



# Integrating Care for Dual Eligibles in New York: Issues and Options

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# Executive Summary

**M**ore than 700,000 people in New York are simultaneously enrolled in both Medicare and Medicaid. These “dual eligibles” and their families, health care providers, and those who operate the two programs are continually challenged by an intricate maze of overlapping and conflicting programs and services, and by the inefficiency, fragmentation, and duplication of services that drives up overall costs for both programs. Dual eligibles get almost all of their physician, hospital, prescription drug, and other short-term acute care services from Medicare, while most of their long-term care services in nursing facilities and in the community are provided through Medicaid. Some services, like home health, nursing facility, hospice, and durable medical equipment, such as wheelchairs, are covered by both programs, but the coverage rules in each program are different. These divisions of payment responsibility between Medicare and Medicaid thwart efforts to reduce preventable hospital, emergency room, and nursing facility use because the costs of prevention are often borne by one program while the financial savings accrue to the other. Divided payment responsibility also fosters wasteful efforts by providers and payers to shift costs from one program to the other. Better coordination and integration of care for dual eligibles could save State and Federal dollars and substantially improve the quality of care for this diverse and vulnerable population.

**Dual eligible characteristics, care needs, and costs.** Almost two-thirds of dual eligibles are over age 65, and more than one-third are under age 65 and have serious disabilities and chronic illnesses. All have low or no incomes, more than half do not have a high school degree, and more than 40% have significant behavioral health or cognitive problems, with behavioral health problems more prevalent among those under age 65, and Alzheimer’s and dementia more common among those over age 65. Twenty percent are living in an institution, and another 27% are living alone.

Not surprisingly, health care costs for dual eligibles are very high. Nationally, while dual eligibles represent only 15% of Medicaid enrollees and 18% of Medicare beneficiaries, they account for 39% of total Medicaid expenditures and 31% of Medicare expenditures. In New York, these cost patterns are magnified—dual eligibles represent 15% of Medicaid enrollees, but account for 45% of total Medicaid expenditures. Significantly, New York’s per-person Medicaid expenditures for dual eligibles are twice the national average and the highest in the nation.

**New York and national initiatives.** Major initiatives are underway both in New York and nationally to improve the coordination and integration of care dual eligibles receive through Medicare and Medicaid. In January 2011, New York Governor Andrew Cuomo appointed the Medicaid Redesign Team (MRT). The MRT recommended—and the Legislature subsequently passed—a number of initiatives aimed at improving the management and coordination of care for dual eligibles and other high-need, high-cost beneficiaries. The major State initiative related to dual eligibles is mandatory enrollment of Medicaid beneficiaries in need of long-term care services in managed long-term care (MLTC) health plans. At the national level, the Medicare-Medicaid Coordination Office (MMCO) and the Center for Medicare and Medicaid Innovation within the Federal Centers for Medicare & Medicaid Services (CMS) joined together in April

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2011 to award \$1 million contracts to New York and 14 other states to design demonstration programs to better integrate care for dual eligibles. Approved demonstration proposals will receive additional CMS funding for implementation.<sup>1</sup>

### Recommendations

**Use the Federal dual eligible demonstration to support and enhance State initiatives for dual eligibles.** The Federal demonstration can test ways to provide more fully integrated Medicare and Medicaid services on a smaller or more geographically limited scale than is planned in the State MRT process. MLTC plans that currently cover Medicaid long-term supports and services (LTSS) in the community and in nursing facilities could, for example, add linkages to primary, acute, behavioral health, and Medicare services for dual eligibles in the New York City area, where the building blocks needed to add these capacities already exist among a variety of health plans. Those aspects of the Federal demonstration that prove successful could be incorporated into the broader State initiatives as they are implemented over time.

**Require greater integration of all Medicaid and Medicare services in capitated managed care programs.** As part of the demonstration, the State could require managed care organizations or other care coordination entities participating in the demonstration to cover all Medicare and Medicaid primary, acute, behavioral health, and long-term supports and services for dual eligibles, or to have close contractual relationships with entities that do.

**Use the CMS financial alignment models to help finance more integrated benefits for dual eligibles.** The financial alignment models that CMS is making available in the demonstration provide a way for states and health plans to share in the savings that can result from better coordination and integration of Medicare and Medicaid benefits for dual eligibles, including Medicare inpatient hospital, emergency room, prescription drug, and skilled nursing facility benefits, and Medicaid LTSS and behavioral health benefits.

**Use three-way capitated contracts to broaden and integrate the benefit package for dual eligibles.** The CMS capitated financial alignment model permits states, CMS, and health plans to enter into three-way contracts that cover all Medicare and Medicaid services for dual eligibles, including benefits that are now provided separately through Medicare and Medicaid health plans, or through fee-for-service (FFS) arrangements.

While few managed care programs in New York fully integrate both acute and long-term care and Medicaid and Medicare benefits, there are health plans that operate plans in several of the Medicaid and Medicare managed care programs in the State that partially integrate these

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<sup>1</sup> Both the State MRT initiatives related to dual eligibles and the CMS dual eligible demonstrations share the goal of developing person-centered approaches to coordinating care for dual eligibles across primary, acute, behavioral health, and long-term supports and services, but the time line for implementation of the State MRT initiatives is somewhat longer and the State initiatives are focused more broadly on all Medicaid beneficiaries and the services they receive, not just dual eligibles.

## Executive Summary *(continued)*

benefits. They include the different types of MLTC plans, Medicare Advantage Special Needs Plans (SNPs), and Mainstream Medicaid Managed Care plans, in addition to the small but fully integrated PACE plans. These plans could serve as building blocks for more fully integrated managed care options for duals. The kinds of partnerships and collaborations among health plans and other entities needed to accomplish this greater degree of integration have already begun in the New York City area, and the dual eligible demonstration could provide further support and encouragement. The biggest challenge in upstate New York will be bringing LTSS into a managed care framework, because few health plans and providers operating in those areas have that experience.

**Use State's health home initiative to increase integration of behavioral health services for dual eligibles.** Another important State initiative related to dual eligibles is establishing “health homes” for Medicaid beneficiaries with complex and costly physical and behavioral health care needs. Nearly 1 million Medicaid beneficiaries in the state have complex physical and behavioral health conditions and could benefit from the greater coordination health homes could provide, and nearly one-third are dual eligibles. Health homes can be used in either managed care or FFS settings, so they could be used as a way of more fully integrating behavioral health into capitated plans, both in the dual eligible demonstration and as part of the MRT process.

**Use health homes funding to cover initial Medicaid care coordination costs.** The Federal Affordable Care Act of 2010 authorizes 90% Federal funding for specified care coordination activities for the first two years of health homes initiatives. Health homes can be a source of upfront funding for the care coordination support systems needed by dual eligibles, with particular focus on the behavioral health care needs that are widely prevalent among dual eligibles under age 65.

**Use passive enrollment to increase enrollment in the dual eligible demonstration.** In order to support the enhanced care coordination activities needed to make the Federal demonstration successful, and to increase the likelihood of Federal Medicare savings that would benefit the State, the demonstration must achieve a significant volume of dual eligible enrollment. CMS has authority to permit states to “passively enroll” dual eligibles in capitated managed care plans for their Medicare services for purposes of the demonstration, as long as those who are passively enrolled have the ability to opt out easily. Beneficiaries must be fully informed about their care options, including their ability to return to the Medicare FFS program at any time.

**Continue and expand stakeholder engagement and consultation.** Extensive stakeholder engagement is one of the major CMS requirements for dual eligible demonstrations. New York has considerable experience with this approach, since it has been a hallmark of the MRT process. Stakeholder engagement will be especially important for generating support for expanding enrollment in the Federal demonstrations through passive enrollment. Beneficiary

## Executive Summary *(continued)*

education and enrollment processes that incorporate the input of beneficiaries and their representatives will be crucial to the success of such an effort.

**Next steps.** The NYSDOH proposal for the design of the dual eligible Federal demonstration proposal is due to CMS in April 2012. The time between now and April can be used to design a demonstration proposal that builds on the strengths of the MRT initiatives by testing approaches that can move New York as quickly and effectively as possible toward programs for dual eligibles that fully integrate and coordinate all of their care.

# Introduction

**M**ore than 700,000 people in New York are enrolled in both Medicare and Medicaid, with each program covering some of the services they need but not others, and sometimes covering the same service under some circumstances but not others. The Federal Medicare program covers mostly short-term acute care services for these “dual eligibles,” like hospital and physician services and prescription drugs, while the State-Federal Medicaid program covers mostly long-term services, like long-term nursing facility and home- and community-based services (HCBS). Some services, like home health, nursing facility care, hospice, and durable medical equipment (wheelchairs, for example) are covered by both programs, but the coverage rules in each program are different. Medicaid provides some services that Medicare covers in only limited ways (vision, dental, transportation, and behavioral health). Medicaid covers some or all of the Medicare Part A and B premiums and beneficiary cost sharing (deductibles, coinsurance, and co-pays) that dual eligibles are responsible for.

Dual eligibles and their families, health care providers, and those who operate the two programs are continually challenged by this intricate maze of overlapping and sometimes conflicting programs and services. Beneficiaries have trouble finding their way to the appropriate care, providers often do not know which program to bill for which services, program operators in one program know little about what is going on in the other, and the inefficiency, fragmentation, and duplication of services that results drives up overall costs for both programs.

## Current Initiatives to Improve Care for Dual Eligibles

There are major initiatives underway both in New York and nationally to improve the coordination and integration of care dual eligibles receive through Medicare and Medicaid. In New York, the Medicaid Redesign Team (MRT), appointed by Governor Andrew Cuomo in January 2011, recommended a number of initiatives aimed at improving the management and coordination of care for dual eligibles and other high-need, high-cost Medicaid beneficiaries; most of these initiatives were approved by the Legislature and are now being implemented. At the national level, the Medicare-Medicaid Coordination Office (MMCO) and the Center for Medicare and Medicaid Innovation in the Federal Centers for Medicare & Medicaid Services (CMS) joined together to award \$1 million contracts in April 2011 to New York and 14 other states to develop demonstration programs to better integrate care for dual eligibles. Demonstration proposals are due to CMS by April 2012 and, if approved, states will receive additional CMS funding for implementation of the demonstration in 2012.

## How We Prepared This Report

We gathered information from a wide range of State and national sources and discussed emerging issues and options with a number of New York stakeholders between January and October 2011. Our main sources of information and perspective were:

## Introduction *(continued)*

- **New York State Department of Health (NYSDOH) staff.** We had our initial discussion with NYSDOH staff by telephone on January 5, 2011, and met with them in person in Albany on January 20, 2011. We had additional telephone discussions with them in March 2011 and May 2011, and met with some of them again in conjunction with James Verdier’s presentation on July 8, 2011, at a meeting in New York City of the MRT Managed Long Term Care Implementation and Waiver Redesign Work Group.
- **Stakeholder discussions.** We conducted in-person and telephone discussions from January 2011 through July 2011, with a number of stakeholders. The MRT made its recommendations on February 24, 2011, and most were approved by the Legislature on March 31, 2011, so we conducted most of our discussions after that period. We talked again with some of the stakeholders with whom we had earlier discussions to get their assessment of the MRT recommendations. The stakeholders we interviewed included representatives of the following organizations:

January 2011	Village Care of New York, Visiting Nurse Service of New York, Healthfirst
February 2011	Greater New York Hospital Association
March 2011	Coalition of New York State Public Health Plans
June 2011	Metropolitan Jewish Health System, Coalition of New York State Public Health Plans, New York Health Plan Association, New York Association of Homes and Services for the Aging, Center for Independence of the Disabled, Visiting Nurse Service of New York, and Healthfirst
July 2011	Medicare Rights Center

- **Public meetings and presentations.** James Verdier participated in a January 19, 2011, panel discussion in New York City sponsored by the New York State Health Foundation and the Citizens Budget Commission (“Medicaid Cost Control Options in New York: Programs for the Elderly and Disabled”) and obtained a variety of stakeholder perspectives at that meeting. He also made a presentation (“Managed Long Term Care: Options for New York and Examples From Other States”) at a July 8, 2011, public meeting in New York City of the MRT Managed Long Term Care Implementation and Waiver Redesign Work Group, and obtained additional stakeholder perspectives at that meeting.
- **MRT website.** We have followed closely the work of the MRT Work Groups and other MRT activities, as reported on the MRT website ([http://www.health.ny.gov/health\\_care/medicaid/redesign/](http://www.health.ny.gov/health_care/medicaid/redesign/)), especially the work of the Managed Long Term Care and Behavioral Health Reform Work Groups.

## Introduction *(continued)*

- **Published reports and studies.** We reviewed a wide range of reports and studies published by NYSDOH, the New York State Health Foundation, the Medicaid Institute at United Hospital Fund, and other organizations in New York and nationally.

### Overview of the Report

In the second section we review dual eligible characteristics, care needs, costs, and service delivery options at the national level, and then discuss some aspects of New York's Medicaid program that present opportunities and challenges for integrated care programs for dual eligibles, including the State's high Medicaid expenditures on long-term care for dual eligibles.

In the third section we discuss New York's options for developing integrated care programs for dual eligibles, focusing on ways in which the State can use the dual eligible demonstration it is developing to strengthen and expand the MRT initiatives related to dual eligibles.

Finally, in the fourth section we summarize experiences and lessons from other states that New York can consider as it develops its programs to provide more integrated care for dual eligibles. An Appendix describes these experiences from other states in more detail.

# Dual Eligibles, Costs, Care Fragmentation, and Who Pays For It

## National Overview

Nationally, nearly 9 million people are enrolled in both Medicaid and Medicare. Nearly 7 million are “full duals”—eligible for all benefits of both programs.<sup>2</sup> Although dual eligibles represented only 18% of Medicare fee-for-service (FFS) beneficiaries and 15% of total Medicaid beneficiaries in 2007, they accounted for a disproportionate share of spending in both programs: 31% of Medicare FFS expenditures and 39% of total Medicaid expenditures.<sup>3</sup>

## Dual Eligible Characteristics, Care Needs, and Costs

**Characteristics.** Almost two-thirds of dual eligibles are over age 65, and more than one-third are under age 65 and have serious disabilities and chronic illnesses. Almost all dual eligibles have low incomes (88% are below 150% of the Federal poverty level), more than half (54%) do not have a high school diploma, and more than 40% have significant behavioral health or cognitive problems, with behavioral health problems more prevalent among those under age 65, and Alzheimer’s and dementia more common among those over age 65. Twenty percent are living in an institution, and another 27% are living alone. More than 40% are racial or ethnic minorities.<sup>4</sup>

**Care needs.** Dual eligibles are more likely to be disabled and have higher rates of diseases, such as diabetes, pulmonary disease, and heart disease. Almost 40% of dual eligibles have both physical and mental/cognitive conditions, compared to only 17% of all other Medicare beneficiaries.<sup>5</sup> Among dual eligibles who qualify because of a disability, 44% have a mental illness and 18% have a developmental disability. Forty-four percent had one or more emergency room visits in 2006 and 29% had one or more inpatient hospital stays.<sup>6</sup> More than half of all nursing facility residents are dual eligibles.<sup>7</sup>

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<sup>2</sup> For “partial duals,” Medicaid pays some or all of Medicare Part A and B premiums and beneficiary cost sharing (deductibles, coinsurance, and co-payments), but Medicaid services are not covered.

<sup>3</sup> Kaiser Commission on Medicaid and the Uninsured. “Dual Eligibles: Medicaid’s Role for Low-Income Medicare Beneficiaries.” Medicaid Facts, May 2011; Medicare Payment Advisory Commission (MedPAC). “A Data Book.” Chart 3-1, p. 31, June 2011.

<sup>4</sup> Kaiser Family Foundation Program on Medicare Policy. “The Role of Medicare for the People Dually Eligible for Medicare and Medicaid,” January 2011, p. 3; MedPAC. “Coordinating the care of dual eligible beneficiaries,” *Report to the Congress*, June 2010, pp. 133-135; MedPAC. “A Data Book.” Chart 3-4, p. 34, June 2011.

<sup>5</sup> Judy Kasper, et al. “Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending.” Washington, DC: Kaiser Commission on Medicaid and the Uninsured, July 2010.

<sup>6</sup> Kaiser. “The Role of Medicare,” p. 3 and p. 4; MedPAC. “Coordinating the care of dual eligible beneficiaries,” p. 133.

<sup>7</sup> James M. Verdier. “Coordinating and Improving Care for Dual Eligibles in Nursing Facilities: Current Obstacles and Pathways to Improvement.” Washington, DC: Mathematica Policy Research, Policy Brief, March 2010, p. 2 and footnote 4.

## Dual Eligibles, Costs, Care Fragmentation, and Who Pays For It (*continued*)

**Unique needs of younger dual eligibles with disabilities.** The approximately 3 million dual eligibles who are under 65 have a unique set of needs that require approaches that are different in many respects from those for dual eligibles age 65 and over. Dual eligibles age 65 and over have care needs that are similar to those of other older Medicare beneficiaries, except that their use of long-term nursing facility services is much higher. Nearly 20% of dual eligibles age 65 and over live in a nursing facility, compared to just 2% of non-dual Medicare beneficiaries.<sup>8</sup> Among under-65 dual eligibles, by contrast, only approximately 11% live in nursing facilities or other institutional settings.<sup>9</sup> The under-65 dual eligibles have much greater behavioral health needs than their elderly counterparts, and they are at higher risk for disability-related medical complications that often lead to hospitalizations, if not effectively monitored. Under-65 dual eligibles may use different providers, including providers of non-medical support services and physicians whose offices accommodate people with disabilities, and they rely more on durable medical equipment, such as wheelchairs. Integrated care for this subset of the dual eligible population must take these characteristics and care needs into account, and may require distinct models of care, delivery system partners, and financing arrangements to be effective.<sup>10</sup>

**Costs.** Not surprisingly, dual eligibles' health care costs are very high. As noted earlier, dual eligibles account for a disproportionate share of total national expenditures for both Medicaid and Medicare. Average annual Medicaid spending per dual eligible in 2007 was \$15,459, almost three times higher than the \$5,163 average for all Medicaid enrollees combined.<sup>11</sup> In Medicare, average spending per dual eligible in 2007 was \$16,512, more than twice as high as the average annual spending of \$7,823 for non-dual-eligible Medicare beneficiaries.<sup>12</sup>

### Service Delivery Fragmentation

**Current division of responsibility for services between Medicare and Medicaid.** As noted earlier, dual eligibles receive most of their acute care services (inpatient hospital, physician, and emergency room care as well as prescription drugs) from Medicare, and most of their long-term supports and services (nursing facility care and home- and community-based services) from Medicaid. Some services are provided by both programs (nursing facility, home health, hospice), with a division of responsibility between Medicare and Medicaid that is not always clear. Medicaid provides some services that Medicare covers in only limited ways (vision, dental, transportation, and behavioral health). Medicaid covers some or all of the Medicare premiums and beneficiary cost sharing (deductibles, coinsurance, and co-pays) for dual eligibles, but

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<sup>8</sup> Teresa Coughlin, et al. "Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2009, Table 1, p. 6.

<sup>9</sup> Ibid.

<sup>10</sup> Individuals with disabilities who are eligible only for Medicaid have similar needs, and require approaches to integration that take these same considerations into account.

<sup>11</sup> Kaiser Family Foundation, <http://statehealthfacts.org/comparemaptable.jsp?ind=300&cat=6&sub=76>. Accessed November 3, 2011.

<sup>12</sup> MedPAC. "A Data Book." Chart 3-5, p. 35, June 2011.

## Dual Eligibles, Costs, Care Fragmentation, and Who Pays For It (*continued*)

many eligible beneficiaries do not enroll for this coverage.<sup>13</sup> The bulk of this care is provided in the FFS system.

**Obstacles to care coordination in the FFS system.** Given their health care needs, dual eligibles often require a complex array of services from multiple providers. In the FFS system, dual eligibles typically receive care that is fragmented and uncoordinated because the system has few incentives, resources, or mechanisms for care coordination. Indeed, most of the financial incentives in the current FFS system impede care coordination for dual eligibles because separate providers are being paid by separate payers for only the pieces of care that they provide, and no one is being paid to bring the pieces together.

**Misaligned financial and service delivery incentives in long-term care settings.** Care coordination for dual eligibles is most impeded in long-term care settings because the Medicaid program is responsible for financing most of this care, but has little ability to influence the use of hospital, physician, and prescription drug services by Medicaid-funded residents of nursing facilities or by those receiving Medicaid-funded long-term care services in the community. As a consequence, there is widespread over-use of inpatient hospital and emergency room services by nursing home residents, oversight of prescription drug use in nursing facilities is limited, and there are few resources to link dual eligible beneficiaries in Medicaid home- and community-based long-term care programs to needed physician, hospital, and other medical services.<sup>14</sup>

**Division of responsibility for physical and behavioral health services.** Responsibility for providing physical and behavioral health services is frequently divided in state Medicaid programs, with behavioral health services being provided separately from physical health services in the FFS system, or through specialized behavioral health managed care programs.<sup>15</sup> This division of responsibility is especially problematic for dual eligibles under age 65, almost 40% of whom have coexisting physical and behavioral health conditions. Since Medicare coverage of behavioral health services is limited, dual eligibles are heavily reliant on Medicaid for these services.

**Managed care options for dual eligibles.** Many states have established managed care programs aimed at improving the coordination of care for Medicaid beneficiaries with complex care needs, such as those who are in the aged, blind, and disabled (ABD), or Supplemental Security Income

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<sup>13</sup> Jack Ebeler, Paul N. Van de Water, and Cyanne Demchak (eds.). "Improving the Medicare Savings Programs." Report of the Study Panel on Medicare/Medicaid Dual Eligibles. Washington, DC: National Academy of Social Insurance, June 2006, pp. 20-24.

<sup>14</sup> For a discussion of these issues, see James M. Verdier. "Coordinating and Improving Care for Dual Eligibles in Nursing Facilities: Current Obstacles and Pathways to Improvement." Washington, DC: Mathematica Policy Research, Inc., March 2010. Available at: [http://www.mathematica-mpr.com/publications/PDFs/health/nursing\\_facility\\_dualeligibles.pdf](http://www.mathematica-mpr.com/publications/PDFs/health/nursing_facility_dualeligibles.pdf). Accessed December 20, 2011.

<sup>15</sup> For a discussion of these issues, and some options states have developed to deal with them, see Allison Hamblin, James Verdier, and Melanie Au. "State Options for Integrating Physical and Behavioral Health Care." Washington, DC: Integrated Care Resource Center, October 2011. Available at: [http://www.integratedcareresourcecenter.com/pdfs/ICRC\\_BH\\_Briefing\\_document\\_1006.pdf](http://www.integratedcareresourcecenter.com/pdfs/ICRC_BH_Briefing_document_1006.pdf). Accessed December 20, 2011.

## Dual Eligibles, Costs, Care Fragmentation, and Who Pays For It (*continued*)

(SSI) eligibility categories. Dual eligibles cannot be required to enroll in such programs for their Medicare services, although enrollment for their Medicaid services can be mandatory. With the transfer of prescription drug coverage for dual eligibles to Medicare in 2006, states are now responsible for only a very small share of the acute care services received by dual eligibles, so dual eligibles have commonly been excluded from these Medicaid managed care programs, or enrolled only on a voluntary basis. Medicare Advantage Special Needs Plans (SNPs) were introduced under the Medicare Modernization Act of 2003, in part to help integrate and coordinate care for dual eligibles, but more than 80% of duals remain in the FFS system.<sup>16</sup> Even when dual eligibles are enrolled in SNPs, there are obstacles to full coordination of care, and most SNP enrollment is concentrated in fewer than a dozen states.<sup>17</sup>

While dual eligibles can benefit from the greater coordination of care that is possible through managed care, they may be concerned about enrolling in a system that could limit their access to providers, given the complexity and range of their care needs. In addition, some providers are reluctant to participate in managed care systems, and the number of managed care organizations that have experience with dual eligibles is limited. A number of states are therefore pursuing options to integrate care for dual eligibles that do not involve SNPs and other capitated managed care arrangements.<sup>18</sup>

### Medicaid and Medicare Expenditures for Dual Eligibles in New York Compared to National Averages

#### High Overall Medicaid Expenditures in New York

New York's Medicaid program as a whole was the costliest of any state in the country in 2008, in terms of both total spending per State resident and total spending per Medicaid enrollee.

Medicaid spending per State resident in New York was \$2,511 in 2009, compared to a national average of \$1,176.<sup>19</sup> This reflects both the relatively high cost of living in New York, and the relatively high percentage of the State's population enrolled in Medicaid—25% in 2008 compared to a national average of 20%.<sup>20</sup> However, it also reflects the relatively costly mix of

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<sup>16</sup> Melanie Bella and Lindsay Palmer. "Encouraging Integrated Care for Dual Eligibles," Hamilton, NJ: Center for Health Care Strategies, July 2009. Available at: [http://www.chcs.org/usr\\_doc/Integrated\\_Care\\_Resource\\_Paper.pdf](http://www.chcs.org/usr_doc/Integrated_Care_Resource_Paper.pdf). Accessed April 27, 2011.

<sup>17</sup> Jessica Kasten, Paul Saucier, and Brian Burwell. "State Purchasing Strategies Drive State Contracts With Medicare Special Needs Plans," Washington, DC: Department of Health and Human Services, Office of Assistant Secretary for Policy & Evaluation, Issue Brief, September 2009. Available at: <http://aspe.hhs.gov/daltcp/reports/2009/stpur.pdf>. Accessed April 27, 2011.

<sup>18</sup> Center for Health Care Strategies. "Options for Integrating Care for Dual Eligible Beneficiaries," Hamilton, NJ: CHCS, March 2010. Available at: [http://www.chcs.org/usr\\_doc/Options\\_for\\_Integrating\\_Care\\_for\\_Duals.pdf](http://www.chcs.org/usr_doc/Options_for_Integrating_Care_for_Duals.pdf). Accessed April 27, 2011.

<sup>19</sup> Steve Eiken, et al. "Medicaid Long-Term Care Expenditures in FY 2009." August 17, 2010. Table Q. Available at: [http://www.hcbs.org/files/194/9675/2009\\_LTC\\_ExpendituresTables.pdf](http://www.hcbs.org/files/194/9675/2009_LTC_ExpendituresTables.pdf). Accessed November 3, 2011. Note that per resident expenditures in the District of Columbia were higher than those in New York.

<sup>20</sup> Kaiser Family Foundation: <http://statehealthfacts.org/comparemaptable.jsp?ind=199&cat=4>. Accessed November 3, 2011.

## Dual Eligibles, Costs, Care Fragmentation, and Who Pays For It (*continued*)

enrollees and services in New York's Medicaid program, with high-cost services for disabled and elderly enrollees accounting for a large share of total state Medicaid expenditures.

Medicaid spending per enrollee was the highest in the country in New York in 2008, with an average annual cost per enrollee of \$9,057, compared to a national average of \$5,432. Annual per-enrollee expenditures for disabled enrollees (\$30,272) were the highest in the nation and those for elderly enrollees (\$22,584) were the second highest, accounting for most of New York's high ranking overall in per-enrollee spending.<sup>21</sup>

This same pattern shows up in Medicaid expenditures for dual eligibles in New York, all of whom fall into the disabled or elderly Medicaid eligibility categories.

### **High Medicaid Long-Term Care Expenditures for Dual Eligibles in New York**

In New York, dual eligibles comprised 15% of Medicaid enrollees in 2007, the same as the national average, but expenditures for dual eligibles were a larger share of total Medicaid expenditures—45% compared to 39% nationally. The main reason for the difference was New York's high level of expenditures on long-term care services for dual eligibles. As shown in Table 1 below, annual expenditures per dual eligible in New York for long-term care services were more than \$23,447 in 2007, compared to a national average of \$10,840.

New York's expenditures for acute care services were also substantially above national averages, but these services make up a relatively small share of Medicaid expenditures for dual eligibles. For all Medicaid services for dual eligibles in 2007, New York spent \$30,384, the highest in the nation and almost twice the national average of \$15,459.<sup>22</sup>

Medicaid payments for acute care services and beneficiary cost sharing not covered by Medicare were approximately 70% above the national average, while Medicaid payments for Medicare Part A and B premiums were closer to the national average.<sup>23</sup>

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<sup>21</sup> Kaiser Family Foundation: <http://statehealthfacts.org/comparemactable.jsp?ind=183&cat=4>. Accessed November 3, 2011.

<sup>22</sup> David Rousseau, et al. "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2010, Table 4a, p. 8.

<sup>23</sup> The relatively high Medicaid payments for Medicare cost sharing reflect in part relatively high Medicare spending per enrollee in New York. See Kaiser Family Foundation: <http://statehealthfacts.org/comparemactable.jsp?ind=624&cat=6>. Accessed November 3, 2011.

## Dual Eligibles, Costs, Care Fragmentation, and Who Pays For It (continued)

**TABLE 1. Medicaid Expenditures By Service Type, Per Dual Eligible, Calendar Year 2007**

SERVICE TYPE	ANNUAL EXPENDITURES PER DUAL ELIGIBLE		NEW YORK COMPARED TO NATION
	NEW YORK	NATION	
<b>ACUTE CARE</b>			
Acute Care Not Covered by Medicare	5,080	3,026	168%
Medicare Acute Care Cost Sharing	3,950	2,304	171%
<b>LONG-TERM CARE</b>	<b>23,447</b>	<b>10,840</b>	<b>216%</b>
<b>PRESCRIPTION DRUGS</b>	<b>232</b>	<b>177</b>	<b>131%</b>
<b>MEDICARE PREMIUMS</b>	<b>1,624</b>	<b>1,398</b>	<b>116%</b>
<b>TOTAL ANNUAL EXPENDITURES PER ENROLLEE</b>	<b>30,384</b>	<b>15,459</b>	<b>197%</b>
NUMBER OF FULL DUAL ELIGIBLES <sup>a</sup>	630,562	7,796,106	

**SOURCE:** Rousseau TD, Clemans-Cope L, Lawton E, Langston J, Connolly J, Howard J. Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. Table 4a: Medicaid Expenditures for Dual Eligibles by State, 2007. Kaiser Family Foundation Issue Paper, December 2010. Pub. No. 7846-02. Available at: <http://www.kff.org/medicaid/upload/7846-02.pdf>.

<sup>a</sup> National totals exclude Arizona. At the time of the report, the MSIS 2007 data quality for the state of Arizona was not adequate to construct measures of complete spending in the state.

### Comparisons of Long-Term Care Expenditures in New York to Other States by Type of Service

As shown in Table 2 below, New York ranked first in the nation in 2009 in per resident Medicaid expenditures for almost all types of long-term supports and services (LTSS). (Per resident expenditures are annual Medicaid expenditures divided by the total state population, not by the number of Medicaid users of each service.<sup>24</sup>) The exception was for home- and community-based service (HCBS) waivers for persons with developmental disabilities (DD) and for the aged and disabled (A/D). A potential explanation for New York's low ranking for HCBS waivers for the aged and disabled may be that many of these services were provided instead through New York's personal care assistance and home health programs, where per capita expenditures were many times higher than the national average in 2009.

<sup>24</sup> Consistent state-by-state comparisons of Medicaid expenditures per enrollee for specific types of services are not readily available. Per resident expenditures are, in effect, a measure of the cost of these services to the state's taxpayers. While this is an imperfect measure that does not adjust for variation in health care costs and income levels across states, it does permit consistent cross-state comparisons annually and over time.

## Dual Eligibles, Costs, Care Fragmentation, and Who Pays For It (continued)

**Table 2. New York State Medicaid Expenditures Per State Resident, Federal Fiscal Year 2009<sup>25</sup>**

TYPE OF SERVICE	NEW YORK STATE	U.S. AVERAGE	NY NATIONAL RANK
All services combined	\$2,710	\$1,193	1
All long-term care	1,139	412	1
Nursing facility	393	166	1
Intermediate care facility for people with mental retardation	164	43	1
Personal care	171	45	1
Home health	95	16	1
HCBS waivers—DD	244	82	3
HCBS waivers—A/D	2	30	50

### Regional Variation in LTSS Among Medicaid Beneficiaries and Dual Eligibles in New York

There are substantial variations in Medicaid expenditures for LTSS in different regions of the State and for different service types. This reflects in large measure differences in service capacity and infrastructure between the New York City area and upstate areas. For example, Medicaid Managed Long-Term Care (MLTC) expenditures are heavily concentrated in the New York City area, which accounted for 93% of total statewide MLTC expenditures in 2007.<sup>26</sup> New York City accounted for 83% of total Medicaid personal care expenditures in the State in that year and 74% of home health care expenditures, but only 53% of nursing facility expenditures.

These regional differences also show up among dual eligibles, who are heavy users of LTSS. While dual eligibles' use of all long-term care services combined did not vary substantially by region in 2005, use of home health and personal care services in New York City was substantially higher than in the rest of the State, and use of nursing facility services by elderly duals was substantially lower.<sup>27</sup> Expenditures per service user for dual eligibles were higher

<sup>25</sup> Steve Eiken, et al. "Medicaid Expenditures For Long-Term Services and Supports: 2011 Update." October 31, 2011. Available at: [http://hcbs.org/moreInfo.php/nb/doc/3661/Medicaid\\_Expenditures\\_for\\_Long-Term\\_Services\\_and\\_S](http://hcbs.org/moreInfo.php/nb/doc/3661/Medicaid_Expenditures_for_Long-Term_Services_and_S). Accessed December 20, 2011. Note that the District of Columbia is omitted from the national rankings in this table. The District of Columbia ranked above New York in total Medicaid expenditures per resident and HCBS waivers—A/D, but not in any other service category shown in the table.

<sup>26</sup> Alene Hokenstad, Meghan Shineman, and Roger Auerbach. "An Overview of Medicaid Long-Term Care Programs in New York." Prepared for the Medicaid Institute at United Hospital Fund, April 2009, p. 11.

<sup>27</sup> Michael Birnbaum, Elizabeth M. Patchias, and Jennifer Heffernan. "Medicaid Long-Term Care in New York: Variation by Region and County." Prepared for the Medicaid Institute at United Hospital Fund, December 2010, p. 6.

## Dual Eligibles, Costs, Care Fragmentation, and Who Pays For It (*continued*)

in New York City than in upstate areas for all long-term care services, with annual per-user expenditures for home health and personal care services more than three times higher in New York City, and per-user nursing facility expenditures about a third higher.<sup>28</sup>

As New York considers options for extending managed care to dual eligibles, these differences in service capacity, utilization, and cost between New York City and the rest of the State present both constraints and opportunities. Efforts to reduce service levels and costs in areas where they are unusually high often encounter resistance from providers and beneficiaries. The higher use of long-term institutional services and the lower use of community services in some upstate areas, however, may present opportunities to rebalance long-term services toward greater use of community-based care.

### Medicare Expenditures for Dual Eligibles in New York

Based on our review of data from 2006 that show both Medicare and Medicaid expenditures per dual eligible by type of service at both state and national levels, we identified areas that NYSDOH staff may want to look at more closely as it analyzes the Medicare data from more recent years.<sup>29</sup> These areas include:

- **Nursing facility services.** While annual Medicaid expenditures per dual eligible enrollee in New York were more than 50% above the national average in 2006, Medicare expenditures per dual for skilled nursing facility services were substantially below the national average.
- **Home health services.** Annual Medicaid expenditures per dual enrollee in New York were substantially higher than the national average, while Medicare expenditures per dual were significantly below the national average.
- **Durable medical equipment.** Both Medicare and the Medicaid expenditures for DME per dual eligible in New York were substantially below the national average.
- **Hospice services.** Both Medicare and Medicaid expenditures for hospice services per dual eligible enrollee in New York were substantially below the national average.

There are a variety of potential explanations for these expenditure patterns, so this kind of analysis of linked Medicare and Medicaid data is just a starting point for discussion of possible policy or program design options. The relatively low Medicare expenditures per dual eligible for nursing facility and home health services in New York suggests, for example, that extensive use of these services in Medicaid may be substituting, to some extent, for comparable Medicare services. The relatively low expenditures per dual eligible by both Medicare and Medicaid

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<sup>28</sup> Birnbaum, et al, p. 7.

<sup>29</sup> The CMS Medicare-Medicaid Coordination Office is preparing state-by-state data profiles for dual eligibles through 2007 that should be available soon, so New York and other states should be able to make similar state-by state and national comparisons when those data become available.

## Dual Eligibles, Costs, Care Fragmentation, and Who Pays For It *(continued)*

for DME and hospice services in New York also suggests that other Medicaid services may be substituting for these services. Personal care assistance and home health services, for example, might lessen the perceived need for wheelchairs and other types of DME among some homebound beneficiaries, while Medicaid nursing facility services may be substituting to some extent for hospice services. More detailed analysis of this service-by-service expenditure data is needed to determine whether this substitution is occurring, however, and the appropriate policy or program design responses. It is also important to look at more than one year of data to determine if these service use patterns persist over time.

# Options for Integrated Care for Dual Eligibles in New York

## Introduction and Overview

**B**oth the State initiatives and the Federal dual eligible demonstrations share the goal of developing approaches to coordinating care for dual eligibles that bring together primary, acute, behavioral health, and LTSS for individual beneficiaries—services that are now divided between Medicare and Medicaid, and fragmented within Medicaid in New York and in other states.

A number of New York's current programs could serve as the building blocks for a more integrated system of care for dual eligibles, and the MRT recommendations related to dual eligibles have put New York on a path toward fuller integration over the next three to five years. The dual eligible demonstration program that NYSDOH is designing with CMS funding requires a demonstration design proposal by April 2012 and—if CMS approves the demonstration—implementation by January 1, 2013. The Federal demonstration would therefore be operating within a shorter timeframe than most of the State's MRT dual eligible initiatives.

**Use the dual eligible demonstration to test potential improvements.** A CMS-funded Federal dual eligible demonstration that started by January 2013 would permit New York to test ways of providing fully integrated Medicare and Medicaid services for dual eligibles on a smaller or more geographically limited scale than is ultimately planned for the State MRT initiatives. The approaches that proved most effective could then be incorporated in the broader and longer-term State MRT initiatives related to duals. The broader State dual eligible initiatives are focused initially on managed long-term care, for example, with less emphasis on the linkages to primary and acute care that will ultimately be needed for full integration. Similarly, State MRT initiatives related to behavioral health care—a major need for a large portion of dual eligibles under the age of 65—are not as fully integrated with physical health services for dual eligibles as they may ultimately need to be. A dual eligible demonstration could incorporate some of these linkages on a smaller scale to help determine how to implement them more broadly.

There are also challenges in this approach, however, because designing and implementing a smaller and more fully integrated program or programs for dual eligibles in the context of a demonstration may distract NYSDOH, health plans, providers, and other stakeholders from the extensive work they need to do to implement the broader State MRT initiatives successfully over the next three to five years. The challenge for NYSDOH and others is to use the demonstration as a learning laboratory to inform and strengthen implementation of the MRT dual eligible initiatives, incorporating the most successful aspects of the demonstration into the MRT initiatives as they are implemented over time.

To help inform consideration of these options, we first provide a brief overview of the programs in New York that currently serve dual eligibles, or that could be adapted to do so. We then summarize the MRT initiatives related to dual eligibles and the timeframe for their

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

implementation. Finally, we outline options for the dual eligible demonstration, and discuss ways in which the demonstration could be used to support the longer-term goal of full integration of Medicare and Medicaid services for dual eligibles in New York.

Because the dual eligible demonstration, if approved by CMS, will operate under more flexible Federal Medicare and Medicaid rules and can be limited geographically to discrete portions of the State, it may present opportunities to test approaches that are not currently incorporated in MRT initiatives, but that may warrant broader adoption if successful in the demonstration. The Federal demonstration should be highly visible in New York and nationally, and will be evaluated by a CMS-funded independent evaluator, making it possible to assess the value of the demonstration's approaches before they are adopted more broadly.

### Current Medicaid and Medicare Managed Care Programs in New York

As shown in Table 3, New York has a number of different types of Medicaid and Medicare managed care that can be built upon to provide more fully integrated care for dual eligibles. The first three programs in the table—Partial Capitation Managed Long Term Care (MLTC), Medicaid Advantage Plus (MAP), and PACE—all cover dual eligibles with substantial LTSS needs. MAP and PACE also cover primary and acute care services for dual eligibles, either through a companion Medicare Advantage (MA) plan, as in MAP, or directly, as in PACE. As shown in the table, these programs currently have relatively low enrollment, and most of it is concentrated in the New York City area.

Medicaid Advantage also provides Medicare coverage through companion MA plans, but—unlike the Medicaid Advantage Plus program—does not cover most Medicaid LTSS. The Medicaid Advantage program has approximately 6,000 enrollees, mostly in the New York City area. Mainstream Medicaid Managed Care does not currently cover dual eligibles, but the program does cover most Medicaid primary and acute care services for more than 300,000 Medicaid SSI enrollees statewide, and they have characteristics and care needs that are very similar to those of many under-65 dual eligibles. The program only covers limited behavioral health services, however, and it does not cover most LTSS, so enrollees must obtain those services from the Medicaid FFS program.

Finally, Medicare Advantage Special Needs Plans (SNPs) currently enroll more than 100,000 Medicare beneficiaries statewide, almost all of whom are dual eligibles. In most cases, these Medicare SNPs do not currently cover Medicaid services, but Federal law requires Dual Eligible SNPs to have contracts with state Medicaid agencies by 2013, so SNPs represent an important option for integration of Medicare and Medicaid services over the next few years.<sup>30</sup>

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<sup>30</sup> The other two SNP types—Chronic Condition SNPs and Institutional SNPs—are not required to contract with state Medicaid agencies, but their enrollment in New York is quite low relative to that of Dual Eligible SNPs, and only about half of their enrollees are dual eligibles. In September 2011, 103,229 of the 111,787 total enrollees in SNPs statewide were in Dual Eligible SNPs.

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

**TABLE 3. Medicaid and Medicare Managed Care Programs in New York**

PROGRAM NAME	POPULATION COVERED	BENEFITS COVERED	SERVICES PAID FOR BY MEDICAID FEE-FOR-SERVICE	NUMBER OF OPERATIONAL PLANS	ENROLLMENT AS OF SEPTEMBER 2011
Partial Capitation Managed Long Term Care	<ul style="list-style-type: none"> <li>• 18 years of age or older</li> <li>• Voluntary enrollment</li> <li>• Require nursing home level of care</li> <li>• Need long-term care services for at least 120 days</li> <li>• Dual eligible or Medicaid-only</li> <li>• Can be concurrently enrolled in a Medicare Advantage plan</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid long-term supports and services (LTSS), transportation, and some ancillary services</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital, physician, pharmacy, and all other Medicaid services not covered by the plan</li> </ul>	14	34,323
Medicaid Advantage Plus	<ul style="list-style-type: none"> <li>• 18 years of age or older</li> <li>• Voluntary enrollment</li> <li>• Require nursing home level of care</li> <li>• Need long-term care services for at least 120 days</li> <li>• Must be a dual eligible with full Medicaid coverage</li> <li>• Must be enrolled in a companion Medicare Advantage plan</li> </ul>	<ul style="list-style-type: none"> <li>• Almost all Medicaid primary, acute, and LTSS</li> </ul>	<ul style="list-style-type: none"> <li>• Limited special needs services and over-the-counter pharmacy</li> </ul>	8	1,548
Program of All-Inclusive Care for the Elderly (PACE)	<ul style="list-style-type: none"> <li>• 55 years of age or older</li> <li>• Voluntary enrollment</li> <li>• Require nursing home level of care</li> <li>• Need long-term care services for at least 120 days</li> <li>• Dual eligible, Medicare-only, Medicaid-only, or private pay</li> </ul>	<ul style="list-style-type: none"> <li>• All Medicaid and Medicare services</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	7	3,789
Medicaid Advantage	<ul style="list-style-type: none"> <li>• 18 years of age or older</li> <li>• Voluntary enrollment</li> <li>• Must be a dual eligible with full Medicaid coverage</li> <li>• Must be enrolled in a companion Medicare Advantage plan</li> <li>• Must disenroll if nursing home placement is permanent</li> </ul>	<ul style="list-style-type: none"> <li>• Most Medicaid and Medicare services</li> <li>• Medicare beneficiary cost sharing</li> </ul>	<ul style="list-style-type: none"> <li>• Most Medicaid LTSS and Rx drugs not covered by Medicare Part D</li> </ul>	11	6,105
Mainstream Medicaid Managed Care	<ul style="list-style-type: none"> <li>• State residents with full Medicaid eligibility</li> <li>• Mandatory enrollment in most counties</li> <li>• Dual eligibles and permanent residents of nursing homes may not enroll</li> </ul>	<ul style="list-style-type: none"> <li>• Most Medicaid primary and acute care services</li> <li>• Limited behavioral health services</li> </ul>	<ul style="list-style-type: none"> <li>• Most LTSS</li> <li>• Most behavioral health for SSI enrollees</li> </ul>	29	309,793 (SSI/disabled enrollees only)
Medicare Advantage Special Needs Plan (SNP)	<ul style="list-style-type: none"> <li>• Medicare beneficiaries who are a dual eligible, or require an institutional level of care, or have a chronic or disabling condition</li> <li>• Voluntary enrollment</li> <li>• Dual eligibles may receive Medicaid services through the SNP, Medicaid Advantage Plus, Medicaid Advantage, or Medicaid FFS</li> </ul>	<ul style="list-style-type: none"> <li>• All Medicare services</li> <li>• Some Medicaid services if dual eligible beneficiary is enrolled in a companion Medicaid Advantage or Medicaid Advantage Plus plan</li> </ul>	<ul style="list-style-type: none"> <li>• All Medicaid services, except to the extent they are included in a companion Medicare Advantage or Medicaid Advantage Plus plan</li> </ul>	48 <sup>a</sup>	111,787 (Includes Dual Eligible, Institutional, and Chronic Condition SNPs)

**SOURCES:** New York State Department of Health. "NYS Public Managed Care Programs." April 2010. Available at: [http://www.health.ny.gov/professionals/patients/discharge\\_planning/docs/managed\\_care\\_program\\_comparison.pdf](http://www.health.ny.gov/professionals/patients/discharge_planning/docs/managed_care_program_comparison.pdf). New York State Department of Health Proposal, "State Demonstrations to Integrate Care for Dual Eligibles," January 28, 2011. Available at: [http://www.healthcarereform.ny.gov/docs/integrating\\_care\\_initiative.pdf](http://www.healthcarereform.ny.gov/docs/integrating_care_initiative.pdf). Both accessed on November 1, 2011. Number of operational plans and September 2011 enrollment are from Table 5 in this report.

<sup>a</sup>A single company may operate several SNP plans. The 48 plans included in the table are operated by 22 companies.

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

### **Implications for Dual Eligible Integrated Care Initiatives**

The MLTC, MAP, and PACE plans all have benefit packages that include LTSS, which is crucial for fully integrated care for dual eligibles. The MAP and PACE enrollment is quite low, however, and is heavily concentrated in the New York City area, so these models may not be easy to expand to other areas of the State. The MLTC enrollment is substantially higher and somewhat less concentrated in the New York City area, but primary and acute care is largely missing from the capitated benefit package. As discussed more fully below, however, including LTSS in managed care is substantially more challenging than including primary and acute care, and many of the entities operating MLTC plans also operate plans that cover primary and acute care services. Thus, the MLTC plans have substantial advantages as building blocks for integrated care for dual eligibles.

The Medicaid Advantage and Mainstream Medicaid Managed Care plans do not cover LTSS, but the Mainstream plans have substantial enrollment throughout the State, including more than 300,000 SSI/disabled enrollees whose characteristics and care needs are very similar to those of dual eligibles under age 65. If LTSS could be included in the benefit package for those programs, they could also provide a viable platform for integrated care for dual eligibles.

The important missing piece in most of these programs (except for MAP and PACE) is the Medicare services that dual eligibles need. Medicare SNPs provide those services, but in most cases do not have contracts with the State for coverage of Medicaid services. This is likely to change by 2013, however, so these plans could also be viable platforms for fully integrated care in the areas of the State where they are available. (Most currently operate in New York City and surrounding counties.)

### **Major State MRT Initiatives Related to Dual Eligibles**

As shown in Table 4, one specific State MRT initiative is directly related to the dual eligible demonstration NYSDOH is developing. The broadest-ranging MRT initiative related to dual eligibles is the requirement for mandatory enrollment in Managed Long Term Care (MLTC) programs starting in April 2012 in New York City for Medicaid beneficiaries (including dual eligibles) who need LTSS for 120 days or more, and extending statewide as MLTC and related capacity is developed. MLTC plans include the Partial Capitation MLTC, MAP, and PACE plans discussed above and shown in Table 3.

Another major MRT initiative related to dual eligibles involves developing health homes for high-cost, high-need Medicaid beneficiaries, including dual eligibles, focusing in particular on beneficiaries with complex physical and behavioral health care needs. Health home programs were authorized in 2010 by the Affordable Care Act, which allows states to receive 90% Federal funding for certain specified health home care coordination activities for a two-year period. Health homes can operate in the Medicaid FFS system, or they can be incorporated into capitated Medicaid managed care programs. Their focus on integrating physical and behavioral

## Options for Integrated Care for Dual Eligibles in New York (continued)

**TABLE 4. New York Medicaid Redesign Team Initiatives Related to Dual Eligibles**

MRT INITIATIVE	TIMELINE	IMPACT ON DUAL ELIGIBLES	SERVICES COVERED	POTENTIAL CARE COORDINATION PROGRAMS OR ENTITIES
<p>Develop Initiatives to Integrate and Manage Care for Dual Eligibles (#101)</p> <ul style="list-style-type: none"> <li>Develop demonstration proposal for submission to CMS</li> <li>Submit proposal to CMS</li> <li>Implement demonstration, if approved by CMS</li> </ul>	<ul style="list-style-type: none"> <li>April 2011–April 2012</li> <li>April 1, 2012</li> <li>October 1, 2012</li> </ul>	<ul style="list-style-type: none"> <li>Direct</li> </ul>	<ul style="list-style-type: none"> <li>All Medicaid and Medicare services</li> </ul>	<ul style="list-style-type: none"> <li>Partial Cap MLTC</li> <li>MAP</li> <li>PACE</li> <li>Medicaid Advantage</li> <li>Mainstream Medicaid Managed Care</li> <li>SNPs</li> <li>Other</li> </ul>
<p>Mandatory Enrollment in Managed Long Term Care (MLTC) Plans/Health Home Conversion (#90)</p> <ul style="list-style-type: none"> <li>Health Home capacity added to MLTC plans</li> <li>Individuals in NYC needing LTSS for more than 120 days required to enroll in MLTC plans</li> <li>Nursing facility residents required to enroll</li> <li>Individuals with developmental disabilities required to enroll, if capacity exists</li> </ul>	<ul style="list-style-type: none"> <li>November 1, 2011</li> <li>April 1, 2012</li> <li>October 1, 2012</li> <li>April 1, 2013</li> </ul>	<ul style="list-style-type: none"> <li>Duals included</li> </ul>	<ul style="list-style-type: none"> <li>MAP and PACE: All Medicare and Medicaid Services</li> <li>Partial Cap MLTC: Nursing facility, HCBS, and ancillary LTSS</li> </ul>	<p>MAP, PACE, and Partial Cap MLTC</p>
<p>Implement Health Home for High-Cost, High-Need Enrollees (#89)</p> <ul style="list-style-type: none"> <li>Health Home provider application form issued</li> <li>Provider applications due</li> <li>Implementation scheduled</li> </ul>	<ul style="list-style-type: none"> <li>August 2, 2011</li> <li>October 3, 2011</li> <li>November 1, 2011</li> </ul>	<ul style="list-style-type: none"> <li>Applies mainly to Medicaid-only beneficiaries, but dual eligibles are included</li> <li>Goal is to enhance coordination of medical and behavioral health care, with focus on persons with multiple chronic illnesses</li> </ul>	<p>Comprehensive care management</p> <ul style="list-style-type: none"> <li>Care coordination and health promotion</li> <li>Comprehensive transitional care from inpatient to other settings</li> <li>Individual and family support</li> <li>Referral to community and social support services</li> <li>Use of health information technology to link services</li> </ul>	<ul style="list-style-type: none"> <li>MCOs</li> <li>BHOs</li> <li>Other entities capable of providing comprehensive, coordinated, and integrated health home services</li> </ul>
<p>Establish Behavioral Health Organizations to Manage Carved-Out Behavioral Health Services (#93)</p> <ul style="list-style-type: none"> <li>Regional BHO RFP issued</li> <li>Conditional awards announced</li> <li>Contract start date</li> </ul>	<ul style="list-style-type: none"> <li>June 24, 2011</li> <li>August 1, 2011</li> <li>October 1, 2011</li> </ul>	<ul style="list-style-type: none"> <li>Duals excluded in the first year</li> </ul>	<ul style="list-style-type: none"> <li>Management of behavioral health services for those not enrolled in managed care, and for SSI enrollees in Mainstream Medicaid Managed Care, whose behavioral health services are currently provided on a FFS basis (i.e., “carved out” of the MMMC benefit package)</li> </ul>	<ul style="list-style-type: none"> <li>Organizations with the capabilities needed to coordinate behavioral and physical health services and reduce avoidable inpatient hospital use</li> </ul>

**SOURCE:** Medicaid Redesign Team web site ([http://www.health.ny.gov/health\\_care/medicaid/redesign/](http://www.health.ny.gov/health_care/medicaid/redesign/)) and authors' analysis.

**PARTIAL CAP MLTC** = Partial Capitation Managed Long-Term Care

**MAP** = Medicaid Advantage Plus

**PACE** = Program of All-Inclusive Care for the Elderly

**SNPS** = Medicare Advantage Special Needs Plans

**MCO** = Managed Care Organization

**BHO** = Behavioral Health Organization

**HCBS** = Home- and community-based services

**LTSS** = Long term supports and services

**SSI** = Supplemental Security Income

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

health care may be especially valuable for dual eligible beneficiaries under age 65, who often have extensive behavioral health care needs.

Finally, the MRT initiative to establish regional Behavioral Health Organizations (BHOs) to manage behavioral health services, which are carved out of capitated managed care programs and provided in the Medicaid FFS system, has important implications for dual eligibles, since most of their Medicaid behavioral health services are currently provided through the FFS system. Integrating or coordinating these services with Medicare and Medicaid primary, acute, and long-term supports and services for dual eligibles will represent a major challenge for New York over the next few years.

### Dual Eligible Options for New York

New York can take advantage of the confluence of the State and Federal initiatives to develop integrated care programs for dual eligibles that have a solid basis in experience and that can grow and strengthen over time. The remainder of this section outlines ways in which New York can build upon this opportunity.

#### **Use the Dual Eligible Demonstration to Support and Enhance State Dual Eligible Initiatives**

The CMS dual eligible demonstration NYSDOH is designing can be used to help New York to move more quickly and comprehensively toward fully integrated Medicare and Medicaid services for dual eligibles than is currently being planned in the MRT process. In particular, New York could use the dual eligible demonstration to strengthen the links between primary/acute services and long-term supports and services, and the links between behavioral and physical health care. In addition, the demonstration provides opportunities for New York to share directly in Medicare savings that may result from better integration and coordination of Medicare and Medicaid services. The inability of states to share in the Medicare savings from reductions in hospital use and other costly Medicare services that result from Medicaid investments in improved care coordination has been a substantial obstacle to integrated care in New York and other states.

#### **Require Greater Integration of All Medicaid and Medicare Services in Capitated Managed Care Programs**

NYSDOH could require MCOs or other care coordination entities participating in the demonstration to cover all Medicare and Medicaid primary, acute, behavioral health, and long-term supports and services for dual eligibles, or to have close contractual relationships with entities that do. As noted above, the existing health plans in New York currently cover some, but not all, of these services in the capitated benefit package.

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

There are several ways in which New York could require or authorize full integration of all these key services for dual eligibles:

- **Long-term supports and services.** As part of the MRT initiatives, personal care services were included in capitated MLTC as of August 1, 2011, long-term home health care and related services are to be included starting April 1, 2012, nursing home services starting October 1, 2012, and institutional and other services for persons with developmental disabilities starting April 1, 2013.
  - These initiatives could be incorporated into a Federal dual eligible demonstration, perhaps relying on the health plans that show the greatest promise and interest in integrating LTSS with primary, acute, and behavioral health care services, and that have the capacity to cover broad areas of the state over the next few years.
- **Primary and acute care services.** While most MLTC plans cover only limited primary and acute care services, the 2011 State legislation authorizing additional MLTC plans requires that MLTC plans “have the readiness and capability to arrange and manage covered services and coordinate non-covered services which could include primary, specialty, and acute care services” funded by Medicaid. The legislation further provides that MLTC plans “may also cover primary and acute care if so authorized.”<sup>31</sup>
  - Building on this new legislative authority, NYSDOH could require MLTC plans that participate in the demonstration to cover, or at least coordinate, primary and acute care services to the maximum extent possible, so that these primary and acute care services are integrated with the LTSS that these plans currently cover.
  - For dual eligibles, integration of primary and acute care services would require MLTC plans to become or partner with Medicare Advantage health plans, since Medicare covers almost all of the primary and acute care services used by dual eligibles. The dual eligible demonstration may provide or allow for other ways of including these Medicare services in the benefit package for dual eligibles.
- **Behavioral health services.** Most behavioral health services are not covered by partial capitation MLTC plans, although they are covered in MAP and PACE plans. Mainstream Medicaid managed care plans cover only very limited behavioral health services for their SSI enrollees. Although new Regional BHOs will begin monitoring and reporting on behavioral health use of inpatient hospital and related services in FFS settings, dual eligibles are explicitly excluded from this initiative, at least for the first year.
  - Health plans or other care coordination entities in the dual eligible demonstration could make their own initial arrangements for behavioral health care services for dual eligibles in

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<sup>31</sup> New York State Public Health Act, as amended in 2011, Title 44, Sections 4403-f(3)(f) and 4403-f(1)(d).

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

2012 without conflicting with this MRT Regional BHO initiative, and could then build upon or coordinate with it over time.

- As discussed below, the dual eligible demonstration could also build upon New York's initiatives to develop "health homes" aimed at enhancing coordination of medical and behavioral health care for persons with multiple chronic illnesses, including dual eligibles.

### **Use the CMS Financial Alignment Models to Help Finance More Integrated Benefits for Dual Eligibles**

To provide the financial incentives and resources needed to bring the fragmented pieces of the care system for dual eligibles in New York together, there must be a way for the State and health plans to share in the savings to Medicare that can result from better integration and coordination of Medicare and Medicaid services for dual eligibles. The major potential sources for these savings are reduced use of avoidable Medicaid inpatient hospital, emergency room, and skilled nursing facility services. There may also be savings for Medicare, Medicaid, or both from more cost-effective and efficient use of services that are provided by both programs, such as home health care, durable medical equipment, nursing facility services, and hospice. CMS has recently made available two major ways for states and health plans to share in these savings.

**CMS financial models to support integration.** As described in a July 8, 2011, CMS letter to state Medicaid directors, there are two main ways for New York and other states to share in the Medicare savings that can result from better coordination and integration of care for dual eligibles:<sup>32</sup>

- **Capitated model.** In this model, the state, CMS, and health plans enter into a three-way contract in which capitated payments from the state and CMS are blended at the health plan level, with state and CMS actuaries jointly estimating the appropriate capitated rates and the savings that may result. The selection of health plans to participate in this arrangement would be conducted jointly by the state and CMS, through a procurement or other mutually agreed-upon process. This model is aimed at states like New York that already have a substantial Medicaid and Medicare managed care infrastructure.
- **Managed FFS model.** States that have not developed a capitated managed care infrastructure or that—like New York—may not have that infrastructure in all parts of the state, can work jointly with CMS to better coordinate their Medicaid FFS program for duals with Medicare services in the state. In this model, CMS would make retrospective performance-based payments to states based on Medicare savings achieved through better integration of Medicaid and Medicare services for dual eligibles. Since New York currently envisions

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<sup>32</sup> Cindy Mann and Melanie Bella, "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees," July 8, 2011. Available at: [http://www.cms.gov/smdl/downloads/Financial\\_Models\\_Supporting\\_Integrated\\_Care\\_SMD.pdf](http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf).

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

expansion of capitated managed care throughout the State over the next three to five years, this managed FFS model may be worth considering as an interim transitional approach in some upstate areas.

### **Use Three-Way Capitated Contracts to Broaden and Integrate the Benefit Packages for Dual Eligibles**

Three-way capitated contracts among New York State, CMS, and health plans that provide a fully integrated package of Medicare and Medicaid benefits for dual eligibles could be the glue that helps bring together many of the integrated care building blocks that already exist in New York. Health plans themselves must first pull together the organizational resources needed to provide fully integrated care for dual eligibles, including both Medicaid and Medicare acute care, behavioral health care, and LTSS. Few plans in New York have all of these resources in one health plan, although there are companies and organizations that own individual plans that provide some, but not all, of those services. In those cases, the organization could build fully integrated capacity from within. In other cases, partnerships among various entities may be a feasible approach.

**Health plan building blocks for integrated care and emerging plan partnerships.** Few health plans in New York currently integrate Medicare and Medicaid acute care, behavioral health care, and LTSS. However, as shown in Table 5, a number of health plans have enrollment in several models that, if combined, could provide a fully integrated benefit package. CMS and the State could contract jointly with those plans for purposes of the dual eligible demonstration. Some examples of plan combinations that might be candidates for such three-way contracts include:

- **Medicare SNPs and Medicaid plans.** Affinity, Amerigroup, Elderplan, GuildNet, Healthfirst, Health Plus, HIP/EmblemHealth, Independent Health Association, MetroPlus, New York State Catholic Health Plan (Fidelis), Senior Whole Health, Touchstone/Prestige, UnitedHealthCare, Visiting Nurse Service of New York, and WellCare all operate both SNPs and Medicaid managed care plans, although not necessarily in the same geographic areas.
- **Partial Capitation MLTC and Mainstream Medicaid Managed Care.** Amerigroup, Healthfirst, New York State Catholic Health Plan, and WellCare operate both types of plans, which could facilitate the addition of acute care capacity to the Partial Capitation MLTC plans, and/or the addition of LTSS to the Mainstream Medicaid Managed Care plans.
- **Behavioral health services.** Since behavioral health services are carved out of the Mainstream Medicaid Managed Care benefit package for SSI enrollees in New York, and since partial capitation MLTC plans do not cover behavioral health services, most health plans in New York would have to add behavioral health capability for the dual demonstration. Health plans may have, or be able to acquire, those capabilities for purposes of the demonstration, perhaps by adding health homes capabilities, or by partnering with newly established Regional Behavioral Health Organizations.

## Options for Integrated Care for Dual Eligibles in New York (continued)

**TABLE 5. Dual Eligible Demonstration Building Blocks—New York State Health Plan Enrollment, September 2011**

PLAN NAME	MAINSTREAM MEDICAID MANAGED CARE - SSI	PARTIAL CAPITATION MLTC	PACE	MEDICAID ADVANTAGE	MEDICAID ADVANTAGE PLUS	MEDICARE ADVANTAGE SPECIAL NEEDS PLANS <sup>a</sup>
Affinity	21,367	—	—	258	—	3,195
Amerigroup	5,272	1,275	—	—	11	439
ArchCare/Catholic SNP	—	—	177	—	—	1,006
Comprehensive Care Management/CCM Select	—	2,778	2,684	—	—	224
Elderplan	—	4,314	—	1	505	1,585
GuildNet	—	6,583	—	—	360	350
Healthfirst/Managed Health, Inc./ Senior Health Partners—TOTAL	45,461	3,017	—	138	—	50,045
• Upstate	—	—	—	—	—	—
• NYC <sup>b</sup>	45,461	3,017	—	138	—	50,045
Health Plus	18,770	—	—	—	—	2,240
HIP/GHI/EmblemHealth	25,910	—	—	2,244	227	12,188
Independent Health Association	6,038	—	—	—	—	1,274
MetroPlus	34,797	—	—	147	—	4,109
NYS Catholic Health Plan (Fidelis) - TOTAL	49,428	410	—	1,154	62	2,608
• Upstate	26,360	410	—	141	24	—
• NYC <sup>c</sup>	23,068	—	—	1,013	38	—
Senior Whole Health	—	—	—	553	259	807
Touchstone/Prestige	—	—	—	1,205	—	1,677
United/Evercare/Oxford	19,909	—	—	25	—	17,097
VNS	—	9,414	—	—	75	4,760
WellCare	5,415	1,629	—	—	49	7,267
Other <sup>d</sup>	77,426	4,903	928	380	—	916
Total plan type enrollment	309,793	34,323	3,789	6,105	1,548	111,787

**SOURCES:** (1) New York Department of Health. Monthly Medicaid Managed Care Enrollment, September 2011. Available from [http://www.health.state.ny.us/health\\_care/managed\\_care/reports/enrollment/monthly/index.htm](http://www.health.state.ny.us/health_care/managed_care/reports/enrollment/monthly/index.htm); and (2) CMS Special Needs Plan Comprehensive Report, September 2011.

<sup>a</sup> Includes Chronic or Disabling Condition, Dual-Eligible, and Institutional Special Needs Plan types.

<sup>b</sup> NYC includes only the 5-borough area.

<sup>c</sup> NYC includes New York City, Nassau, Suffolk, and Westchester Counties.

<sup>d</sup> Other plans include: Amida Care SN, Arcadian Health Plan of New York, Capital District Physicians Health Plan, CHS Buffalo Life, Eddy Senior Care, Elant, ElderServe, Excellus, HealthNow/BCBS-WNY/Community Blue, HHH Choices, Hudson Health Plan, Independence Care Systems, Independent Living for Seniors, Liberty Health Advantage, MVP Health Plan, Neighborhood Health Providers, NYPS Select Health SN, PACE CNY, PCMP II-A Special Care, SCHC Total Care, Senior Network Health, Southern Tier, Total Aging in Place Program, Total Senior Care, and Univera.

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

In addition to plans shown in Table 5 that are already operating one or more types of plans in specific areas of the State, there may be new plans that want to participate in the demonstration, existing plans that want to expand to cover new geographic areas, or new partnerships that will be formed for purposes of the demonstration. For example, some new health plan partnerships have already begun to form in New York:

- **Healthfirst acquisition of Senior Health Partners (August 2010).** Healthfirst, a 560,000-member not-for-profit health plan with large enrollment in Mainstream Medicaid Managed Care and a Medicare Advantage SNP, acquired Senior Health Partners, a 2,200-member partial capitation MLTC plan, in August 2010, substantially increasing Healthfirst's ability to manage LTSS.<sup>33</sup> (See Table 5 for enrollment details.)
- **Amerigroup purchase agreement with Health Plus (October 2011).** Amerigroup, a for-profit plan with 109,000 Medicaid enrollees in New York, including Mainstream Medicaid Managed Care, partial capitation MLTC, MAP, and a Medicare Advantage SNP, announced a purchase agreement with Health Plus on October 25, 2011. Health Plus has 320,000 total enrollees in New York, including Mainstream Medicaid Managed Care and a Medicare Advantage SNP. (See Table 5 for enrollment details.)

New York can use the demonstration to encourage these ways of expanding the integrated care options available to dual eligibles, especially those that build on existing health plan capabilities and experience.

### **Use State's Health Homes Initiative to Increase Integration of Behavioral Health Services for Dual Eligibles**

One important resource New York and other states have is the ability to use the Affordable Care Act's new authority to strengthen care coordination in both the FFS and managed care systems through "health homes."<sup>34</sup> This health homes authority provides 90% Federal funding for eight calendar quarters to support a variety of care management and care coordination activities for Medicaid beneficiaries—including dual eligibles—with multiple chronic illnesses, including both physical and behavioral health conditions. As shown in Table 4, New York is moving aggressively to take advantage of this health homes opportunity, focusing in particular on using it as a way of improving the coordination of physical and behavioral health services for beneficiaries with multiple chronic illnesses, including dual eligibles.

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<sup>33</sup> For details, see "Healthfirst Acquires Senior Health Partners" at: <http://www.healthfirstny.org/press/Healthfirst-Acquires-Senior-Health-Partners.asp>. Accessed November 6, 2011.

<sup>34</sup> Section 2703 of the Patient Protection and Affordable Care Act.

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

According to NYSDOH estimates in July 2011, there are nearly 1 million Medicaid beneficiaries in the State with complex physical and behavioral health conditions who could benefit from the greater coordination health homes could provide, and nearly one-third are dual eligibles.<sup>35</sup> Approximately half of these Medicaid beneficiaries with complex conditions are in Medicaid managed care. Health homes may be used in either FFS or managed care settings, so they could be used as a way of more fully integrating behavioral health into capitated plans.

New York's current plans for using health homes resources in Medicaid managed care envision use of this new capacity primarily for beneficiaries needing LTSS for fewer than 120 days. Since the MLTC plans currently cover only beneficiaries who need LTSS for 120 days or more, there is little overlap between these two initiatives. If MLTC coverage is expanded to include primary and acute care services, however, these plans will need to have care coordination and behavioral health capacities similar to those in health homes. It may be more effective for MLTC and related plans to develop these capacities internally, funding them through the reductions in unnecessary use of costly inpatient, emergency room, and nursing facility services that are likely to result from better coordination of services. As an interim or transitional measure, however, New York may want to make health homes resources available to MLTC and related plans that need short-term assistance in developing these care coordination capacities.

For Mainstream Medicaid Managed Care Plans, which have demonstrated the ability to cover acute care services for Medicaid-only SSI beneficiaries, health homes could be used to supply better links to behavioral health, if these plans wanted to participate in the dual eligible demonstration. As with the MLTC plans, an important consideration for both the State and the health plans is whether the plans can develop and finance these links with behavioral health services internally, or whether additional interim assistance from the health homes initiative would facilitate development of this capacity.

### **Use Health Homes Funding to Cover Initial Medicaid Care Coordination Costs**

In both the Capitated and the Managed FFS models, the State faces the risk that the Medicaid resources devoted to improved coordination may not result in the savings upon which the projected capitated rates are predicated in the Capitated Model, or in the retrospectively calculated savings in the Managed FFS model. To hedge against this risk, it is prudent for states to take maximum advantage of the upfront 90% Federal match for health home services to cover some of the Medicaid investment in care coordination, as New York is currently doing.

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<sup>35</sup> Presentation by Greg Allen to the Medicaid Redesign Team Behavioral Health Work Group, July 12, 2011, Slide 14. Available on the MRT website at: [http://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health\\_reform.htm](http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_reform.htm). Accessed November 6, 2011.

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

The two years of enhanced health homes funding for care coordination can help fill the gap in time between states' initial investment in care coordination activities and the return on that investment, which can take a year or more to show up in the form of reduced use of Medicare inpatient hospital, emergency room, and other costly services. In addition, it is commonly the case that beneficiaries with complex care needs who have been served primarily in the FFS system will come into managed care with accumulated and costly unmet care needs that must be addressed before their use of expensive services can be reduced.

### **Use Passive Enrollment to Increase Enrollment in the Dual Eligible Demonstration**

In order to be able to support the enhanced care coordination activities needed to make the demonstration successful, and to increase the likelihood that there will be Medicare savings the State can share in, the Federal demonstration must achieve a significant volume of dual eligible enrollment. CMS has authority to permit states to "passively enroll" dual eligibles in capitated managed care plans for their Medicare services for purposes of the dual eligible demonstration, as long as those who are passively enrolled have the ability to opt out easily and remain in the Medicare FFS system, should they choose to do so. Beneficiaries must be fully informed about their care options, including their ability to return to the Medicare FFS program at any time. This new passive enrollment authority for Medicare services reduces what has been a substantial obstacle to achieving significant enrollment in integrated Medicare and Medicaid programs.<sup>36</sup> States have long had the authority to mandate managed care enrollment for Medicaid services, as long as states receive appropriate Medicaid waiver or state plan approval from CMS.

**Building on existing New York authority and options.** NYSDOH has new State legislative authority to require mandatory enrollment in MLTC and related plans covering Medicaid LTSS for Medicaid beneficiaries who are expected to require LTSS for 120 days or more, including dual eligibles.<sup>37</sup> For Medicaid beneficiaries who do not require 120 days or more of LTSS, enrollment in MLTC and related plans remains voluntary. These MLTC enrollment provisions only apply to Medicaid beneficiaries, and they apply initially only in the New York City area, where almost all MLTC and related plans are located. NYSDOH estimates that there are more than 70,000 dual eligibles in the New York City area who need 120 days or more of LTSS, over 90% of whom are over age 65.<sup>38</sup>

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<sup>36</sup> James M. Verdier, Melanie Au, and Jessica Gillooly. "Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans." Prepared by Mathematica Policy Research for the Medicare Payment Advisory Commission, October 15, 2010. Published by MedPAC in June 2011. Available at: [http://www.medpac.gov/documents/Jun11\\_ManagingDualEligibles\\_CONTRACTOR.pdf](http://www.medpac.gov/documents/Jun11_ManagingDualEligibles_CONTRACTOR.pdf). Accessed December 27, 2011.

<sup>37</sup> New York State Public Health Act, as amended in 2011, Title 44, Sections 4403-f(7)(b)(1).

<sup>38</sup> New York State Department of Health. "Managed Long Term Care: The Next Steps." Presentation to the MRT Managed Long Term Care Implementation and Waiver Redesign Work Group, July 8, 2011, Slide 79. Available at: [http://www.health.ny.gov/health\\_care/medicaid/redesign/managed\\_ltc\\_workgroup.htm](http://www.health.ny.gov/health_care/medicaid/redesign/managed_ltc_workgroup.htm). Accessed November 11, 2011.

## Options for Integrated Care for Dual Eligibles in New York *(continued)*

While MLTC plans themselves do not cover Medicare services, as noted above, many of them are owned by companies that do provide such services through the MAP program and/or through Medicare Advantage SNPs. As a result, there may be opportunities for the State and health plans to build on this expanded dual eligible enrollment in MLTC plans to encourage enrollment in more fully integrated plans for both Medicaid LTSS and Medicare services.

In addition, the State could encourage more extensive use of the MAP program by both health plans and dual eligibles because that program covers both primary/acute care and LTSS, and MAP plans are required to have companion Medicare Advantage plans that cover Medicare benefits for MAP enrollees. The State could provide information to dual eligibles explaining the availability of this option, and health plans themselves could market this option to their enrollees in less integrated plans.

### **Continue and Expand Stakeholder Engagement and Consultation**

The kinds of changes in health plan configurations, benefit coverage, and enrollment requirements that are being phased in through the State MRT process, and that are likely to be included in the dual eligible demonstration that New York is developing, require a substantial degree of consultation with a wide range of stakeholders, including health plans, providers, beneficiaries and their representatives, and others. Much of the success of the MRT process was due to the extensive and open consultation and collaboration that was an integral part of that process, and that has been continued with the work of the State MRT Work Groups.<sup>39</sup>

Stakeholder engagement will be especially important in generating support for State efforts to expand enrollment in the demonstration through passive enrollment of dual eligibles in health plans for their Medicare benefits. Beneficiaries and their representatives will want to be assured that those who are passively enrolled will have the best information possible on enrollment options and the consequences of their choices. Stakeholder engagement in the design and implementation of these beneficiary education and enrollment processes will be crucial to their success.<sup>40</sup>

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<sup>39</sup> The MRT Work Groups and their work are featured at: [http://www.health.state.ny.us/health\\_care/medicaid/redesign/](http://www.health.state.ny.us/health_care/medicaid/redesign/). Accessed October 21, 2011.

<sup>40</sup> For a discussion of effective ways of engaging stakeholders in the development of integrated care programs for dual eligibles, see Alice Lind, "Communicating the Value of Integrated Care to Stakeholders," Center for Health Care Strategies, Policy Brief, November 2011. Available at: [http://www.chcs.org/usr\\_doc/CommunicatingValueof\\_IntegratedCareToStakeholders\\_110211.pdf](http://www.chcs.org/usr_doc/CommunicatingValueof_IntegratedCareToStakeholders_110211.pdf). Accessed December 26, 2011.

# Perspectives and Lessons From Other States

## Overview of Dual Eligible and Related Initiatives in Other States

A number of states have had extensive experience with programs for dual eligibles that are similar to those New York already has in place, and some of those states have programs that come closer to full integration of Medicare and Medicaid services than current programs in New York. New York can build upon these experiences from other states as it crafts approaches that fit its own context for the Federal dual eligible demonstration, and for the State MRT initiatives related to dual eligibles.

In addition to New York, 14 other states are currently developing dual eligible demonstration proposals for submission to CMS in April 2012, and a number of states are developing health homes initiatives similar to the one being implemented in New York.<sup>41</sup> Mathematica is working with these states under a technical assistance contract with CMS; insights from these states are also reflected in this section, to the extent the information from those states and from CMS guidance to them is publicly available.<sup>42</sup>

### Major Examples From Other States

The examples from other states that are likely to be most relevant to New York as it develops programs for dual eligibles are summarized below. Additional details on these states and their programs for dual eligibles are in the Appendix and in Table 6.

- **Medicaid managed long-term care programs.** Arizona, California, Massachusetts, Minnesota, New Mexico, Tennessee, Texas, and Wisconsin have capitated managed care programs that include LTSS for dual eligibles. Unlike the Partial Capitation MLTC program in New York, all of these programs include acute care services in the capitation, except for the Family Care program in Wisconsin. Texas excluded inpatient hospital services from the STAR+PLUS capitation until this year, but inpatient hospital services will be included starting in March 2012.
- **SNP-based programs for dual eligibles.** Arizona, California, Massachusetts, Minnesota, New Mexico, Texas, and Wisconsin all rely on SNPs to varying degrees to provide services to dual eligibles. SNPs in all these states contract with the state to cover Medicaid services for

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<sup>41</sup> For a summary of the latest publicly available information on the status of dual eligible demonstration efforts by the 15 states, see Kaiser Commission on Medicaid and the Uninsured, "Financial Alignment Models for Dual Eligibles: An Update." November 2011. Available at: <http://www.kff.org/medicaid/upload/8260.pdf>. For a summary of the latest information on state health home initiatives, see: [http://www.chcs.org/usr\\_doc/State\\_by\\_State\\_HH\\_SPA\\_matrix\\_120511.pdf](http://www.chcs.org/usr_doc/State_by_State_HH_SPA_matrix_120511.pdf). Both accessed on December 27, 2011.

<sup>42</sup> For the latest information on this technical assistance effort, see the Integrated Care Resource Center website at: <http://www.integratedcareresourcecenter.com/Default.aspx>. Accessed December 27, 2011.

## Perspectives and Lessons From Other States *(continued)*

dual eligibles, but dual eligibles do not necessarily receive all their Medicare and Medicaid services from the SNPs because they are free to receive their Medicare services from the Medicare FFS system or from another Medicare health plan.

- **PACE programs for dual eligibles.** California, Massachusetts, New Mexico, Tennessee, Texas, and Wisconsin all have PACE programs but, as in New York, enrollment is low.
- **Mandatory enrollment of Medicaid SSI/disabled beneficiaries in capitated Medicaid managed care programs.** Arizona, California, Minnesota, New Mexico, Tennessee, and Texas all mandate enrollment of Medicaid-only beneficiaries with disabilities and chronic illness into Medicaid managed care programs, as New York does. Since Medicaid-only SSI beneficiaries have clinical needs that are very similar to those of under-65 dual eligibles, State and health plan experience in providing their care can lay the groundwork for extending this kind of managed care coverage to dual eligibles.
- **FFS-based care management programs for SSI/disabled beneficiaries and/or dual eligibles.** North Carolina, Oklahoma, and Vermont have experience with such programs, which may be of interest for parts of upstate New York where capitated managed care capacity is limited. The CMS Managed FFS financial model for dual demonstration states is intended to support this approach. Health homes initiatives can also be used with this approach.
- **Coordination of behavioral and physical health.** Minnesota, Tennessee, Texas, and Wisconsin include most behavioral health services in capitated Medicaid managed care programs for SSI/disabled enrollees. California, Massachusetts, New Mexico, and North Carolina provide most behavioral health services through separate behavioral health managed care plans or, as New York does, in FFS Medicaid.

### Lessons for New York

Each state has its own context and history, so program models and lessons from implementation of those models in one state cannot be directly applied to other states without an appreciation of those state differences. Nonetheless, there are lessons from these other states that may be useful to New York as it develops its dual eligibles demonstration and continues implementation of duals-related MRT initiatives.

**Building on existing managed care models that cover Medicaid-only beneficiaries with complex care needs is a prudent first step in developing capitated arrangements that cover both Medicare and Medicaid services.** States like New York that have experience with programs like Partial Capitation MLTC and Mainstream Medicaid Managed Care can use these Medicaid-only plans as a building block for more fully integrated models for dual eligibles. Health plan

## Perspectives and Lessons From Other States *(continued)*

capacity, provider networks, information technology infrastructure, financing arrangements, stakeholder relationships, and a track record are already there to build upon. Enrollment can be mandatory for Medicaid services, and most financing and administrative requirements are largely within state control.

**Medicaid Managed long-term care programs can be more difficult to build than managed acute care programs because Medicaid MCO experience with these plans is more limited and provider and beneficiary advocate resistance may be stronger.** While Medicaid managed long-term care programs exist in a number of states, they have all had to face resistance from nursing facility and community-based LTSS providers, and concerns from beneficiaries and their advocates that access to services they need might be diminished. Prior experience with such programs can provide valuable reassurance that critical concerns can be addressed, particularly if those existing programs are well regarded. New York's experience with the Partial Capitation MLTC program gives the State a substantial advantage as it moves to broaden that model to include acute care and Medicare services.

**Coordinating behavioral and physical health services is often a significant challenge.**

While existing models in Minnesota and Wisconsin have been reasonably successful, and promising new initiatives are in place or under development in Arizona, Iowa, Massachusetts, Pennsylvania, Tennessee, and other states, examples of fully integrated programs are still fairly limited. A new technical assistance brief from the CMS-Mathematica-CHCS Integrated Care Resource Center summarizes recent state experiences and options for integrating physical and behavioral health services.<sup>43</sup>

**Building enrollment in managed care plans for dual eligibles that is sufficient to support a care coordination infrastructure and financial viability is likely to require some form of assigned or "passive" enrollment in health plans for Medicare services, with an ability for enrollees to opt out easily.** The only states that currently have substantial enrollment of dual eligibles in SNPs for both their Medicare and Medicaid services are states that were able to passively enroll dual eligibles enrolled in their Medicaid managed care plans in 2006 into newly created SNPs operated by the same plans (Arizona, California, and Minnesota). CMS has authority to approve similar passive enrollment approaches for the dual eligible demonstrations, provided that states can ensure that dual eligibles will be fully informed of the implications of enrolling in a plan for both their Medicare and Medicaid services, and that they will have an easy way to opt out of the plan and obtain their Medicare services elsewhere if they are not satisfied with the integrated managed care arrangement.

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<sup>43</sup> Allison Hamblin, James Verdier, and Melanie Au. "State Options for Integrating Physical and Behavioral Health Care." Technical Assistance Brief, October 2011. Available at: [http://www.integratedcareresourcecenter.com/pdfs/ICRC\\_BH\\_Briefing\\_document\\_1006.pdf](http://www.integratedcareresourcecenter.com/pdfs/ICRC_BH_Briefing_document_1006.pdf). Accessed November 7, 2011.

## Perspectives and Lessons From Other States *(continued)*

**The new CMS financial alignment models to support state efforts to integrate care for dual eligibles can enable states to share in Medicare savings that result from better care coordination, but major program design and implementation issues remain with these models.**

The CMS capitated financial model is similar to the three-way contract arrangement that existed in the Massachusetts Senior Care Options (SCO) program for age 65 and older dual eligibles between 2004 and 2006, and to the contracting model now used in the PACE program. In this capitated model, CMS and the State would contract jointly with health plans to provide both Medicare and Medicaid services on a capitated basis, with the Medicaid portion of the capitation largely determined by the State and its actuaries, and the Medicare portion largely determined by CMS actuaries. The key issue for states in this model is how the CMS actuaries will calculate prospectively the Medicare savings that are likely to result from better integration of Medicaid and Medicare services. How this will be done is still being determined. Similarly, the Managed FFS financial model includes a retrospective calculation of Medicare savings after a year or more of experience with the model in the demonstration context. Again, the CMS actuaries would be largely responsible for making these Medicare savings estimates, and how they would do that is still being determined.

# Conclusions

New York's current managed care programs and the new MRT initiatives position the State well to make major progress in providing more coordinated and integrated care for dual eligibles, both through a Federal dual eligible demonstration and the ongoing implementation of the State MRT initiatives related to dual eligibles:

- **Managed long-term care capacity.** New York's MLTC programs have given the State, health plans, providers, and beneficiaries crucial experience in managing LTSS for dual eligibles and other Medicaid beneficiaries—experience that most other states do not yet have.
- **Mandatory enrollment in Medicaid managed care.** New York's largely successful experience in enrolling Medicaid SSI/disabled beneficiaries on a mandatory basis in Mainstream Medicaid Managed Care, combined with the upcoming mandatory enrollment of Medicaid beneficiaries needing more than 120 days of long-term care into MLTC plans, gives the State a strong base to build upon if passive enrollment of dual eligibles in health plans for their Medicare services is authorized by CMS for the dual eligible demonstration.
- **Behavioral and physical health integration.** Integrating behavioral and physical health care services remains a challenge in New York and in other states, but the new Regional Behavioral Health Organizations and other MRT initiatives related to behavioral health can lay the groundwork for greater integration of these services for dual eligibles in the future.
- **Medicare and Medicaid savings from improved integration.** Medicare and Medicaid savings from improved integration and coordination of care for dual eligibles are more likely when a managed care infrastructure that can be built upon already exists, as it does to a considerable extent in New York. Nonetheless, New York and other states should not expect measurable net savings to show up for a year or more, even under favorable circumstances, since substantial additional investments in care management infrastructure will be needed first, and those costs will offset some of the savings.
- **Support from health homes initiatives.** Health homes initiatives, like those being developed in New York and other states, can help to build the care management infrastructure needed to improve care for Medicaid beneficiaries with costly and complex physical and behavioral health care needs, including dual eligibles, and 90% Federal funding for the first two years is available for specified care coordination activities. This can help cover some of the care management infrastructure costs that might otherwise offset savings from Medicare and Medicaid integration for dual eligibles.

# Appendix

## Summaries of Other State Programs for Dual Eligibles<sup>44</sup>

### ARIZONA

Arizona is unique among states in that almost all Medicaid beneficiaries have been enrolled in capitated managed care arrangements since the inception of the state's Medicaid program in 1982. Arizona provides Medicaid managed care coverage for dual eligibles through the Arizona Health Care Cost Containment System (AHCCCS), which covers Medicaid acute care services, and through the Arizona Long Term Care System (ALTCS), which is under the AHCCCS umbrella and covers Medicaid acute and long-term care services for those in need of nursing facility-level care. Enrollment in the programs is mandatory for almost all Medicaid beneficiaries, including dual eligibles both over and under the age of 65. Arizona required participating AHCCCS plans in Maricopa County (Phoenix) to become SNPs in 2006 and encouraged ALTCS plans to do so, or at least to partner with SNPs. Dual eligibles enrolled in AHCCCS/ALTCS health plans for Medicaid services in 2006 were "passively enrolled" for Medicare services in companion SNPs operated by the same companies if such SNPs were available, although beneficiaries could choose other Medicare options if they wished.

Largely as a consequence of passive enrollment in 2006, more than 30,000 dual eligibles in Arizona now receive Medicaid and Medicare services from side-by-side Medicaid plans and SNPs run by the same company. Many duals in Arizona are not enrolled in these integrated arrangements, however. While duals enrolled in AHCCCS/ALTCS plans for Medicaid services may choose to receive Medicare services from an SNP operated by the same company, they may also receive those services from another SNP, another Medicare Advantage plan, or Medicare FFS. As of August 2010, 30,902 duals enrolled in AHCCCS/ALTCS plans for Medicaid services received Medicare services from a dual-eligible SNP operated by the same company ("aligned" duals), while 41,862 received Medicare services from another SNP, another MA plan, or Medicare fee-for-service (FFS) ("unaligned" duals).<sup>45</sup> As shown in Table 6, there were approximately 111,000 full dual eligibles in Arizona in 2009.

Arizona has recently announced a new effort to manage the care for individuals with Serious Mental Illness (SMI), to include duals, that would allow one or more "specialty Regional Behavioral Health Organizations (RBHAs)" to be fully at risk for all physical and behavioral health services for the SMI population. Currently, most behavioral health services are carved out of the primary benefit package and provided through Regional Behavioral Health Authorities

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<sup>44</sup> The summaries of most of the state programs in this Appendix and in Table 6 are adapted from James M. Verdier, Melanie Au, and Jessica Gillooly. "Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans." Prepared by Mathematica Policy Research for the Medicare Payment Advisory Commission, October 15, 2010. We updated these summaries, in some cases, to reflect activities in the past year, and added state summaries for California, Tennessee, Texas, and Wisconsin, based largely on information available from state websites.

<sup>45</sup> Email messages from Kari Price of AHCCCS to James Verdier, September 14–16, 2010.

## Appendix (continued)

(RBHAs) that function as specialized managed care organizations. Under the new proposal, the RBHAs will provide more fully integrated physical and behavioral health care by becoming certified as SNPs and by exercising the Medicaid health home option.<sup>46</sup>

### CALIFORNIA

California has covered dual eligibles and other Medicaid beneficiaries for many years in the Medicaid managed care programs in County Organized Health Systems (COHS) in 10 counties (Orange Merced-Monterey-Santa Cruz, Napa-Solano-Sonoma-Yolo, Santa Barbara, San Mateo). Enrollment is mandatory for Medicaid SSI/disabled beneficiaries, and the capitated benefit package covers both acute and long-term care services. Three of the COHS plans also operate Medicare Advantage dual eligible SNPs, which had the following enrollment in February 2012:

- Orange County (OneCare): 13,152
- San Mateo (HPSM Care Advantage): 8,376
- Napa-Solano-Yolo (PartnershipAdvantage): 7,141

California received approval from the Centers for Medicare & Medicaid Services (CMS) in November 2010 to implement a new Section 1115 waiver that authorizes mandatory enrollment of Medicaid seniors and persons with disabilities into managed care medical home arrangements, which could include enhanced primary care case management programs, provider-based accountable care organizations, specialty health care plans, or Medi-Cal managed care health plans. Dual eligibles are exempt from the mandatory enrollment requirement,<sup>47</sup> but the state intends to develop a strategy that addresses duals by the third year of waiver, which could include mandatory enrollment.<sup>48</sup> The majority of plans that California currently contracts with in Medi-Cal do not include long-term care beyond 60 days, so the extent to which nursing facility and HCBS services will be included in these managed care arrangements in the future remains to be determined.

### MASSACHUSETTS

The Massachusetts Senior Care Options (SCO) program began operating in 2004 as a CMS dual demonstration program; the participating managed care organizations converted to SNPs in 2006. Currently, SCO serves only duals age 65 and older, although Massachusetts is currently

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<sup>46</sup> Bethlach, Thomas, and Janice Brewer. "Health Homes for Enrollees with Chronic Conditions." Letter to Cindy Mann, Centers for Medicare and Medicaid Services, March 11, 2011. Accessed September 28, 2011 from: [http://www.azahcccs.gov/reporting/Downloads/HealthCareReform/CoverLetter\\_LetterRequest.pdf](http://www.azahcccs.gov/reporting/Downloads/HealthCareReform/CoverLetter_LetterRequest.pdf).

<sup>47</sup> Artiga, Samantha and Andy Schneider. California's "Bridge to Reform" Medicaid Demonstration Waiver. Kaiser Family Foundation Commission on Medicaid and the Uninsured Policy Brief, June 2011. Publication No. 8197-R. Accessed September 30, 2011 from <http://www.kff.org/medicaid/upload/8197-R.pdf>.

<sup>48</sup> Medi-Cal. California Section 1115 Comprehensive Demonstration Project Waiver Vision for 2014. Accessed September 30, 2011 from <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/2014%20Vision%207-2-10%20gf%20SAC.pdf>.

## Appendix (continued)

developing a program for its dual eligible demonstration that is similar to SCO but that would serve duals who are under age 65 and disabled. SCO is a voluntary program, but those who choose to enroll must use one health plan for both their Medicaid and Medicare services. As a result, all dual-eligible SCO enrollees participate in an integrated plan that covers acute and long-term care services.

The state's four SCO SNPs enrolled just over 13,600 dual eligibles in August 2010, or approximately 11% of the 130,000 full dual eligibles age 65 and older in Massachusetts. The fact that enrollment is voluntary for both Medicaid and Medicare services explains a large part of the low enrollment, since beneficiary awareness of this option has been limited. In addition, the SCO plans do not operate in all parts of the state, although the covered areas include most of the state's population. The state agencies responsible for the SCO program have resource constraints that limit their ability to inform Medicaid beneficiaries about SCO options, and SCO plan representatives told us in our MedPAC site visit that some CMS marketing requirements constrain their efforts to expand enrollment.

### MINNESOTA

**Duals Age 65 and Older.** Minnesota covers dual eligibles age 65 and over through the Minnesota Senior Health Options (MSHO) program, a longstanding voluntary Medicaid and Medicare managed care program that began operating in 1997 as a CMS dual demonstration project. As in Massachusetts, participating plans converted to SNPs in 2006. While Medicaid enrollment in the statewide MSHO program is voluntary, a separate statewide Medicaid managed care program for seniors (Minnesota Senior Care Plus or MSC+) mandates enrollment for all seniors, including duals, unless they enroll in MSHO. The state contracts with the same SNPs for both programs, and the benefits are identical, except that MSC+ covers only Medicaid benefits. Approximately 36,500 seniors (both duals and non-duals) were enrolled in MSHO as of January 2012 while only 11,500 were enrolled in MSC+. Approximately 70% of MSHO enrollees meet state long-term care criteria (40% are in community-based waiver programs and 30% in nursing facilities), and all are dual eligibles. There were approximately 67,000 full dual eligibles age 65 and older in Minnesota in 2007.

**Under-65 Disabled Duals.** For dual eligibles under age 65 and disabled, Minnesota offered the SNP-based Minnesota Disability Health Options (MnDHO) program in the Twin Cities area between 2001 and 2010. Most of MnDHO's enrollees transferred in 2011 to the SNP-based Special Needs Basic Care (SNBC) program, which had approximately 10,500 enrollees in January 2012. The SNBC program, which started in 2008 and operates statewide, provides benefit coverage similar to MnDHO's coverage, except that most Medicaid long-term care services are provided through FFS rather than through the SNPs. Enrollment in SNBC is voluntary for Medicaid services, and both duals and Medicaid-only beneficiaries who are under age 65 and disabled may enroll. Approximately 40% of SNBC's enrollees met state

## Appendix (continued)

long-term care criteria, approximately 30% had a primary diagnosis of mental illness, and approximately 66% were dual eligibles. There were approximately 51,000 under-65 full dual eligibles in Minnesota in 2007.

### NEW MEXICO

New Mexico's statewide Coordination of Long-Term Services (CoLTS) Medicaid managed care program began operating in 2008 following four years of planning. It covers primarily Medicaid long-term care services, in contrast to earlier programs in other states that focused on integrating both acute and long-term care. Enrollment is mandatory for almost all Medicaid beneficiaries who meet nursing facility level-of-care requirements, including dual eligibles both over and under age 65. As of September 1, 2010, 31,570 CoLTS enrollees were dual eligibles, and 6,513 were non-duals. There are approximately 38,000 full dual eligibles in New Mexico, so the program covers Medicaid long-term care services for a large segment of the dual-eligible population.

The designers of CoLTS sought, in 2004, to improve the management and cost-effectiveness of the state's Medicaid long-term care services, especially community-based personal care services, and to lay the groundwork for better integration of Medicaid and Medicare services. The personal care services program was operating at that time with few limits and was experiencing rapid cost growth. The state also hoped that improved integration of Medicare services for duals could be built on a base that started with better management of Medicaid long-term care services. Accordingly, the state required that plans participating in CoLTS be SNPs. Although the two health plans currently participating in the program (AMERIGROUP and Evercare) are dual-eligible SNPs, most dual eligibles enrolled in CoLTS receive Medicare services through Medicare FFS or other Medicare Advantage plans. Only 1,600 of the 31,000 CoLTS dual eligible enrollees in June 2010 were receiving both Medicaid and Medicare services through a CoLTS SNP. Two of the major Medicare Advantage plans in New Mexico (Lovelace and Presbyterian) chose not to participate in the CoLTS program, even though they operate plans in the state's Salud! Medicaid managed care program. A number of dual-eligible CoLTS enrollees receive Medicare services from Lovelace or Presbyterian.

### NORTH CAROLINA

North Carolina has been a long-time leader in managing care for non-dual Medicaid beneficiaries through its partially capitated enhanced primary care case management (PCCM) program, Community Care of North Carolina (CCNC), which began operating in 1998. North Carolina's integrated care program for dual eligibles is a CMS demonstration under Section 646 of the Medicare Modernization Act of 2003 and builds on the CCNC program. Implementation of the 646 demonstration began in January 2010 under a separate nonprofit organization called North Carolina Community Care Networks (NC-CCN), which operates through eight of CCNC's 14 community-based provider networks. As with CCNC, the 646 demonstration focuses mainly on primary and acute care rather than on long-term care. It functions as a medical home model for

## Appendix (continued)

duals both over and under age 65 and is supported by the community-based care management system that was developed under CCNC. While the demonstration does not provide nursing facility and home- and community-based long-term care services, program officials are encouraging nursing facility pilot projects that they hope will improve the care of nursing facility residents and reduce unnecessary emergency room visits and hospital admissions.

NC-CCN provides administrative, care management, and data support to the eight networks and their providers. For the first two years of the five-year demonstration, NC-CCN will be supported by the per-member, per-month (PMPM) Medicaid CCNC payments to the networks (\$3.72 for most enrollees and \$13.72 for ABD enrollees).<sup>49</sup> For the demonstration's remaining three years, NC-CCN hopes to show savings from enrollees' use of Medicare services that CMS would then share with NC-CCN to help cover the cost of new Medicare enrollees and improve the coordination and integration of care for dual eligibles. CMS and North Carolina demonstration representatives are still determining how the savings will be measured and shared. A portion of the shared savings (50% in the first year) is contingent upon success in meeting a number of performance measures that are focused mainly on acute care (diabetes care, heart health), and that include a measure of potentially avoidable hospital readmissions.

In the first two years of the demonstration, NC-CCN seeks to enroll 30,000 of the state's 280,000 dual eligibles. As of September 2010, enrollment totaled just under 20,000. At the beginning of year three, the demonstration will add 150,000 Medicare-only beneficiaries who receive care from practices participating in the demonstration. (There are currently more than 1.4 million Medicare beneficiaries in North Carolina.) The demonstration had planned to enroll dual eligibles in the demonstration for their Medicare services by assigning them to the practice from which they receive their Medicaid services under the CCNC program. However, CMS has raised concerns about this approach and the letter that was to be used to explain the assignment, so it is now on hold. The CMS concern appears to be that the approach NC-CCN proposed did not make it sufficiently clear to potential enrollees that they could decline the assignment for their Medicare services, or receive those services outside the NC-CCN network.

### OKLAHOMA

Oklahoma's Medicaid enhanced PCCM program (SoonerCare Choice) dates back to 1996 and was modified in 2009 to incorporate additional medical home features and some pay-for-performance and practice assistance features for providers. Under the program, nurse care managers employed by the Medicaid agency help providers with care management. In addition, the state established a Health Management Program in 2008 to focus on up to 5,000 high-cost,

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<sup>49</sup> Participating providers also receive PMPM payments of \$2.50 for most Medicaid enrollees and \$5.00 for ABD enrollees. Almost all ABD enrollees age 65 and over are dual eligibles, and about half of those under age 65. Medicaid reimbursement for physicians in North Carolina is relatively high (95% of Medicare), which facilitates provider participation.

## Appendix (continued)

high-need enrollees.<sup>50</sup> The state is also developing a Health Access Network pilot program in up to four sites. Nonprofit administrative entities would operate the pilot networks, which would work with community providers to coordinate and improve care for Medicaid enrollees. To date, the state has explicitly excluded dual eligibles from these Medicaid care management programs, since it does not believe it has sufficient leverage over Medicare services to ensure effective management of dual eligibles' care. However, the state is considering extending the current care coordination program and/or creating an ACO in the Tulsa area to serve dual eligibles.<sup>51</sup> The state has also been engaged in preliminary discussions with SNPs interested in contracting with Medicaid.

### TENNESSEE

Tennessee's new TennCare CHOICES Medicaid managed long-term care program, which was implemented in 2010, provides nursing facility and community-based long-term care services to Medicaid beneficiaries age 65 or older, or 21 and older with physical disabilities, who are in nursing facilities, or who are living in the community and need a nursing facility level of care or who are at risk of institutionalization. CHOICES also covers Medicaid acute care and behavioral health services for those who are enrolled. Enrollment is mandatory for those who meet the eligibility standards, including dual eligibles. However, dual eligibles receive their Medicare services from the traditional FFS Medicare program, or from Medicare Advantage managed care plans.

Initial enrollment in the CHOICES program in 2010 was about 28,000, approximately 23,000 of whom were in nursing facilities, with the remaining 5,000 in HCBS waiver programs. The program operates statewide, and services are provided by three MCOs: AmeriChoice/UnitedHealthcare Community Plan, AMERIGROUP, and Blue Cross/Blue Shield. While dual eligibles do not receive their Medicare services through the CHOICES program, United operates two dual eligible SNPs in Tennessee with a combined enrollment in February 2011 of 19,655, and AMERIGROUP operates a dual eligible SNP in Nashville that had 1,122 enrollees in February. Some CHOICES enrollees may, therefore, have the option of enrolling in a SNP operated by the same company as their CHOICES plan, with the potential for better integration of their Medicare and Medicaid services. Tennessee hopes to further integrate the care for full benefit dual eligibles by offering Medicare Part A and B services, as well as care coordination, through the TennCare Plus program that it is developing for its dual eligible demonstration.<sup>52</sup>

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<sup>50</sup> For details on the Oklahoma programs, see Verdier, James, Vivian Byrd, and Christal Stone. "Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States." Hamilton, NJ: Center for Health Care Strategies, September 2009. Available at: [http://www.chcs.org/usr\\_doc/EPCCM\\_Full\\_Report.pdf](http://www.chcs.org/usr_doc/EPCCM_Full_Report.pdf). Accessed September 17, 2010.

<sup>51</sup> Heater, Buffy. Coordinating Care for Members Dually Eligible for Medicare and SoonerCare: Exploring a New Frontier. Kansas City, MO: Presentation to the National Academy for State Health Policy Conference, October 5, 2011. Accessed October 6, 2011 from: <http://www.nashpconference.org/wp-content/uploads/2011/heater.19.duals.ppt>.

<sup>52</sup> For more information, see the CMS Summary of Tennessee's Initial Design Concepts to Integrate Care for Dual Eligible Individuals, May 2011. Accessed October 6, 2011 from: <https://www.cms.gov/medicare-medicaid-coordination/downloads/CMSMCODualsDemoStateSummaryTN.pdf>.

## Appendix (continued)

### TEXAS

The Texas STAR+PLUS Medicaid managed care program for SSI/disabled beneficiaries (including dual eligibles) has been operating since 1998, and as of August 2011 had nearly 260,000 enrollees in selected (mostly urban) counties in the state. The STAR+PLUS program is expanding into three additional geographic areas in March 2012, which will add approximately 100,000 new enrollees. STAR+PLUS covers Medicaid acute care services (although inpatient hospital services and prescription drugs are currently covered on a FFS basis until March 2012) and community-based long-term care services. It does not cover nursing facility services, but it does cover HCBS waiver services, personal attendant services, and other community-based services. Medicaid enrollment is mandatory in the parts of the state where STAR+PLUS is operating, which include Houston, Austin, San Antonio, Corpus Christi, Galveston, and surrounding counties and—beginning in February 2011—Dallas, Fort Worth, and surrounding counties.

As of August 2011, the MCOs participating in STAR+PLUS included AMERIGROUP, Bravo Health, Evercare, Molina, Superior (Centene), Health Spring, and United Healthcare Community Plan. Dual eligible enrollees in STAR+PLUS obtain their Medicare services on a fee-for-service basis, or from a Medicare Advantage managed care plan. Several of the STAR+PLUS plans also operate Medicare Advantage dual eligible Special Needs Plans in Texas, so some dual eligibles may be getting their Medicaid services from a STAR+PLUS plan and their Medicare services from a dual eligible SNP that is operated by the same company. While we do not know at this point what the extent of this overlapping membership might be, here are the enrollment data for February 2011<sup>53</sup> for the dual eligible SNPs that are operated by STAR+PLUS plans:

AMERIGROUP	6,194 (Houston Metro area)
Bravo	7,234 (Select counties)
Evercare	8,602 (Houston and Austin)
Molina	533 (South central and eastern counties)
Superior	942 (San Antonio and Corpus Christi)

### VERMONT

No commercial managed care organizations (MCOs) participate in the Medicaid program in Vermont, and only approximately 4% of Medicare beneficiaries are enrolled in any form of Medicare managed care. However, the state has a Medicaid 1115 waiver called Global Commitment under which the state functions as a Medicaid MCO. It receives capitated

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<sup>53</sup> At the time of this report, enrollment data was not yet available for the two new plans awarded contracts in August 2011 (Health Spring and United Healthcare Community Plan).

## Appendix (continued)

payments from CMS that cover all Medicaid services except for the Children’s Health Insurance Program (CHIP) and long-term care services. More than 137,000 beneficiaries were enrolled in Global Commitment in mid-2009, including nearly 15,000 of the state’s 20,000 full dual eligibles.<sup>54</sup> The state also operates an 1115 waiver for long-term care services called Choices for Care that gives all Medicaid long-term care enrollees a choice of nursing home or HCBS.

The state is proposing to build on these programs to cover both Medicaid and Medicare services for dual eligibles under an arrangement in which the state would function as a Medicare managed care plan, much as it now functions as a Medicaid managed care plan. The state is in discussions with CMS about how such an integrated program for dual eligibles would operate, particularly with respect to funding and accountability. Section 3021 of the Patient Protection and Affordable Care Act of 2010 (PPACA) authorizes the new CMS Center for Medicare and Medicaid Innovation to test models “[a]llowing States to test and evaluate fully integrating care for dual-eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.”

### WISCONSIN

Wisconsin operates three managed care programs in which dual eligibles may enroll:

- **Family Care Partnership.** This is a fully integrated program that provides both Medicare and Medicaid acute and long-term-care services. Enrollees must need a nursing home level of care. Enrollment is voluntary, and the program operates only in limited areas of the state. The Partnership program began in 1994 and became a dual eligible demonstration program in 1999. There were 3,930 enrollees in August 2011.<sup>55</sup> Services are provided through four Medicaid managed care plans: Care Wisconsin, Community Care, Independent Care, and Partnership. These plans also operate as Medicare Advantage SNPs.
- **Family Care.** This program, which began in 1998, provides Medicaid nursing facility, HCBS, and care management services to Medicaid beneficiaries with long-term care needs. It does not cover Medicaid acute care services, or any Medicare services. The Family Care program operates in most, but not all, areas of the state, and had 33,525 enrollees in August 2011. Enrollment is voluntary. It has two major organizational components:
  - Aging and Disability Resource Centers (ADRCs), which serve as single entry points for information and advice on long-term care service options; and

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<sup>54</sup> In addition, a small Program of All-Inclusive Care for the Elderly (PACE) plan had 108 enrollees in June 2010. The Kaiser Family Foundation. “Medicaid Enrollment in Managed Care by Plan Type,” as of June 30, 2009; CMS “Medicaid Managed Care Program Summary,” as of July 1, 2010. For details on the Global Commitment waiver, see [<http://ovha.vermont.gov/administration/2008-global-commitment-to-health-documents>]. Accessed September 17, 2010.

<sup>55</sup> Family Care, Partnership and PACE Enrollment Data. Monthly Snapshot as of September 1, 2011—Total MCO Enrollment by Target Group. Available at: <http://www.dhs.wisconsin.gov/lcicare/Generalinfo/enrollmentdata.pdf>

## Appendix *(continued)*

- Managed Care Organizations (MCOs), which manage and deliver the Family Care benefit. There are currently nine community-based MCOs in the program.
- **PACE.** This plan had 901 enrollees in August 2011, mostly in the Milwaukee area. It is operated by the Community Care Health Plan, which also operates a Partnership plan. The PACE program began in Wisconsin in 1989.

Wisconsin seeks to further integrate care for dual eligibles by securing new Federal authority for the state to function as the Medicare/Medicaid entity. The state hopes to receive a Medicare capitation payment for each enrollee, which it will combine with Medicaid funds to create a single, fully integrated capitation payment. The state will then pay contracted managed care organizations to provide all acute, primary and long-term care services that, unlike PACE, will not be restricted to a specific physical site.<sup>56</sup>

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<sup>56</sup> For more information, see "Wisconsin Proposal for Innovative Demonstration Project for dual Medicaid/Medicare Members," accessed October 6, 2011 from <http://www.dhs.wisconsin.gov/wipartnership/pace/grant-submission.pdf>.

Appendix (continued)

**TABLE 6. Major Features of Programs for Dual Eligible Beneficiaries in Selected States**

STATE	PROGRAM NAME AND START DATE	POPULATION COVERED	TOTAL NUMBER OF FULL DUAL ELIGIBLES IN THE STATE (2007) <sup>a</sup>	NUMBER OF DUALS IN INTEGRATED PLANS/ PROGRAMS	INTEGRATION MODEL/ PARTICIPATING PLANS	BENEFITS COVERED	GEOGRAPHY	MEDICAID ENROLLMENT
Arizona	Arizona Health Care Cost Containment System (AHCCCS) (1982)	All Medicaid beneficiaries, including duals	111,119	28,414 (8/2010)	SNPs	Acute care	Statewide	Mandatory
	Arizona Long-Term Care System (ALTCS) (1989)	All Medicaid beneficiaries needing nursing home level of care, including duals		1,678 (8/2010)	SNPs	Acute and LTC	Statewide	Mandatory
California	County Organized Health Systems (COHS) with Dual Eligible SNPs (2006)	All Medicaid beneficiaries, including duals, are enrolled in COHS	1,144,012	25,627 (2/2011)	SNPs	Acute and LTC	Orange, San Mateo, and Napa-Solano-Yolo Counties	Mandatory
	PACE	Age 55+ and needing nursing home level of care		2,311 (6/2009)	PACE	Acute and LTC	Selected urban areas	Voluntary
Massachusetts	Senior Care Options (SCO) (2004)	Duals and Medicaid-only beneficiaries age 65 and over	240,464	13,616 (8/2010)	SNPs	Acute and LTC	Statewide	Voluntary
	PACE	Age 55+ and needing nursing home level of care		2,178 (6/2009)	PACE	Acute and LTC	Boston area	Voluntary
Minnesota	Minnesota Senior Health Options (MSHO) (1997)	All Medicaid beneficiaries age 65 and over, including duals	117,691	36,500 (1/2012) Includes non-duals	SNPs	Acute and LTC	Statewide	Voluntary
	Minnesota Senior Care Plus (MSC+) (1985)	All Medicaid beneficiaries age 65 and over, including duals; duals get Medicare through FFS		11,500 (1/2012)	SNPs	Acute and LTC	Statewide	Mandatory
	Minnesota Disability Health Options (MnDHO) (2001-2010)	All Medicaid beneficiaries age 18-64 with physical disabilities, including duals		1,300 (5/2010) Includes non-duals	SNPs	Acute and LTC	Twin Cities metro area	Voluntary
	Special Needs Basic Care (SNBC) (2008)	All Medicaid beneficiaries age 18-64 with physical disabilities, including duals		10,500 (1/2012) Includes non-duals	SNPs	Acute and most (but not all) LTC	Statewide	Voluntary
New Mexico	Coordination of Long-Term Services (CoLTS) (2008)	All duals and Medicaid-only beneficiaries needing nursing home level of care	37,880	31,579 duals and 6,513 non-duals in CoLTS for Medicaid (9/2010); 1,600 duals obtain Medicare from CoLTS SNPs (6/2010)	SNPs	Medicaid acute and LTC; Medicare acute care for duals that choose CoLTS SNPs for Medicare	Statewide	Mandatory
	PACE	Age 55+ and needing nursing home level of care		376 (6/2009)	PACE	Acute and LTC	Albuquerque area	Voluntary
North Carolina	North Carolina Community Care Networks, Inc. (2010)	All duals	248,468	19,923 (9/2010)	Nonprofit community-based networks	Acute care only	Statewide, but only in selected counties	Voluntary
	PACE	Age 44+ and needing nursing home level of care		50 (6/2009)	PACE	Acute and LTC	Selected counties	Voluntary

*continued on next page*

Appendix (continued)

**TABLE 6. Major Features of Programs for Dual Eligible Beneficiaries in Selected States** (continued)

STATE	PROGRAM NAME AND START DATE	POPULATION COVERED	TOTAL NUMBER OF FULL DUAL ELIGIBLES IN THE STATE (2007) <sup>a</sup>	NUMBER OF DUALS IN INTEGRATED PLANS/ PROGRAMS	INTEGRATION MODEL/ PARTICIPATING PLANS	BENEFITS COVERED	GEOGRAPHY	MEDICAID ENROLLMENT
Oklahoma	SoonerCare Choice (1996)	Non-dual Medicaid beneficiaries	93,309	None	Enhanced primary care case management/ health management program for high-cost beneficiaries	Acute care only	Statewide	Mandatory
	PACE	Age 55+ and needing nursing home level of care		49 (6/2009)	PACE	Acute and LTC	Selected rural counties	Voluntary
Tennessee	TennCare Choices (2010)	Age 65+ or 21+, in nursing facility, needing nursing home level of care, or at risk of institutionalization	208,802	None	n.a.	Medicaid acute and LTC	Statewide	Mandatory
	PACE	Age 55+ and needing nursing home level of care		309 (6/2009)	PACE	Acute and LTC	Selected counties	Voluntary
Texas	STAR+PLUS (1998)	SSI/disabled Medicaid beneficiaries not in nursing facilities, including duals	380,594	TBD	SNPs	Medicaid acute and LTC; Medicare services provided separately	Selected urban counties	Mandatory
	PACE	Age 55+ and needing nursing home level of care		889 (6/2009)	PACE	Acute and LTC	Selected counties	Voluntary
Vermont	In development	All duals	19,795	None	TBD	TBD	TBD	TBD
Wisconsin	PACE	Age 55+ and needing nursing home level of care	126,107	76 (6/2009)	PACE	Acute and LTC	Selected counties	Voluntary
	Family Care Partnership (1994)	All duals, plus Medicaid-only beneficiaries needing nursing facility level of care		3,644 (11/2010) Includes non-duals	SNPs	Medicare and Medicaid acute and LTC	Selected counties	Voluntary
	Family Care (1998)	Age 65+ and age 18+ with physical or developmental disabilities		31,101 (11/2010) Includes non-duals; not integrated	Community-based MCOs	Medicaid LTC	Selected counties	Voluntary
	PACE (1989)	Age 55+ and needing nursing facility level of care		848 (11/2010)	PACE	Acute and LTC	Milwaukee	Voluntary

<sup>a</sup> David Rousseau, et al. "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2010, Table 2. Full dual eligibles are eligible for all Medicaid benefits, while "partial" dual eligibles are only eligible for Medicaid payment of some or all of their Medicare premiums and cost sharing. More recent state-by-state data on dual eligibles do not distinguish between full and partial duals. The number of duals shown is an unduplicated count of duals receiving Medicaid services in calendar year 2007.

n.a. = not applicable.

TBD = to be determined.

SOURCE: James M. Verdier, Melanie Au, and Jessica Gillooly. "Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans." Prepared by Mathematica Policy Research for the Medicare Payment Advisory Commission, October 15, 2010, supplemented and updated by authors' analysis of state websites.



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