

Integrating Care for Medicare-Medicaid Enrollees Using a Managed Fee-for-Service Model

In July 2011, the Centers for Medicare & Medicaid Services (CMS) announced two financial alignment models that states can use to integrate care for beneficiaries who are dually eligible for Medicare and Medicaid (also known as Medicare-Medicaid enrollees). The managed fee-for-service (FFS) model and the capitated financial alignment model are designed to help states improve the quality of care for Medicare-Medicaid enrollees. These models offer states the opportunity to share in Medicare savings that can result from better integration of care for Medicare-Medicaid enrollees. Accordingly, states that pursue these models will want to focus on care for Medicare-Medicaid enrollees with complex needs and resulting high costs who are often not well served in the existing FFS system. Such targeting has the most potential to improve care and generate savings by reducing unnecessary Medicare-funded hospital, emergency room, and skilled nursing facility use, particularly for those with behavioral health needs.

Managed FFS generally refers to contracting arrangements between states and other entities that outline rules for service delivery and provider networks, but that fall short of fully-capitated managed care. More recently, the term has come to mean adding new strategies onto the FFS delivery system to: improve care management, quality, and access; increase accountability; and contain costs. The managed FFS financial alignment model may be of interest to states that already have an established non-capitated infrastructure. It is also a viable option for states in which capitated managed care organizations are not available, interested in, or capable of meeting state needs, or when opposition to capitated managed care makes alternative approaches more feasible.

At this time, there are few examples of managed FFS models that focus on Medicare-Medicaid enrollees. However, experience in Medicaid and Medicare with primary care case management (PCCM), health homes, administrative service organizations (ASOs), and related FFS-based care management models provides insight into the key program design elements needed to improve outcomes and produce a measurable impact on expenditures.¹ This brief from the *Integrated Care Resource Center (ICRC)* examines PCCM and other managed FFS models to identify the elements needed

IN BRIEF: Integrating care for Medicare-Medicaid enrollees through managed fee-for-service (FFS) models offers a new opportunity for states to improve service delivery and benefit from savings that can result from improved quality and more effective service use in both Medicare and Medicaid. This brief from the *Integrated Care Resource Center (ICRC)* reviews primary care case management and related FFS models to gather insights into key program design elements needed to manage care for high-need, high-cost beneficiaries with multiple conditions.

Well-designed managed FFS programs will have a clear vision of integration implemented through an accountable entity capable of bringing together the fragmented pieces of the FFS system, and making significant upfront investments in management, staff, and information systems. Other key program design elements include: (1) identification of high-need, high-cost beneficiaries; (2) use of a multidisciplinary care team; (3) comprehensive assessment of beneficiaries; (4) development of a person-centered care plan; (5) implementation of comprehensive care management interventions; (6) real-time information exchange; and (7) financial alignment.

for a successful managed FFS program for Medicare-Medicaid enrollees.*

Clear Vision for Integration

The overall vision for the managed FFS financial alignment model should be one of full integration of Medicare-covered services, Medicaid-covered long-term services and supports (LTSS) and behavioral health, and all other Medicaid-covered services. While the tools available to accomplish this kind of full integration in the managed FFS model are more limited than in the capitated model, the program design elements outlined in this brief can help states move toward this goal through greater coordination of the full range of Medicare and Medicaid services.

* This document was prepared by the Integrated Care Resource Center (ICRC) to assist states in improving outcomes and cost effectiveness for high-need, high-cost beneficiaries, including Medicare-Medicaid enrollees. It does not represent the official opinion of CMS regarding provisions of the managed fee-for-service model nor indicate CMS criteria for approval of this model. For official guidance from CMS on this model, please visit <https://www.cms.gov/medicare-medicaid-coordination>.

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Accountable Entity

An accountable entity or entities should be responsible for bringing the fragmented pieces of the FFS system together to meet the complex needs of Medicare-Medicaid enrollees in an integrated and coordinated way. This includes responsibility for care management, administrative oversight, and performance measurement and reporting. In most PCCM programs, the state is the accountable entity, although states operating enhanced PCCM programs often contract with an outside vendor that helps the state perform many of these functions.

In many states, responsibility for acute care is separate from LTSS and behavioral health, and, in fact, LTSS and behavioral health services may be managed by different agencies of state and local government. Centralizing accountability in these circumstances can present organizational and political challenges, but doing it in the context of a demonstration and for a narrowly defined population like Medicare-Medicaid enrollees may make it more feasible.

If a state chooses to contract with an outside entity to operate the managed FFS program, it should set clear, time-specific goals for these entities to take on the full range of responsibility for primary and acute care, behavioral health, and LTSS.

If a state chooses to operate the managed FFS program in-house with state staff, and to pay for all services under separate FFS arrangements, it retains the accountability for integrating care for beneficiaries. In both cases, the programs should include the key design elements described in this brief.

Identification of High-Need, High-Cost Beneficiaries

Predictive modeling, in combination with health risk assessment, referrals, and ongoing monitoring of care needs, should be used to identify those at highest risk – both those who could benefit from care management and those at high risk of institutional care. Intensive care

management programs should be targeted to the highest-risk beneficiaries.

Both Oklahoma and Indiana have implemented care management programs that use predictive modeling to identify at-risk Medicaid beneficiaries.

Oklahoma implemented the Health Management Program in 2008, using a commercial predictive modeling process, the *MEDai Risk Navigator Clinical tool*,² to identify potential enrollees most likely to benefit from the program. The enrollees were divided into two tiers for care management purposes: approximately 1,000 enrollees in the top tier received active care management from nurse care managers in Oklahoma, while the remaining 4,000 enrollees received mainly telephonic support from the Iowa Foundation for Medical Care.³

Indiana implemented the Care Select program in 2008 to provide enhanced care management and coordination services for older adult beneficiaries and those with disabilities. The state used two care management organizations (CMOs) to provide predictive modeling to identify beneficiaries in need of enhanced care management. Schaller Anderson/Aetna, one of the contracted CMOs, used a claims-based predictive modeling tool (Pathways to Predictive Modeling, or PPM) to identify enrollees at risk of high-cost service use who may benefit from care management. This tool included information from: (1) claims analysis; (2) a health-risk questionnaire completed by beneficiaries; (3) informal reports from when beneficiaries, families, practitioners, community case managers, and others asked for assistance; and (4) environmental and psycho-social risk factors (housing instability, social isolation, cognitive impairment). The predicted risk of high-cost service use was combined with an assessment of the extent to which care management could have an impact on that risk.

Schaller Anderson/Aetna eventually integrated behavioral health conditions into the PPM tool and found that these conditions are critically important in

predicting overall utilization risk as well as risk of emergency room visits and inpatient readmissions. The psychosocial risk factors were also found to have a significant influence on the identification of members' care needs and the skills and resources needed by care managers.⁴ Based on the results of the PPM tool, Schaller Anderson/Aetna stratified beneficiaries into groups and tailored interventions accordingly.

Multidisciplinary Care Team

Staffing should reflect the diverse medical, physical, behavioral, and social care needs of Medicare-Medicaid enrollees, relying on registered nurses, with assistance from behavioral health specialists, social workers, and/or peer supports as appropriate. Following are guidelines for care teams:

- Staffing of care teams may vary with different subpopulations of Medicare-Medicaid enrollees. For example, people with serious mental illness may have a primary care manager relationship with their mental health case worker, while beneficiaries with multiple chronic conditions might have a nurse as their care manager;
- Care managers and physicians need to have frequent interactions; and
- The “go-to person” acting as the main care manager needs to be well connected to other case or care managers in the system.

Comprehensive Assessment

Beneficiaries identified at high risk for hospitalization, emergency department use, or nursing facility placement should be given a comprehensive assessment and offered the opportunity to participate in developing a plan of care with person-centered goals and actions. These beneficiaries should be assessed along the following dimensions:

- Ability to self-manage chronic medical conditions, including pain;
- Need for assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs);
- Need for supports to address cognitive and mobility issues;
- Current medication regimen so that beneficiaries have a single comprehensive list of all medications that is reconciled after every institutional admission;
- Need and qualification for LTSS;
- Need for mental health and chemical dependency services;
- Informal support network, including caregivers' need for training;
- Individual goals and preferences; and
- Ability to meet basic needs, such as housing and food.

Identified beneficiaries should be given a comprehensive assessment and offered the opportunity to participate in developing a plan of care with person-centered goals and actions.

Person-Centered Care Plan

All beneficiaries receiving a comprehensive assessment should have a care plan that is updated regularly and accessible by critical providers identified by the beneficiary, regardless of whether Medicare or Medicaid is the provider's primary payer. The care plan should:

- Document clearly-defined goals developed with the participation of the beneficiary;
- Include both the needs and strengths of the beneficiary, with referral and linkage to meet those needs;
- Contain interventions that are evidence-based to the extent possible; and
- Identify a single “go-to” person for every beneficiary.

While a comprehensive, real-time data and information exchange system is the ideal for coordinating care for Medicare-Medicaid enrollees, states may find ways to implement interim measures that begin to address a managed FFS program's real-time information needs until a more extensive system can be implemented.

Comprehensive Care Management Interventions

Care management is integral to the success of managed FFS models. As care management has evolved, research has demonstrated that in order to improve quality of care and reduce costs, programs should focus on beneficiaries with multiple comorbid conditions rather than on those with a single diagnosis.⁵ More promising care management approaches have become broader in focus, managing all of an individual's needs across a spectrum of health and social service settings – ambulatory and acute care as well as post-acute care and in-home services and supports.⁶ By improving physician-beneficiary communication, increasing beneficiaries' adherence to recommended medications and self-care regimens, facilitating greater communication between care providers, and encouraging the use of clinical practice guidelines, care management has been shown to improve outcomes for certain people with chronic conditions.^{7,8}

Ideally, appropriate interventions are initiated during the process of care planning, and should include:

- In-person contact between care managers and beneficiaries, as well as by telephone;
- Frequent contacts with beneficiaries, dictated by the need for follow-up and intervention;
- Health education and social services, including education on self-management of care (especially medications) and social supports when needed;
- Follow-up during and after hospitalization; and
- Transitions coordinated as the beneficiary moves from one delivery system or care setting to the next.

Real-Time Information Exchange

The managed FFS program should create, or contract for, a data and information exchange system that accesses and combines Medicare and Medicaid claims and encounter data, assessment data, and eligibility information. Such a system does not yet exist at the state level and will be difficult for most states to develop and implement in the short term. As a stop gap, states may develop interim strategies that begin to address the program's real-time information needs until a more extensive system can be implemented. The communication and data-sharing system needs to encompass critical providers and payment for primary, acute, behavioral health, and LTSS. The information system should include:

- Real-time information on inpatient hospital admissions and discharges and emergency room utilization, so crucial transitions between hospitals and other care settings can be handled appropriately and unnecessary use of these expensive services can be minimized.
- Medicare Part A, Part B and Part D service utilization data, so care managers have hospital, provider, and pharmacy use information.
- Medicaid LTSS assessment and reassessment data to ensure that the individual's person-centered plan of care meets the individual's needs as they evolve.
- Medicaid LTSS utilization data to ensure that needs for those services are being met and that consumer-directed models of care are functioning appropriately.
- Medicaid behavioral health data to identify behavioral health needs and ensure that they are addressed in the plan of care.
- Medicaid eligibility information to help monitor continuation of an individual's Medicaid eligibility. This is important for monitoring changes in level of care needs and

transitions between various settings (e.g., from institutional to home- and community-based services). Even if the eligibility information is provided via a monthly run from the organization that handles Medicaid eligibility, care managers could help ensure that services match an individual's level of care status and that eligibility is not lost due to administrative omissions (such as an individual moving and not updating his or her address with social services).

Financial Alignment

Through the CMS-created managed FFS financial alignment model, states have a new opportunity to align financing for Medicare-Medicaid enrollees, even in the absence of a capitated managed care infrastructure. This opportunity rests on the state's ability to deliver or contract for the following activities, in cooperation with CMS:

- Provide Medicare and Medicaid financial oversight and ensure that incentives are coordinated and cost savings shared;
- Review Medicare and Medicaid service utilization and expenditure information when determining state provider reimbursement or financial incentive structures;
- Establish system capacity to track and review Medicare and Medicaid cost data and cost drivers;
- Ensure that payment methods are an incentive to providers to move or maintain beneficiaries in home- and community-based settings whenever possible; and
- Design a system that supports greater alignment of incentives across primary, acute, LTSS, and behavioral health systems for all payers.

Potential Barriers to Implementing Managed FFS

For managed FFS programs to succeed, they must not only incorporate the key elements described above, but also address several barriers:

- There are no completely replicable models that have focused on Medicare-Medicaid enrollees for states to follow. Time and resources will have to be expended to create managed FFS programs that reflect a state's unique environment.
- If there is no single accountable entity that is responsible for coordinating care for Medicare-Medicaid enrollees, states may have to develop work-around solutions to obtain information on care provided outside of the accountable care system.
- While obtaining real-time information on hospital admissions and discharges and emergency room use is crucial to maximizing the success of managed FFS programs for Medicare-Medicaid enrollees, states have very little leverage over hospital behavior in these programs, since Medicare-Medicaid enrollees' hospital care is paid for primarily by Medicare. Hospitals generally do not benefit financially from reducing avoidable hospital and emergency room visits, since these services are major revenue sources for hospitals, so hospitals have little financial incentive to cooperate with states in these situations.

States have a new opportunity to align finances for Medicare-Medicaid enrollees, even in the absence of a capitated managed care infrastructure.

Many Medicare-Medicaid enrollees have extensive behavioral health needs, and integrating these services in a managed FFS program is imperative.

Some states have been successful in obtaining real-time information on hospital service use when Medicaid is the primary payer for hospital services. While it is more difficult for states when

Medicare is the primary payer, it may be possible for states to use their leverage as a Medicaid payer to obtain hospital admission and discharge information on Medicare-Medicaid enrollees, especially from hospitals that are heavily reliant on Medicaid payments.

Case Studies in Implementing Managed FFS

Several states have been successful in enhancing their Medicaid PCCM programs to serve as a single coordinating entity for beneficiaries, at least for primary and acute care services. Notable examples of enhanced PCCM programs include those in North Carolina, Oklahoma, and Pennsylvania.⁹

States developing managed FFS programs can learn valuable lessons from states that have implemented additional components of what will be needed in a fully-integrated managed FFS program. Many

Medicare-Medicaid enrollees have extensive behavioral health needs, and integrating these services in a managed FFS program is imperative. New York's Chronic Illness Demonstration Project (CIDP) provides an example of how a state can structure a care management system for FFS beneficiaries. Washington, through its Chronic Care Management (CCM) program, offers an example of how states with a managed FFS program can use nurse care management services and technology to save costs and lower mortality rates for beneficiaries with multiple chronic health and/or behavioral conditions and/or complex long-term care needs.

Though these two programs outlined on the following pages address Medicaid-only enrollees, they offer several lessons for management of complex populations.

Both New York's CIDP and Washington's CCM programs target high-need, high-cost individuals who are similar in many ways to Medicare-Medicaid enrollees. Both approaches also incorporate intensive strategies for cost savings and avoidance of inappropriate utilization of services.

NEW YORK: CHRONIC ILLNESS DEMONSTRATION PROJECTS

Description

In 2008, New York developed the Chronic Illness Demonstration Project (CIDP) to improve health outcomes and reduce costs for beneficiaries with complex needs. Beneficiaries targeted for these demonstrations have varying combinations of multiple chronic medical conditions, mental illness, and chemical dependency, and typically require services from multiple providers. CIDP is a three-year pilot project that includes New York City and three other areas and enrolls FFS Medicaid beneficiaries only. Each CIDP is required to have relationships with an integrated network of providers to ensure facilitated access to medical, mental health and substance abuse services for participants and collaboration with community-based social service providers.

Each enrollee receives an assessment through the CIDP program and an individualized care plan is developed. Each CIDP contractor must provide participants with comprehensive care management through a multidisciplinary team (nurses, social workers, behavioral health specialists) and work toward improving beneficiary self-management and caregiver/family involvement. Care plans must also address social service needs that impede enrollees from managing their chronic conditions.

Provider payments include start up, enrollment costs, and a monthly care coordination fee (MCCF) for each enrollee for year one. Providers receive only a MCCF for each enrollee for contract years two and three. The CIDP contractors are at risk for a portion of their MCCF payments in contract years two and three and are also able to participate in a shared savings incentive pool of \$6 million if a reduction in Medicaid expenditures is achieved. The CIDPs are being closely evaluated to assess the impact of the interventions on participants' patterns of care, costs and health outcomes. The CIDP experience to date has been critical in informing the state's emerging model of health home services.

Outcomes

Outcomes data from the CIDP evaluation are expected in 2012. Experience to date has highlighted the challenges of reaching and engaging populations with a complex mix of physical, behavioral and psycho-social needs. The CIDP programs report that, in the majority of cases, initial assessments reveal numerous social and urgent care needs requiring immediate attention. It is only after these needs are addressed and a trusting relationship is developed between the care manager and enrollee, that care management, education and work can begin to foster patient self-management of this population's chronic condition(s). Overall program enrollment is approximately 70 percent of the possible maximum enrollment of 2,250 enrollees – indicating the challenges associated with location and engagement. Following enrollment, however, retention has been strong, and the state has been pleased by initial indicators around emergency department diversion, the level of assistance with housing and transportation, and the establishment of medical homes.¹⁰

Lessons Learned

- Intense outreach is needed to achieve and maintain active enrollment for an opt-in program. Voluntary opt-out enrollment strategies may be more successful in achieving scale.
- The complexity of the target population's needs and functional status should not be underestimated.
- A system of strong community supports, especially related to housing and peer services, specialty services, and access to timely post-discharge services is imperative to optimally manage care for this population.
- Payment models should address the need for resources to support initial outreach and engagement.
- Beneficiaries should be assigned to a provider based, to the extent possible, on existing relationships with health care providers or health care system relationships, geography, and/or qualifying condition.

Key Program Design Elements Incorporated

- Accountable entity
- Comprehensive assessment
- Identification of high-need, high-cost beneficiaries
- Multidisciplinary care team
- Person-centered care plan
- Comprehensive care management interventions

WASHINGTON: CHRONIC CARE MANAGEMENT PROGRAM

Description

Washington's Chronic Care Management (CCM) program provides enhanced nurse care management services to beneficiaries with multiple chronic health and/or behavioral conditions and/or complex long-term care needs. The goal of the program is to improve health outcomes and control costs of enrollees. There are five pilot sites in the state serving a relatively small number of clients. The pilots employ nurse-led interventions based on evidence-based chronic disease self-management practices. Care management is supported by a central web-based predictive risk intelligence system (PRISM) that provides care managers with client risk and service histories.¹¹ Enrollees are Medicaid-only, SSI-eligible beneficiaries who qualify for home- and community-based services (HCBS) and have risks related to HCBS status (live alone or possess other risks identified in assessment). The pilots did not integrate medical and behavioral health.

Outcomes

An evaluation of the CCM program by the Washington Department of Social and Health Services found cost savings and lower mortality rates for beneficiaries enrolled in CCM versus beneficiaries on the CCM waiting list over a 22-month follow-up period. Enrollees had lower medical costs, saving the state an estimated \$253 per month per enrollee, primarily as a result of reduced emergency room use associated with a hospital admission. Long-term care spending was higher for people enrolled in the CCM program by \$46 per month, but beneficiaries enrolled in the CCM program had an overall net savings of \$27 per member per month. The mortality rate for people enrolled in CCM was lower than that for people on the waiting list for the 22-month period.¹²

Lessons Learned

- Integrated information technology supported integrated care management by providing predictive modeling that enabled care managers to identify complex, multi-system clients and client risk and service histories.
- Experienced nurses were crucial because they possessed the clinical expertise needed for managing a population with multiple chronic health and/or behavioral conditions and/or complex long-term care needs.
- The CCM program used high-cost interventions with low nurse-to-beneficiary ratios, but it achieved savings overall and lower mortality rates for enrollees.

Key Program Design Elements Incorporated¹³

- Accountable entity
- Comprehensive assessment
- Identification of high-need, high-cost beneficiaries
- Multidisciplinary care team
- Person-centered care plan
- Comprehensive care management interventions

Conclusion

The managed FFS financial alignment model offers an opportunity for states to improve service delivery and reduce costs for Medicare-Medicaid enrollees by providing better coordination of the fragmented FFS care these beneficiaries currently receive. States seeking to implement this new model will be blazing new paths, since completely replicable programs do not currently exist. Lessons from existing enhanced PCCM programs, and intensive care management models like those in Washington and New York, can help guide states toward

fully integrated care for Medicare-Medicaid enrollees through use of managed FFS model.

Developing a managed FFS program will require significant program and infrastructure planning and upfront investments from already cash-strapped states in order to achieve Medicare and Medicaid savings in subsequent years. Though there are challenges, this new financial model gives states an additional option to make a difference in the lives of Medicare-Medicaid enrollees.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The *Integrated Care Resource Center* is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicaid's high-need, high-cost beneficiaries. The state technical assistance activities provided within the *Integrated Care Resource Center* are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

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Endnotes

¹ For a review of critical program design elements from the consumer perspective, see: S. Gore and A. Lind. *From the Beneficiary Perspective: Core Elements to Guide Integrated Care for Dual Eligibles*. Center for Health Care Strategies. December 2010. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261212.

² For more information about the MEDai Risk Navigator Clinical tool please visit <http://www.medai.com/products/risk-navigator-solutions/risk-navigator-clinical/>.

³ J. Verdier, V. Byrd, and C. Stone. *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*. Center for Health Care Strategies. September 2009. Available at: http://www.chcs.org/usr_doc/EPCCM_Full_Report.pdf.

⁴ Verdier, op.cit.

⁵ M. Charlson, R. Charlson, W. Briggs, and J. Hollenberg. "Can Disease Management Target Patients Most Likely to Generate High Costs? The Impact of Comorbidity." *The Journal of General Internal Medicine*, vol.22 no.4 (2007): 464–469.

⁶ R. Brown. "The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses." A report commissioned by The National Coalition on Care Coordination, March 2009. Available at http://socialwork.nyam.org/nsw/care/Brown_Executive_Summary.pdf.

⁷ D. Peikes, A. Chen, and J. Schore. "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials." *Journal of the American Medical Association*. 301 no.6 (2009): 603-618. Available at <http://jama.ama-assn.org/content/301/6/603.full>.

⁸ C. Boulton, A. Green, L. Boulton, J. Pacala, C. Snyder, and B. Leff. "Successful Models of Comprehensive Care for Older Adults with Chronic Conditions: Evidence for the Institute of Medicine's "Retooling for an Aging America" Report. 2009." *Journal of the American Geriatrics Society*, 57 no.12 (2009): 2328-2337. Available at <http://www.ncbi.nlm.nih.gov/pubmed/20121991>.

⁹ Verdier, op.cit.

¹⁰ Summarized from "Chronic Illness Demonstration Projects Overview" provided by the New York Department of Health. For additional information on the Chronic Illness Demonstration Projects see <http://www.health.ny.gov/funding/rfp/inactive/0801031003/>.

¹¹ Washington State Department of Social and Health Services, Research and Data Analysis Division. "Saving Costs and Transforming Lives through Integrated Case Management in Washington State Human Services," March 2011, RDA Report Number 11.162.

¹² Washington State Department of Social and Health Services, Research and Data Analysis Division "Chronic Care Management Pilots Show Early Promise, Controlling Medicaid Costs and Improving Health Outcomes. November 2009, Number 8.28.

¹³ Washington's PRISM system did not provide real-time alerts to care managers regarding inpatient hospital admissions, discharges, or emergency room visits, but other integrated clinical data was available.