ULTCS Workgroup
Integration and Care Management Subcommittee
April 7, 2010

MEMBERS PRESENT:

Anita Allen, OPRA
Steve Mould, OHCA
Nilu Ekanayake, ODADAS
Sara Abbott, JFS/OHP, Subcommittee Co-leader
Bridget Gargan, OHA
Judy Patterson, ODA
Beth Foster, OCHC
Christine Kozobarich, SEIU 1199
Joe Ruby, AAA 10A
Janet Grant, CareSource/OAHP
Marc Molea, ODA, Subcommittee Co-Leader
Hilary Stai, LTC Ombudsman

At its March 1, 2010 meeting the Subcommittee identified the need for better coordination of care for dual-eligible consumers. As a result, the Subcommittee focused the discussion of this meeting on better understanding the delivery services to dual-eligible consumers, identifying issues related to serving dual-eligible consumers and developing preliminary recommendations to support better care and integration of dual-eligible consumers.

OVERVIEWS

Prior to the meeting Marc Molea and Sara Abbott forwarded to the members the following resources to provide a good overview of integrating care for dual eligible consumers.

- Providing Long Term Services and Supports in a Managed Care Delivery System - Enrollment Authorities and Rate Setting Techniques: http://www.cms.gov/CommunityServices/Downloads/ManagedLTSS.pdf
- Integrating Care for Dual Eligibles: An Online Toolkit http://www.chcs.org/publications3960/publications_show.htm?doc_id=606732

Janet Grant, representing health plans, Joe Ruby, representing AAAs, Sara Abbott, representing State Medicaid LTCSS Services, and Beth Foster, representing Home Health, each provided an overview from his/her discipline's perspective. All agreed that serving dual eligibles is complicated at many levels (e.g., policy, provider, consumers) and that there was a need for more consistency and better communication across levels. Attached is an excellent handout provided by Janet Grant.
IDENTIFICATION OF ISSUES

The Subcommittee then began to identify issues that were barriers to better integrating care of dual-eligible consumers. Issues include, but are not limited to:

- Need to better identify dual eligibles. Many consumers don't self-identify themselves as eligible to receive both Medicaid and Medicare services.
- Need to better maximize the Medicare benefit both at the front door (consumer engagement) and back door (e.g., billing).
- Too much fragmentation, difficult navigating benefits and benefit packages at the consumer, point-of-care, provider and benefit/policy levels.
- Complexity of the multitude of regulations that, at times, conflict.
- Limited role of the physician in integrating care for dual eligibles. This issue needs to be addressed as we promote the development of the patient-centered medical home.
- Poor integration, resulting in readmissions/higher health care cost. Through better communications and integration consumers would understand their benefits and get the services they are entitled to receive.

THEMES FOR RECOMMENDATIONS

The Subcommittee began identifying the following themes for recommendations. These will be developed in more detail at the next meeting.

- Improving care management support at different levels.
- Better educating consumers and providers about options
- Identifying fixes (e.g., better consumer education, care manager education, discharge manager education) that could be implemented at the front door that could improve ongoing integration.
- Developing statewide consistency.
- Better sharing of data and information across levels of care and systems.
- Defining the role of Accountable Care Organizations?

NEXT MEETING/AGENDA

May 7, 2010, Time to be announced.

Agenda will include development of detailed recommendation for better coordination of dual eligibles. If time permits, we will begin discussing integration across health care and community settings.

Dual Eligibles: A Health Plan Perspective

ULTCS Work Group

April 7, 2010

CareSource

Dual Eligibles

- Eligible for Medicare and Medicaid

- Over 8.8 million in US; 268,000 in OH
  - 92% full duals/8% partial in OH vs 81% full/19% partial in US
  - 15% of Medicaid recipients in OH (18% US)
  - 16% of Medicare enrollees in OH (21% US)
  - 34% are under the age of 65
  - In 2005 represented 50% of Medicaid spending in OH (46% US)--$22,021/yr ($14,972 US); 25% of Medicare spending
  - 1.6 million duals with annual Medicaid costs greater than $25,000 account for 70% of all dual spend

- Medicaid liability
  - Medicare coinsurance
  - Long term care
  - Wrap around benefits
  - Pharmacy moved to Medicare January 2006 with Part D implementation; clawback costs to states $6.6 billion/year ($208M for OH)

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Special Needs Plans (SNPs)

- MMA provision to allow plans to target Medicare Advantage enrollment
- CMS chosen integration vehicle; dual integration demonstration states transitioned to SNP model
- SNP Plan growth
  - 276 SNPs in 2006
  - 471 SNPs in 2007
  - 769 SNPs in 2008
  - 702 SNPs in 2009
- **As of September 2009:**

SNP Type	Number of Contracts	Number of Plans	Sub Total Enrollment
Chronic or Disabling Condition	100	212	293,569
Dual-Eligible	252	407	951,590
Institutional	63	83	115,500
Totals	**415**	**702**	**1,360,659**

Ohio SNP Enrollment

Special Needs Plan Comprehensive January 2010 Enrollment Report

Plan Name	Service Area	Plan Enrollment	Special Needs Plan Type
CareSource Advantage	17 Counties	589	Dual-Eligible
Buckeye Community Health Plan	15 Counties	227	Dual-Eligible
Evercare Plan DH	13 Counties	6,460	Dual-Eligible
Molina Medicare Options Plus (HMO)	9 Counties	0	Dual-Eligible
Unison Advantage Plus	2 Counties	0	Dual-Eligible
WellCare Access	8 Counties	453	Dual-Eligible
Total Enrollment		7,729	

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Medicaid SNP Interaction

- OH SNPs are only administering the Medicare portion of enrollees benefits – not the Medicaid portion
- Providers have to bill both SNP and FFS Medicaid
- Medicaid is secondary to Medicare and states will usually cover only up to the Medicaid allowable
- Members have to navigate FFS Medicaid on own; have two cards

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ODJFS SNP Integrated Agreement

- CMS dual SNP requirement
  - New plan applications
  - Service area expansions for existing plans
- Basic agreement defining current roles
- Executed fall 2009
- True integrated contract would include administration responsibilities for Medicaid benefit with capitation and virtual integration at plan level for members and providers

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SNP Stability Issues

- CMS placed SNP expansion moratorium for 2009
  - No new applications accepted
  - No service area expansions accepted
- MIPPA 2008 SNP revisions
  - State contract required for dual SNPs (for new/expansion)
  - Limited complex diagnosis set for chronic SNPs
  - Model of care oversight
  - SNP quality measures and targets
- SNP reauthorization passed in health care reform expires December 31, 2013
  - State contract for dual SNPs required by January 1, 2013
  - NCQA accreditation required by CY 2012

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SNP Integration Challenges

- Voluntary Medicare enrollment
- Medicare reaps initial savings; Medicaid longer term savings
- Development of State/SNP relationships
- Conflicting plan regulations
- Reauthorization only through 2013
- Medicare payment rate reductions
- Scaling of SNPs

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Health Care Reform on Dual Integration

- Federal Coordinated Health Care Office (CMS "Office of the Duals") (Sec 2602)
- Center for Medicare and Medicaid Innovation (Sec 3021)
- Duals 5yr Demonstrations (sec 2601)

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