Medicare is the primary payer) that appear inconsistent with a medical home model (i.e., no coordination of care). In those cases, the state will conduct outreach with patients and caregivers to stress the importance of a medical home and the benefits it can provide.

  The state's regional networks, which serve as the organizing entities for Community Care, will have a "chronic care champion" to provide leadership in caring for Medicaid-only seniors and people with disabilities and educate providers about available supports and services in the community. The nine networks are also developing clinical protocols and promoting an understanding of what is involved in coordinating services (e.g., ancillary services, therapies, home health, pharmacy, etc.).

  Finally, the regional networks will assist primary care providers in developing transitional care plans, disease management initiatives, and a behavioral health integration effort. Plus, the networks will be expanded to include specialty providers as necessary. At present, the state has four experienced clinicians on staff to assist the regional networks.[7]

- **Create processes to coordinate services.** Oregon uses a fee-for-service approach to LTSS, but a managed care approach for the medical services received by Medicaid only and dual eligible beneficiaries who are 65 and older and have disabilities. One health plan in the state is testing strategies for better coordinating across those sets of services (see CareOregon sidebar). The state's case managers are also working with Medicare-only beneficiaries who are in inpatient hospital settings. They are using a care transition model with the idea that helping people smoothly discharge back to home will prevent them from becoming Medicaid beneficiaries as future nursing home residents.

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[7] G. Engquist, C. Johnson, and W. Courtland Johnson. *Medicaid-Funded Long-Term Supports and Services: Snapshots of Innovation.* Center for Health Care Strategies. May 2010.

CareOregon: An Innovative Approach to Integrating Care for Dual Eligibles

CareOregon serves as a capitated Medicaid managed care plan for thousands of dual eligibles. Several years ago, CareOregon established a Medicare SNP to better serve this population. One of the biggest challenges it faced in taking on more responsibility for dual eligibles was the continued payment and operational carve-out of LTSS. To address this challenge, CareOregon instituted the following actions:

- Providing case manager training on services and eligibility;
- Offering training at Adult and Disability Services (ADS) offices on CareOregon's case management role;
- Creating a telephone tree, organized by ZIP code and case manager's supervisor;
- Updating eligibility software so case managers can view services that are provided;
- Providing the LTSS nurse care manager's name to CareOregon's care manager when duals are enrolled to facilitate co-case management;
- Alerting the LTSS case manager to potential safety issues; and
- Requesting a screen for LTSS when new services are indicated.

During the summer of 2010, ADS staff began work on a second pilot with CareOregon's medical director to establish information sharing. This process expedites authorization for needed services for their shared population. Previously, a person with skin breakdown might have been denied a cost-effective alternating pressure mattress because he or she did not meet the criteria for approval. This individual, however, could have been approved for the much costlier alternative: to have a home health aide manually turn him or her every four hours. By identifying such cases, the pilot will help facilitate more appropriate care. ADS and CareOregon are also working together to identify the best way to care for frequent emergency department users and providing appropriate services to keep them out of institutional care.

In addition, ADS is working with CareOregon to do a "warm hand-off" from its hospital Transition Team to the CareOregon care manager. ADS wants to ensure that community placements are appropriate, and has asked CareOregon to send it lists of hospitalized patients. To date, however, this is only occurring on a case-by-case basis, in part because CareOregon does not have a formal contractual relationship with ADS. Alternatively, CareOregon is improving its concurrent review program, for stronger collaboration with hospitals to better facilitate the warm hand-off from the hospital discharge planners to the CareOregon nurse care manager.

Conclusion: Looking Ahead to New Options under Health Reform

Since On Lok broke ground toward achieving Medicare-Medicaid integration three decades ago, states have been challenged to provide more integrated and effective care for dual eligibles. Today, there are promising new directions for states for achieving meaningfully integration of care for this population. In early 2010, a CHCS policy brief outlined four core options for integrating care: (1) Medicare Advantage SNPs; (2) expanding the scope of PACE programs without undermining essential elements of the model; (3) shared savings models; and (4) the state serving as the integrated care entity.[8] The four options outlined therein still stand, although the other features of ACA – most notably the reduction in MA payment rates – may "deteriorate the SNP market" in the words of one state official. There is growing policy interest among some federal and state officials in Option Four: the state as integrating entity. However, many political and regulatory barriers remain and, as others have observed, "it does not yet exist in nature."

There are compelling reasons for this shift. The most obvious is that SNPs could be an endangered species as the federal government implements provisions of the ACA to ratchet down the capitation rates paid to Medicare Advantage Plans. In addition, if SNPs are no longer able to provide extra benefits like vision, dental, and well care, these plans may not be as attractive to individuals. Ideally SNPs need to be more successful in demonstrating that they add more value to beneficiaries through care coordination and greater flexibility of services associated with having both Medicare and Medicaid funds at their disposal. Simultaneously, states are beginning to see that they can potentially manage not only LTSS, but also acute care for a 65-year-old Medicare beneficiary whose care they likely were managing at age 62 or 64 prior to Medicare eligibility. This is particularly true for states with sophisticated contracting and care management capabilities for complex populations. Further, the states can see the potential for keeping the financial savings from better care management that would otherwise be kept by multiple contractors or by Medicare. Again, it will take more evidence of state care management capacity and considerable "out of the box thinking" at CMS for these kinds of models to develop.

As demonstrated by initial lessons from the state innovators profiled in this roadmap, focusing on existing state strengths is the place to start in considering the best approach for integrating care for dually eligible beneficiaries. Moving forward post-ACA, states should expect valuable guidance from CMS' Office of the Duals. With increased momentum at the federal level, there are significant new opportunities for states, after all these years, to finally find meaningful solutions to integrate care for the duals.

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[8] M.Bella and L.P. Barnette. *Options for Integrating Care for Dual Eligible Beneficiaries*. Center for Health Care Strategies, March 2010.

Appendix A: List of State and Plan Interviewees

Arizona

Arizona Health Care Cost Containment System (AHCCCS) Staff:
Kate Aurelius, Deputy Director
Kim Elliot, Administrator, Clinical Quality Management
Alan Schafer, ALTCS Manager

Bridgeway Health Solutions Staff:
Duane Angulo, Director of Pharmacy
Richard L. Fredrickson, Chief Executive Officer
Robert Krauss, MD, Medical Director
Nicole Larson, Vice President of Operations and Compliance
Mary Reiss, Director of ALTCS Case Management

Mercy Care Plan Staff:
Kathy Eskra, Vice President of Long Term Care for Aetna Medicaid
Chad Corbett, Director Long Term Care
Mark Fisher, President and Chief Executive Officer

Yavapai County Long Term Care Staff:
Leona Brown, Compliance/Program Development Manager
Jesse Eller, Director

Hawaii

Hawaii Department of Human Services Med-Quest Division:
Patti Bazin, Health Care Services Branch Administrator

Evercare Hawaii:
Dave Heywood, Executive Director
Bill Guptail, Chief Operating Officer
Jeri Kakuno, Director of Operations, MDX Hawaii
Mary Campos, Director, Field Clinical Services
Debbie Hughes, Director of Operations
Cheryl Ellis, MD, Medical Director

Ohana Health Plan
Erhardt Preitauer, President, Hawaii Region
Linda Morrison, Senior Director, Operations and IT
Wendy Morriarty, Senior Director, Field Clinical Programs
Jayme Pu'u, Senior Manager, Network Management
James Tan, MD, Senior Medical Director

New Mexico

New Mexico Division of Medical Assistance
Carolyn Ingram, Former Medicaid Director

Oregon

James Toews, Assistant Director, Seniors and People with Disabilities, Department of Human Services
DeAnna Hartwig, Administrator, Federal Resource & Financial Eligibility, Seniors and People with Disabilities
Angela Munkers, Interim Field Services Manager, Seniors and People with Disabilities
Judy Mohr-Peterson, Assistant Director, DHS Medical Assistance Programs

CareOregon
Rebecca S. Ramsay, Senior Manager of CareSupport and Clinical Programs

Tennessee

TennCare Bureau of Long Term Care Staff:
Carolyn Fulghum, Director of Quality and Administration for Elderly and Disabled Services
Keith Gaither, Managed Care Director
Jarrett Hallcox, Director of Long Term Care Project Management
Patti Killingsworth, Assistant Commissioner and Chief of Long Term Care
Julie Johnson, LTC Appeals Manager
Casey Dungan, Assistant Director, Fiscal/Budget

Texas

Texas Health and Human Services Commission Staff:

Pam Coleman, Former Deputy Director for Managed Care Operations (has since retired from state)

Joe Vesowate, Deputy Director for Managed Care Operations

David "DJ" Johnson, STAR+PLUS Project Specialist

Ivan Libson, Implementation Coordinator Managed Care operations

Scott Schalchlin, Director for Health Plan Operations

Rich Stebbins, Manager of Finance

Paula Swenson, Director of Health Plan Management

Marc Gold, Special Advisor for Policy and Promoting Independence, Texas Department of Aging and Disability Services

Evercare of Texas:

Leah Rummel, Vice President, Strategic Account Development

Catherine Anderson, Vice President, Business Development

Beth Mandell, Regional Executive Director

Superior Health Plan:

Cindy Adams, Chief Operating Officer

Ceseley Rollins, Vice President, SSI

Amerigroup

Cathy Rossberg, Chief Operating Officer

Wisconsin

Wisconsin Department of Health and Family Services Division of Long Term Care Staff:

Fredi-Ellen Bove, Deputy Administrator

Susan Crowley, Administrator

Monica Deignan, Managed Care Section Chief

Charles Jones, Family Care Program Manager

Tom Lawless, Fiscal Management and Business Systems Section Chief

Kathleen Luedtke, Planning and Analysis Administrator

Karen McKim, Quality and Research Manager

Alice Mirk, Care Management Services Manager

Portage Aging and Disability Resource Center:

Janet Zander, Director

Cindy Pitrowski, Assistant Director

Community Care of Central Wisconsin Staff:

Darren Bienvenue, Director of Service Coordination

Jim Canales, Chief Executive Officer

Dana Cyra, Director of Quality Management

Rick Foss, Director of Service Coordination

Mark Hilliker, Chief Operations Officer

Julie Strenn, Director of Provider Network Services

Appendix B: National Advisory Group Members & CMS Participants (in addition to state interviewees)

Joseph Caldwell
Director, Long-Term Services and Supports
Policy, National Council on Aging

Mike Cheek
National Association of State United for Aging
and Disabilities

Sara Galantowicz
Senior Research Leader, Thomson Reuters
Research Department, Community Living
Systems Group

Cyndy Johnson
Independent Consultant

Diane Justice
Senior Program Director, National Academy for
State Health Policy

Enid Kassner
Director, Independent Living/LTC
AARP Public Policy Institute

Harriet L. Komisar
Senior Research Analyst
University of Maryland, Baltimore County
The Hilltop Institute

Barbara Lyons
Vice President, Deputy Director KCMU
Kaiser Family Foundation

Anne H. Montgomery
Senior Policy Advisor, Senate Special Committee
on Aging

Martha Roherty
Executive Director, National Association of State
United for Aging & Disabilities

James M. Verdier
Senior Fellow, Mathematica Policy Research, Inc.

Centers for Medicare & Medicaid Services

Linda Peltz
Director, Division of Coverage and Integration

Carrie Smith
Technical Director, Division of Coverage and Integration

Mary Sowers
Director, Division of Community and Institutional Services
Center for Medicaid, CHIP & Survey Certification
Disabled and Elderly Health Programs Group

CHCS Online Resources

This roadmap is part of CHCS' *Profiles of State Innovation* series, made possible through The SCAN Foundation to help Medicaid programs develop high-quality, cost-effective, and consumer-focused approaches for delivering long-term supports and services. In addition, through support from The Commonwealth Fund, CHCS has developed an extensive toolkit to help states develop integrated approaches for duals.

Following are additional documents in the series as well as further resources available at www.chcs.org.

- *Profiles of State Innovation: Roadmap for Rebalancing Long-Term Supports and Services* – Outlines key mileposts to help states achieve an equitable balance between institutional and home-and community-based care.

- *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services* – Outlines key mileposts to help states better manage the full array of long-term supports and services.

- *Integrating Care for Dual Eligibles: An Online Toolkit –* This online toolkit contains a wealth of policy-related materials, hands-on tools, and templates to help guide state efforts for designing and implementing integrated programs for duals.

www.chcs.org