CHCS Center for Health Care Strategies, Inc.

Policy Brief

Medicaid Best Buys: Critical Strategies to Focus on High-Need, High-Cost Beneficiaries

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Roughly five percent of Medicaid beneficiaries account for nearly 60 percent of total program spending. Improving the quality of care for the program's most complex and costly patients is among the few viable options to curb rising costs over the long-term.

With the passage of health reform, Medicaid is poised to become the nation's largest insurer — for as much as 25% of the population. But even before the addition of a potential 15-20 million people to Medicaid rolls, the recession and resulting unemployment are testing the limits of the nation's publicly financed health coverage programs. For the first time in the past decade, Medicaid enrollment rose in every state last year. Enrollment growth averaged 7.5 percent nationally in FY2009, with rates of 10 percent or higher in 13 states and Maryland experiencing the steepest climb of more than 20 percent. On a parallel track, Medicaid spending rose by nearly eight percent — the highest increase in six years.[1]

In response, almost every state is undertaking, or considering, substantial cuts to Medicaid programs, such as decreasing provider rates and paring medical benefits, ranging from vision and dental coverage to adult day health services. But as Medicaid directors recognize, these types of cuts tend to offer fleeting relief at best. Such cuts can reduce access to necessary care, often resulting in more expensive emergency room visits, hospital stays, and/or nursing home placements down the road.

Focusing instead on redesigning how care is delivered and financed for Medicaid's highest-need patients may offer the most significant means to both improve health care quality and rein in costs over the long term. Roughly five percent of Medicaid beneficiaries account for close to 60 percent of total program expenditures.[2] Annual outlays for this high-cost subset are estimated at roughly $190 billion.[3] Reducing even a fraction of spending for this high-cost population by improving care can provide meaningful savings for states.

Three promising strategies that states can consider to improve care for their most expensive patient subsets include:

(1) Enhancing fee-for-service through primary care case management programs;

(2) Integrating physical and behavioral health services; and

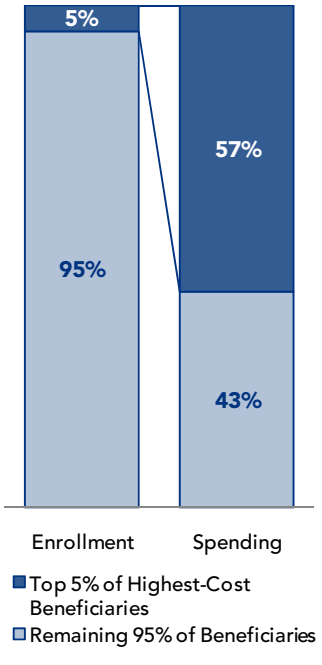
(3) Integrating care for adults who are dually eligible for Medicare and Medicaid.

This brief outlines these opportunities and begins with a look at the ideal program elements necessary for enhancing care for high-need, high-cost beneficiaries.

Rethinking Care for Medicaid's Highest-Need Populations

Over the last decade the number of Medicaid beneficiaries in managed systems of care has risen dramatically, from roughly 56 percent of the population in 1999 to over 70 percent in the last few years.[4] Managed care offers

5% of Medicaid Beneficiaries Account for More than Half of Spending



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on MSIS 2004.

states a mechanism to improve access and coordination of care, monitor quality, reward improvements in care, and control spending. Yet, because the majority of those currently enrolled in managed care are relatively healthy, managed care spending represents only 20 percent of total Medicaid spending. Meanwhile, the bulk of beneficiaries with the most challenging health care needs are in the fragmented and uncoordinated fee-for-service delivery system.

States are developing a variety of new programs to better manage the needs of their highest-risk beneficiaries. Whether the payment arrangement is more traditional capitated full-risk managed care, partial capitation, or enhanced fee-for-service, these programs typically incorporate a core set of critical elements designed to integrate care and comprehensively address beneficiaries' complex needs (Fig. 1).

The state programs described herein can help ensure that patients are receiving the right care in the right setting at the right time.

Enhancing Primary Care Case Management

Through traditional primary care case management (PCCM) programs, the state contracts with providers to deliver basic primary, and orchestrate access to specialty, care. More recently a number of states have enhanced their PCCM fee-for-service models to provide more intensive care management for patients with complex needs.

Enhanced models (often referred to as EPCCM) offer a variety of added features including tailored care management, additional provider payments or targeted provider incentives, access to health information technology, and increased use of performance measures. A recent report examining state EPCCM models found that well-designed programs may equal, or in some cases even exceed, full-risk health plan programs in terms of access, cost, and quality of care.[5]

Oklahoma, for example, has invested considerable resources in enhancing its SoonerCare Choice PCCM program to provide cost-effective care coordination for Medicaid beneficiaries. A recent evaluation found that this program increased the number of annual primary care visits and reduced emergency room (ER) utilization. During the first three years of the program, the overall rate of preventable hospital and ER utilization among adults declined.[6] Oklahoma evolved their program further in 2009 by transitioning to a patient-centered medical home model in response to provider feedback.

Within its SoonerCare Choice program, Oklahoma coordinates specialized initiatives targeting particularly high-need populations. The SoonerCare Health Management Program, for example, uses a tiered approach for the state's highest-need adult beneficiaries. The state stratifies patients who are at highest risk for poor outcomes and increased costs into two levels of care, providing face-to-face care management for the higher-risk group and less intensive call center-based care management for the second tier. The program targets 5,000 beneficiaries, focusing on 1,000 in the top tier and 4,000 in the second tier.[7]

Oklahoma also focuses on patients with particularly high ER use, i.e., 30 or more visits in a nine-month time span, for its ER

Figure 1: Core Elements of Integrated Care Models

Following are critical elements for designing integrated care models for people with complex needs:

1. Stratification and triage by risk/need;
2. Integration of services;
3. Designated "care home" and personalized care plan;
4. Consumer engagement strategies;
5. Provider engagement strategies;
6. Information exchange among all stakeholders including consumers;
7. Performance measurement and accountability; and
8. Financial incentives aligned with quality care.

Utilization Program. While only a small fraction of the state's total Medicaid population, these frequent ER users incur exceptionally high costs. Identified "persistent ER users" receive personalized outreach to encourage appropriate use of primary care services instead of relying on ER services.[8] From 2003 through 2007, ER use for Oklahoma's identified persistent users decreased by 55 percent.[9]

Additional states with innovative EPCCM models include Arkansas, Indiana, North Carolina, and Pennsylvania.[10] The states use a variety of resources to provide care management, including state staff, community-based networks, contractors, and physician practices, with some EPCCM programs focusing on specific diseases and conditions, while others are designed to broadly address patients with multiple conditions. Recent evaluations of Pennsylvania's Access Plus program and the Community Care of North Carolina EPCCM program show evidence of cost savings related to reduced utilization.[11]

In sum, EPCCM programs provide states with a flexible model to address the care needs of specific beneficiary populations that can be adapted to fit each state's unique environment. Just as importantly, these programs provide states with purchasing leverage to monitor and influence health care quality. States with more basic PCCM programs and/or those looking for alternatives to full-risk health plans may want to consider developing an EPCCM approach to target high-risk beneficiaries.

Integrating Physical and Behavioral Health Services

Mental illness and substance use disorder are widespread among Medicaid's highest-need, highest-cost beneficiaries, many of whom also have multiple chronic physical conditions. More than 50 percent of Medicaid beneficiaries with disabilities are diagnosed with mental illness.[12] This pervasiveness is particularly high among the program's most expensive five percent of patients, with mental illness present in three of the top five most prevalent pairs of disease for this high-cost subset (Fig. 2).[13]

Figure 2: Mental Illness Among Medicaid's Highest-Cost Population

Medicaid's highest-cost patients are likely to have both chronic physical and behavioral health conditions, reflecting a critical opportunity to integrate physical and behavioral health services to improve care and curb unnecessary spending.

Prevalent Disease Pairs	Frequency Among Highest-Cost 5% of Medicaid Beneficiaries
Psychiatric illness and cardiovascular disease	40.4%
Psychiatric illness and central nervous system disorders	39.8%
Psychiatric illness and pulmonary disorders	28.6%

Source: R.G. Kronick, M. Bella, T.P. Gilmer. *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions.* Center for Health Care Strategies, Inc., October 2009.

It is widely recognized that mental illness is closely linked to poor health outcomes and the presence of mental illness can exacerbate problems related to chronic physical conditions. For instance, a recent analysis of commercially insured patients with depression or severe anxiety found that those who also have a chronic medical condition have health care costs averaging roughly $500-600 more per month than similar patients without a behavioral health diagnosis.[14]

Yet despite the high prevalence as well as the human and financial costs of mental illness, the majority of Medicaid beneficiaries with mental illness are in bifurcated systems of care. Behavioral health services are typically provided separately from physical health care with little to no coordination between the two delivery systems. As a result, patients typically receive care from a confusing array of disparate providers that are frequently in the dark about individual patients' overall needs or the treatments and prescriptions they are receiving from other providers.

States are challenged to find efficient solutions for integrating the delivery and management of disjointed physical and behavioral health services. Pennsylvania's Department of Public Welfare designed its *Innovations Project* to respond to the high

burden of mental illness, substance use disorder, and physical comorbidities found among the state's highest-cost Medicaid beneficiaries. Through two regional pilots, launched in June 2009, the state is testing strategies to break down the silos and increase communication between physical and behavioral health managed care organizations, providers, and patients. The pilots are part of CHCS' *Rethinking Care Program*, which is fostering new strategies to improve health care quality and control spending for Medicaid's highest-need, highest-cost populations.

The two pilots — based in Pennsylvania's Southeastern and Southwestern regions — involve stakeholders across the physical and behavioral health care system, including Pennsylvania's Medicaid agency; physical and behavioral health managed care organizations; county behavioral health systems; physical and behavioral health providers; and consumers.

The innovative integration effort is seeking to establish integrated physical/behavioral health care homes for up to 10,000 adults with serious mental illness and chronic physical conditions. Pilot features that support physical and behavioral health integration through comprehensive information exchange include:

- Personalized, integrated patient care plans;
- Real-time hospital notification across plans;
- Care navigators; and
- Improved pharmacy management.

A unique shared incentive pool in the Pennsylvania pilot links payment to performance measures that the physical health and behavioral health organizations can jointly influence. In the first year, the measures are process-oriented, representing tangible steps necessary for integrating care, e.g., identification and stratification of the population; development of a care plan; notification of hospital admission; and identification of medication gaps. In year two, additional financial incentives will be tied to reductions in hospital and ER admissions. Despite severe budget shortfalls, Pennsylvania has remained committed to investing in this joint incentive program, which underscores the potential it sees for the improvements in health care quality and cost savings related to the pilot effort.

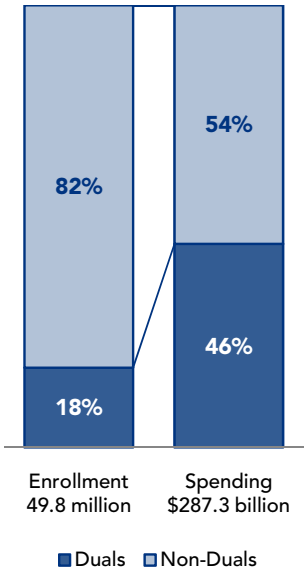
Other states pursuing innovative strategies to integrate physical and behavioral health services for Medicaid beneficiaries include New York and Washington. Through its Chronic Illness Demonstration Project, New York is focusing on improving care management for high-need, high-cost patients in fee-for-service who are at greatest risk for unnecessary hospitalizations. Not surprisingly, the state found a high incidence of mental illness and substance use within its target population. Washington State is testing two approaches to improving care for adults with co-occurring mental illness and/or chemical dependency and physical health conditions, including one care management model rooted in the physical health system and another in the mental health system.

Integrating Care for Dual Eligibles

Momentum is growing across the country to focus on Medicaid and Medicare's most chronically ill and costly population — adults who are dually eligible for both programs (the "duals"). This high-need group accounts for 46 percent of Medicaid spending and 25 percent of Medicare, with health care costs practically five times those of other Medicare beneficiaries.[15,16] Yet, the majority of the nearly nine million duals receive fragmented and poorly coordinated care, often resulting in unnecessary emergency room utilization, hospitalizations, and nursing home placement.

Efforts to integrate these two programs are challenging because Medicaid and Medicare have their own delivery, financing, and administrative policies and procedures. Yet, integrating Medicare and Medicaid services offers tremendous promise in ensuring that dual eligible beneficiaries receive the right care in the right setting, rather than receiving care driven by conflicting state and

Dual Eligibles' Share of Medicaid Enrollment and Spending, FFY 2005



Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2008.

federal rules and misaligned siloed funding streams.

One mechanism for integrating care and financing for the duals is to contract with Medicare Advantage Special Needs Plans (SNPs). To date, only roughly 100,000 dual eligible beneficiaries are in SNPs that fully integrate Medicaid and Medicare services. Progress has been slow for a variety of reasons, including competing priorities for states, confusion on the part of beneficiaries, and in some areas, the absence of SNPs.

Accordingly some states are exploring alternative vehicles to integrating Medicare and Medicaid. Vermont, for example is seeking to establish a unique integrated model for duals in which the state assumes responsibility for both the Medicare and Medicaid benefit. The state is one of seven states participating in CHCS' *Transforming Care for Dual Eligibles* initiative to develop and implement innovative strategies for integrating care.

Vermont is the only state with two 1115 waivers that allows it to both serve as the managed care entity as well as to equalize the entitlement between nursing home and home- and community-based long-term care services for Medicaid beneficiaries. Through its proposed approach for duals, Vermont would receive a Medicare waiver and/or demonstration authority and Medicare funding to integrate the full range of Medicaid and Medicare services, e.g. primary, acute, behavioral health, and long-term supports and services. By combining this Medicare waiver with the existing Medicaid 1115 waivers, the state would be able to serve as the managed care entity for dual eligible individuals. Vermont is currently working with the Centers for Medicare and Medicaid Services (CMS) to secure authority to support this arrangement.

Like Vermont, North Carolina is also establishing an alternative model to integrate care for duals. The state recently received approval through a demonstration waiver to provide enhanced care management to dual eligibles through its North Carolina Community Care Networks program. This medical home model links primary care practices with regional "community care networks" to support care coordination and collect/analyze quality information. Under this novel approach, the state and federal government will share realized Medicare savings above an agreed-upon threshold with the state and providers. Additional states pursuing integrated care for duals include Arizona, California, Colorado, Maryland, Massachusetts, Michigan, Minnesota, New Mexico, New York, Pennsylvania, Washington, Wisconsin, and Texas.[17]

Integrating care for duals offers tremendous potential to significantly improve patient health outcomes and generate Medicare and Medicaid savings, but little progress has been made due to administrative and operational challenges, financial misalignment, and the limited array of proven models. As states face unprecedented fiscal pressure, this long-awaited reform may finally get its due.

Conclusion

With high unemployment expected through 2010 and states facing the steepest consecutive drop in tax revenues since the Great Depression, the next fiscal year will be "the most difficult to date," according to a recent National Governor's Association survey of 45 states.[18,19] Concurrently, by 2014 health reform will add significantly to the Medicaid population, expanding coverage to 15-20 million Americans and putting new demands on state budgets.

Focusing on improving care and reducing avoidable expenditures for Medicaid's most complex and expensive subset of patients, including those with chronic physical and behavioral health needs and dual eligibles, may be the best way to address long-term rising costs and extend coverage to additional populations. In doing so, Medicaid can serve as a model for other payers, including Medicare and commercial insurance, for uncovering high-quality and cost-effective care delivery options for the nation's most chronically ill and costly patient populations.

Medicaid Best Buys – CHCS Resources

This brief is part of CHCS' *Medicaid Best Buys* series developed to help states, health plans, and policymakers identify programs that have the greatest potential to improve health care quality and control costs for beneficiaries with complex needs. The series synthesizes CHCS' work with multiple funding partners, including the California HealthCare Foundation, The Colorado Health Foundation, The Commonwealth Fund, Kaiser Permanente, the New York State Health Foundation, the Robert Wood Johnson Foundation, The SCAN Foundation, and the United Hospital Fund.

Visit CHCS' website at **www.chcs.org** for a variety of resources to support the development and implementation of strategies outlined in this brief, including:

- ***Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*** – Examines five state EPCCM programs with a particular focus on strategies that can improve care management for beneficiaries with chronic illnesses and disabilities.
- ***Providing Behavioral Health Services to Medicaid Managed Care Enrollees: Options for Improving the Organization and Delivery Services*** – Explores state best practices for integrating physical and behavioral health care and reducing avoidable high-cost services.
- ***Designing Integrated Care Programs: An Online Toolkit*** – Provides a practical set of resources to guide states in designing approaches to integrate Medicaid and Medicare services. Includes policy options, how-to tools, and sample materials from other states.
- ***Options for Integrating Care for Dual Eligible Beneficiaries*** – Summarizes four options to integrate care for Medicare and Medicaid dual eligibles: (1) Special Needs Plans (SNPs); (2) Program for All-Inclusive Care for the Elderly (PACE); (3) Shared Savings Models; and (4) States as Integrated Care Entities.

Endnotes

[1] Kaiser Commission on Medicaid and the Uninsured (2010). "State Fiscal Conditions and Medicaid." Available at http://www.kff.org/medicaid/7580.cfm.
[2] Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimate based on 2004 MSIS data.
[3] CHCS estimate using Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimate based on Centers for Medicare and Medicaid Services-64 reports, March 2009; and National Health Expenditure Projections, 2009-2019.
[4] Kaiser Commission on Medicaid and the Uninsured (2010). "Medicaid and Managed Care: Key Data, Trends, and Issues." Available at http://www.kff.org/medicaid/8046.cfm.
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[8] Oklahoma Health Care Authority (2009). "ER Utilization and Persistent Population Fast Facts: July – September 2009." Available at https://www.ohca.state.ok.us/research.aspx?id=87.
[9] J. Verdier, M. Colby, D. Lipson, et al., op cit.
[10] For simplicity, this brief groups programs under the "enhanced primary care case management" heading, but states refer to these programs in a variety of ways, e.g., primary care case management, enhanced primary care case management, complex care management, etc.
[11] Mercer Government Human Services Consulting (2007). "Updated Comparative Cost Study: ACCESS Plus versus Voluntary HMO." Prepared for the Commonwealth of Pennsylvania. Mercer savings estimates are on the "Program Impact" section of the Community Care website at: http://www.communitycarenc.com.
[12] R. G. Kronick, M. Bella, T.P. Gilmer. *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions.* Center for Health Care Strategies, Inc., October 2009.
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[15] J. Holahan, D. M. Miller, and D. Rousseau. *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005.* Kaiser Commission on Medicaid and the Uninsured. February 2009.
[16] T. Coughlin, T. Waidmann and M. O'Malley Watts. *Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries.* Kaiser Commission on Medicaid and the Uninsured. April 2009.
[17] List is not exhaustive. For more details of select state programs to integrate care for duals, see http://www.chcs.org/usr_doc/ICP_State-by-State_Dashboard.pdf.
[18] D.J. Boyd and L. Dadayan. *Revenue Declines Less Severe, But States' Fiscal Crisis Is Far From Over.* The Nelson A. Rockefeller Institute of Government. April 2010.
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