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# Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans

*A report by staff from Mathematica Policy Research, Inc.  
for the Medicare Payment Advisory Commission*

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Final Report

October 15, 2010

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Policy Research, Inc.

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## IN BRIEF

The nearly 9 million people enrolled in both Medicaid and Medicare for health care services in 2006-2007 accounted for 39 percent of total Medicaid expenditures and 27 percent of total Medicare expenditures but only 15 percent of Medicaid enrollment and 16 percent of Medicare enrollment. All dual-eligible beneficiaries have low incomes, about two-thirds are over age 65, and about one-third are under age 65 and have disabilities and chronic illnesses.

Responsibility for health care services for dual eligible beneficiaries is divided in complex ways between Medicare and Medicaid. Medicare is responsible for most acute care services (hospital, physician, post-acute skilled nursing facility, and prescription drug services) and Medicaid for most long-term-care services (nursing facility and home- and community-based services). Both programs are responsible for some services, such as home health and hospice care. Medicaid also covers some services Medicare generally does not, including vision and dental services, and pays Medicare premiums and cost sharing for dual eligibles.

Several states have established programs aimed at improving the coordination and management of Medicaid and Medicare services for dual eligibles, improving beneficiary care, and reducing unnecessary expenditures. Medicare Advantage (MA) Special Needs Plans (SNPs) for dual eligibles began operating in 2006, and several states have incorporated SNPs into their integrated care programs.

The Medicare Payment Advisory Commission (MedPAC) asked Mathematica and MedPAC staff to review selected state programs and the SNPs in these programs to determine how they are working and how they might become more effective and more widely available.

We reviewed current state programs and planning efforts and SNPs in Arizona, Maryland, Massachusetts, Minnesota, New Mexico, North Carolina, Oklahoma, Vermont, and Virginia. Our major findings are:

- Strong state political and organizational leadership and commitment over time is crucial to the success of integrated care programs, as is consultation and collaboration with key stakeholders.
- Building enrollment in the programs has posed a major challenge owing to lack of beneficiary awareness, limited state resources for marketing, federal marketing requirements for SNPs, and Medicare's requirement that managed care enrollment for Medicare services must be voluntary.
- Many states have been reluctant to establish integrated care programs for duals because most potential short-term savings accrue to Medicare rather than to Medicaid, and longer-term savings require substantial investments in care management.
- There are substantial commonalities in how integrated programs coordinate care for dual eligibles, but the programs' overall structure varies, reflecting differences in the structure of the state Medicaid programs on which they are based.
- States face a series of design issues in developing integrated care programs, including whether to rely on private managed care organizations or develop options in which the state assumes more managed care responsibilities, whether to develop separate programs for duals over and under age 65, and how to incorporate Medicaid long-term care and behavioral health services.
- The development and operation of integrated care programs has been hindered by conflicting Medicaid and Medicare rules and requirements.
- States and SNPs are hopeful that the new Federal Coordinated Health Care Office in the Centers for Medicare & Medicaid Services (CMS) will help resolve some of the issues that have limited the development of integrated care programs.

## INTRODUCTION

The Medicare Payment Advisory Commission has had an interest in dual eligible beneficiaries for several years.<sup>1</sup> That interest has intensified as dual eligible beneficiaries' complex and costly care needs, and the lack of coordination in their care, have become more apparent. In its June 2010 Report to the Congress, MedPAC reviewed data on Medicare and Medicaid service use and expenditures for dual eligible beneficiaries and provided an overview of state and health plan efforts to improve coordination of care.<sup>2</sup>

As a followup to the commission's discussion of dual eligible beneficiaries and current approaches to integrated care earlier this year, MedPAC asked Mathematica to assist MedPAC staff in a study of state programs that effectively manage the care of dual eligible beneficiaries, including programs that incorporate Medicare SNPs.

The study aimed to:

- Learn more about current and emerging approaches to coordinating and integrating care for dual eligibles, including which Medicare and Medicaid benefits are included in the programs, how beneficiaries are enrolled, how care is coordinated, how access to care and quality is measured, and how programs are financed
- Identify barriers to implementation and expansion
- Assess the replicability of the programs in other states and contexts

This report summarizes our findings.

### Background on Dual Eligible Beneficiaries

Nearly 9 million people are enrolled in both Medicaid and Medicare. Dual eligibles account for about 15 percent of Medicaid enrollment and 16 percent of Medicare enrollment, but expenditures on their behalf account for a much larger share of each program's costs: 39 percent of total Medicaid expenditures in 2007 and 27 percent of Medicare's expenditures in 2006.<sup>3</sup> Slightly more than 7 million are "full duals"; that is, they are eligible for all benefits of both programs.<sup>4</sup> Almost

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<sup>1</sup> MedPAC. "Dual-Eligible Beneficiaries: An Overview." Report to the Congress: New Approaches in Medicare, Chapter 3. Washington, DC: MedPAC, June 2004.

<sup>2</sup> MedPAC. "Coordinating the Care of Dual-Eligible Beneficiaries." Report to the Congress: Aligning Incentives in Medicare, Chapter 5. Washington, DC: MedPAC, June 2010.

<sup>3</sup> Smith, Vernon, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder. "Hoping for Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage, and Policy Trends." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2010, p. 12. Available at [<http://www.kff.org/medicaid/upload/8105.pdf>]. Accessed October 7, 2010. MedPAC. "Healthcare Spending and the Medicare Program." June 2010, p. 33. Available at [<http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf>]. Accessed September 16, 2010.

<sup>4</sup> For "partial duals," Medicaid pays some or all Medicare Part A and B premiums and beneficiary cost sharing (deductibles, coinsurance, and co-payments), but Medicaid services are not covered.

two-thirds are age 65 and older, and about one-third are under age 65 and have disabilities and chronic illnesses.

**Care Needs and Characteristics.** On average, dual eligibles have higher levels of chronic illness than other Medicare and Medicaid enrollees. They are more likely to be disabled and have higher rates of diseases such as diabetes, pulmonary disease, and stroke. They make up over half of all nursing facility residents. They have low incomes and relatively low levels of education and family and community support.<sup>5</sup>

**Division of Responsibility for Services.** Dual eligibles receive most of their acute care services (inpatient hospital, physician, emergency room, prescription drugs) from Medicare and most of their long-term-care services (nursing facility and home- and community-based care) from Medicaid. Both programs provide some services (nursing facility, home health, hospice), with the dividing lines between Medicare and Medicaid responsibility not always clear. Medicaid provides some services that Medicare covers in only limited ways (vision, dental, transportation, behavioral health) and is responsible for some or all Medicare premiums and beneficiary cost sharing (deductibles, coinsurance, and co-pays) for dual eligibles, although beneficiaries must enroll separately for this premium and cost-sharing coverage, and many do not. In addition, Medicaid is required to pay beneficiary cost sharing only if total payment to a provider does not exceed the amount Medicaid would pay for the service, resulting in small or no cost-sharing payments when Medicaid reimbursement rates are lower than Medicare's.

**Obstacles to Care Coordination in the Fee-for-Service (FFS) System.** Given their health care needs, dual-eligible beneficiaries often require a complex array of services from several providers. In the FFS system, dual eligibles often receive fragmented and uncoordinated care under a system that lacks incentives, resources, or mechanisms for care coordination.

**Managed Care Options.** Many states have established managed care programs aimed at improving care coordination for Medicaid beneficiaries with complex care needs, such as those in the aged, blind, and disabled (ABD) eligibility categories. States commonly exclude dual eligibles from these Medicaid managed care programs, however, or permit them to enroll only on a voluntary basis. There are several reasons for this. Dual eligibles cannot be required to enroll in managed care programs for their Medicare services, although enrollment for Medicaid services can be mandatory. In addition, with the transfer of prescription drug coverage for dual eligibles to Medicare in 2006, states are now responsible for only a small share of the acute care services received by dual eligibles. Finally, Medicaid long-term-care and behavioral health services that many dual eligibles need are often not included in Medicaid managed care programs. On the Medicare side, the Medicare Modernization Act of 2003 introduced Medicare Advantage SNPs to help integrate and coordinate care for dual eligibles, but more than 80 percent of duals remain in the Medicare FFS system and its

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<sup>5</sup> MedPAC. "Coordinating the Care of Dual-Eligible Beneficiaries." Report to the Congress, Chapter 5. Washington, DC: MedPAC, June 2010. Kasper, Judy, Molly O'Malley Watts, and Barbara Lyons. "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. Available at [<http://www.kff.org/medicaid/upload/8081.pdf>]. Accessed September 17, 2010. Coughlin, Teresa, Timothy Waidmann, and Molly O'Malley Watts. "Where Does the Burden Lie? Medicaid and Medicare Spending for Dual-Eligible Beneficiaries." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2009. Available at [<http://www.kff.org/medicaid/upload/7895-2.pdf>]. Accessed September 17, 2010.

“treatment silos.”<sup>6</sup> Even when dual eligibles are enrolled in SNPs, there are obstacles to full coordination of care (most SNPs currently do not cover Medicaid long-term care services or contract with states), and beneficiary access to this option is limited since SNP enrollment is concentrated in fewer than a dozen states.<sup>7</sup>

**Concerns About Managed Care.** While dual eligibles can benefit from the greater coordination of care that is possible in managed care arrangements, the complexity and range of their care needs can prompt concerns among beneficiary advocates and potential enrollees about a system that may limit access to some providers. In addition, some providers are reluctant to participate in managed care systems because of concerns about payment or service limits, and the number of managed care organizations that have experience with dual eligibles and their long-term care and behavioral health service needs is limited. Several states are therefore pursuing options to integrate care for dual eligibles that do not involve SNPs and other capitated managed care arrangements.<sup>8</sup>

## How We Selected States for the Study

In accordance with MedPAC’s interest in learning about a range of currently operating models for managing care for dual eligibles, we began by selecting—with MedPAC staff and our Center for Health Care Strategies (CHCS) partners—nine states that have taken, plan to take, or have tried different approaches to coordinating care for dual eligibles. In choosing states for the study, we looked for examples that could help us understand why states have adopted different approaches to dealing with dual eligibles, why some states have made more progress than others in developing and implementing programs to coordinate care for duals, and what lessons might be learned from their experience by other states and federal policymakers. We therefore selected some states with well-established integrated care programs for duals (Minnesota, Massachusetts, and Arizona), some that developed their programs more recently or are trying newer approaches (New Mexico, North Carolina, and Vermont), one that excludes duals from its existing Medicaid care management programs but may include them in the future (Oklahoma), and two that tried to set up integrated care programs for duals but failed (Maryland and Virginia). We also sought some geographic and demographic diversity. In addition, we looked at several recently published reports on how states are approaching care for dual eligibles, and we drew on the experience of our partners at CHCS who have been providing assistance to a wide range of states in developing integrated care programs for dual eligibles.<sup>9</sup>

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<sup>6</sup> Bella, Melanie, 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 September 16, 2010.

<sup>7</sup> Kasten, Jessica, Paul Saucier, and Brian Burwell. “State Purchasing Strategies Drive State Contracts with Medicare Special Needs Plans.” Issue brief. Washington, DC: U.S. Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation, September 2009. Available at [<http://aspe.hhs.gov/daltcp/reports/2009/stpur.pdf>]. Accessed September 16, 2010.

<sup>8</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 September 16, 2010.

<sup>9</sup> We reviewed the following reports: CHCS. “Options for Integrating Care for Dual-Eligible Beneficiaries,” March 2010; Kasten, Saucier, and Burwell. “Medicaid Contracts with Special Needs Plans Reflect Diverse State Approaches to

## How We Conducted the Study

We held one-hour telephone discussions with state agency representatives from all nine states in June and July 2010 and then visited three of the states (New Mexico, North Carolina, and Massachusetts) in July and August for two days each. We chose those three states for site visits because of the diversity of their approaches to integrating care and their geographic and demographic variation. In addition, the newer programs in New Mexico and North Carolina are not yet as fully documented as those in Minnesota and Arizona. During the site visits, we held extensive discussions with state agency representatives and met with representatives of health plans, providers, a beneficiary, and beneficiary counselors.

For the telephone discussions and site visits, we developed detailed state-specific discussion guides for state agencies, health plans, nursing facility providers, home- and community-based service (HCBS) and related providers, and consumers/beneficiaries. We sent the discussion guides in advance to all those we were talking or meeting with and, in several cases, received detailed written responses to our questions, most often from health plans. During each discussion, we used the guides to structure and direct the discussion, but we did not seek answers to every question. Those we met with often provided us with documents before and after our meetings that answered many of the questions we did not have time to get to in our discussions. State officials and others we met with also reviewed drafts of the site visit and telephone discussion summaries for accuracy and clarity.

## Organization of the Report

The report begins with an overview of the major features of the programs we reviewed in the nine states, followed by a summary of the major themes and issues that emerged from our interviews and site visits. We then provide summaries of our three site visits, including discussions of plan and provider contracting, financing and payments, care coordination, beneficiary participation and enrollment practices, performance and quality monitoring, the impact of health care reform, barriers to implementation and expansion, and lessons learned and future plans.

### OVERVIEW OF STATE PROGRAM FEATURES

Among the nine states selected for the study, three have well-established programs that rely primarily on SNPs and similar capitated managed care arrangements to integrate care (Massachusetts, Minnesota, Arizona); three are developing newer approaches (New Mexico, North Carolina, Vermont); one (Oklahoma) has not developed an integrated care program for duals but has some of the ingredients for such a program; and two provide lessons from unsuccessful

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*(continued)*

Dual-Eligible Beneficiaries,” November 2009; Kasten, Saucier, and Burwell. “State Purchasing Strategies Drive State Contracts with Medicare Special Needs Plans,” September 2009; Barbara Coulter Edwards et al. “Integrating Medicare and Medicaid: State Experience with Dual-Eligible Medicare Advantage Special Needs Plans.” Washington, DC: AARP Public Policy Institute, September, 2009; and James Verdier, Marsha Gold, and Sarah Davis. “Do We Know If Medicare Advantage Special Needs Plans Are Special?” Washington, DC: The Henry J. Kaiser Family Foundation, January 2008. For details on the CHCS initiatives on dual eligibles and integrated care, see [[http://www.chcs.org/info-url\\_nocat5108/info-url\\_nocat\\_list.htm?attrib\\_id=8408](http://www.chcs.org/info-url_nocat5108/info-url_nocat_list.htm?attrib_id=8408)]. Accessed September 23, 2010.

attempts to implement integrated care programs (Maryland and Virginia). In Table 1, we summarize the major features of the programs in the nine states.

## States with Well-Established SNP-Based Programs

### 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 age 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, over 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 a 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 FFS ("unaligned" duals).<sup>10</sup> There were approximately 112,000 full dual eligibles in Arizona in 2005.<sup>11</sup>

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<sup>10</sup> Email messages from Kari Price of AHCCCS to Jim Verdier, September 14–16, 2010.

<sup>11</sup> Holahan, John, Dawn M. Miller, and David Rousseau. "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2009, Tables 2 and 3, pp. 5 and 7. Available at [<http://www.kff.org/medicaid/upload/7846.pdf>]. Accessed September 16, 2010. Unless noted otherwise, data on the total number of dual eligibles by state that we use in this report come from this source. While the 2005 data in the 2009 Kaiser report are not current, they are reasonably consistent with data from more recent years that either do not distinguish between full and partial dual or are not consistent across states. The number of duals in this source is an unduplicated count of duals receiving services in calendar year 2005, not a monthly snapshot of enrollment or average monthly enrollment during the year.

**Table 1. Major Features of Programs for Dual Eligible Beneficiaries in Nine Selected States**

State	Program Name and Start Date	Population Covered	Total Number of Full Dual Eligibles in the State (2005) <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	112,495	28,414 (8/2010)	SNPs	Acute care	Statewide	Mandatory
	Arizona Long-Term Care System (ALTCS) (1989)	All Medicaid beneficiaries needing nursing home care, including duals		1,678 (8/2010)	SNPs	Acute and LTC	Statewide	Mandatory
Maryland	Community Choice Managed Long-Term Care (not implemented)	All duals	70,483	None	n.a.	n.a.	n.a.	n.a.
Massachusetts	Senior Care Options (SCO) (2004)	Duals and Medicaid-only beneficiaries age 65 and over	218,559	13,616 (8/2010)	SNPs	Acute and LTC	Statewide	Voluntary
Minnesota	Minnesota Senior Health Options (MSHO) (1997)	All Medicaid beneficiaries age 65 and over, including duals	112,858	36,000 (5/2010) 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		12,500 (5/2010) Includes non-duals	SNPs	Acute and LTC	Statewide	Mandatory

Table 1 (continued)

State	Program Name and Start Date	Population Covered	Total Number of Full Dual Eligibles in the State (2005) <sup>a</sup>	Number of Duals in Integrated Plans/Programs	Integration Model/ Participating Plans	Benefits Covered	Geography	Medicaid Enrollment
Minnesota (continued)	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		4,500 (5/2010) 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 care	37,353	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
North Carolina	North Carolina Community Care Networks, Inc. (2010)	All duals	250,136	19,923 (9/2010)	Nonprofit community-based networks	Acute care only	Statewide, but only in selected counties	Voluntary
Oklahoma	SoonerCare Choice (1996)	Non-dual Medicaid beneficiaries	89,495	None	Enhanced primary care case management/ health management program for high-cost beneficiaries	Acute care only	Statewide	Mandatory
Vermont	In development	All duals	18,375	None	TBD	TBD	TBD	TBD

Table 1 (continued)

State	Program Name and Start Date	Population Covered	Total Number of Full Dual Eligibles in the State (2005) <sup>a</sup>	Number of Duals in Integrated Plans/Programs	Integration Model/ Participating Plans	Benefits Covered	Geography	Medicaid Enrollment
Virginia	Virginia Acute and Long-Term Care Integration (VALTC) (not Implemented)	All duals	118,906	None	n.a.	n.a.	n.a.	n.a.

<sup>a</sup> John Holahan, Dawn M. Miller, and David Rousseau. "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2009, 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 2005.

n.a.= not applicable.

TBD = to be determined.

## Massachusetts

The Massachusetts Senior Care Options (SCO) program began operating in 2004 as a Centers for Medicare & Medicaid Services (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 in the process of developing a program for 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 currently enroll just over 13,600 dual eligibles, or about 11 percent of the 120,000 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 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 long-standing voluntary Medicaid and Medicare managed care program that began operating in 1995 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. About 36,000 seniors (both duals and non-duals) were enrolled in MSHO as of May 2010 while only 12,000 were enrolled in MSC+. About 70 percent of MSHO enrollees meet state long-term-care criteria (40 percent are in community-based waiver programs and 30 percent in nursing facilities), and all are dual eligibles. There were about 66,000 full dual eligibles age 65 and older in Minnesota in 2005.

**Under-65 Disabled Duals.** For dual eligibles under age 65 and disabled, Minnesota has been offering the SNP-based Minnesota Disability Health Options (MnDHO) program in the Twin Cities area since 2001. Enrollment in MnDHO's one plan, operated by UCare, is relatively low (1,300 enrollees in May 2010). Because of the program's high costs and concerns about the adequacy of SNP reimbursement for this population, UCare has decided to terminate its MnDHO plan as of the end of 2010. The SNP-based Special Needs Basic Care (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 both programs is voluntary for Medicaid services, and both duals and Medicaid-only beneficiaries who are under age 65 and disabled may enroll. As of May 2010, there were 4,500 enrollees in the SNBC program. About 40 percent met state long-term-care criteria, about 30 percent had a primary diagnosis of mental illness, and about 66 percent were dual eligibles. There were about 47,000 under-65 full dual eligibles in Minnesota in 2005.

## **States Developing Newer Approaches**

### **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 37,000 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 were seeking in 2004 both 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 non-profit organization called North Carolina Community Care Networks (NC-CCN), which operates through 8 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 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>12</sup> For the demonstrations' 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 percent in the first year) is contingent on 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 is seeking 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 3, the demonstration will add 150,000 Medicare-only beneficiaries who receive care from practices participating in the demonstration. (There are currently over 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.

## Vermont

No commercial managed care organizations (MCOs) participate in the Medicaid program in Vermont, and only about 4 percent 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 payments from CMS that cover all Medicaid services except for the Children's Health Insurance Program (CHIP) and long-term care services. Over 137,000 beneficiaries were enrolled in Global Commitment in mid-2009, including nearly 15,000 of the state's 18,000 full dual eligibles.<sup>13</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.

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<sup>12</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 percent of Medicare), which facilitates provider participation.

<sup>13</sup> In addition, a small Program of All-Inclusive Care for the Elderly (PACE) plan had 76 enrollees in June 2009. The Kaiser Family Foundation. "Medicaid Enrollment in Managed Care by Plan Type, as of June 30, 2009" and "Total Dual-Eligible Enrollment in Medicaid Managed Care, as of June 30, 2009." Available at [<http://www.statehealthfacts.org/>]. Accessed October 8, 2010. For details on the Global Commitment waiver, see [<http://ovha.vermont.gov/administration/2008-global-commitment-to-health-documents>]. Accessed September 17, 2010.

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 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.”

## **State Currently Excluding Duals from Medicaid Care Management Programs**

### **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, high-need enrollees.<sup>14</sup> The state is also developing a Health Access Network pilot program in up to four sites. Non-profit administrative entities would operate the pilot networks, which would work with community providers to coordinate and improve care for Medicaid enrollees. The state explicitly excludes 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, state officials told us that further development of the Medicaid enhanced medical home framework could prompt consideration of extending the programs to duals. (“The literature says you’re better off managing your at-risk population.”) The state has also been engaged in preliminary discussions with SNPs interested in contracting with Medicaid.

## **States Unable to Implement Integrated Programs for Duals**

### **Maryland**

In response to a legislative directive, Maryland began developing its CommunityChoice Managed Long-Term Care program in 2004. The program would have served dual eligibles both over and under age 65 and would have covered both acute and long-term care services. Maryland submitted a waiver request to CMS in August 2005 and conducted discussions with CMS and stakeholders in Maryland both before and after submission of the request. The state learned in January 2007 that CMS planned to deny the waiver request, in part because of disagreement between CMS and Maryland over the type of waiver authority to be used. Nursing facility and other long-term care providers in Maryland also voiced substantial opposition to the waiver, while a variety of stakeholders said the state had not consulted with them sufficiently in developing the proposed

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<sup>14</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.

program. As a result, when a new administration took office in January 2007, the state decided not to pursue further development of CommunityChoice.

## Virginia

Virginia Medicaid agency staff began developing the Virginia Acute and Long-Term Care Integration (VALTC) program in 2006 in response to a directive from Virginia's new governor. Program planning and consultation with stakeholders continued through the end of 2008, when the state decided not to implement the program. As initially designed, the program would have operated statewide and covered all dual eligibles for both acute and long-term care Medicaid and Medicare services, along with participants in several HCBS waiver programs. It was to be operated through SNPs and other MCOs. In response to substantial opposition from nursing facility and other providers and limited interest from MCOs and beneficiary advocates, the state substantially scaled back the program so that it ultimately would have covered only a limited number of beneficiaries, services, and geographic areas. ("VALTC started like the QE2 but ended up as a rowboat," one program designer told us.) Facing severe state budget problems and the end of the governor's term in late 2009 (Virginia's governors are limited to one four-year term), the state decided at the end of 2008 not to proceed with the program's planned July 2009 launch. The state still sees value in streamlining and integrating care for dual eligibles, however, and is exploring opportunities that may be available as a result of the new federal health care reform law.

## MAJOR THEMES AND ISSUES

As summarized below, several major themes and issues emerged from our telephone discussions and site visits. Two important factors that accounted in significant measure for both the successes and failures in the states we looked at were political and agency **leadership** and **stakeholder consultation**. We then review three issues that all the states we looked at have addressed in various ways: **enrollment**, **financing**, and **care coordination**. We then look at some of the considerations that the states addressed in deciding between **capitated and non-capitated approaches** to integrated care. Next, we look briefly at another threshold program design issue that some states considered: whether to cover all duals in one program or to cover **under- and over-65 duals** separately. We then examine how some of the states reviewed here dealt with two service areas under their integrated programs: **long-term care** and **behavioral health**. We summarize next some of the major **barriers to implementation and expansion** encountered by the states, and some of the ways in which **health care reform** is likely to affect integrated care programs. We conclude with a summary of the **major questions that remain open** as programs for duals continue to evolve.

### Leadership and Stakeholder Consultation

**Strong leadership and stability at political and managerial levels is important to the successful design, implementation, and continuity of integrated managed care programs for dual eligible beneficiaries, but the commitment that is needed can be difficult to maintain with turnovers in gubernatorial and agency leadership.** The development and success of new programs depends heavily on strong and dedicated leadership to shepherd them through the design, stakeholder consultation, and implementation processes. In New Mexico's case, the Medicaid director's personal experience with uncoordinated long-term care influenced the state's entry into integrated care and the development of the CoLTS program. "I was thinking I'm the Medicaid director and this is Albuquerque, and I can't get care for my grandparents and no one could help

me,” she told us. Support from New Mexico’s governor also helped to overcome some political and organizational opposition. In North Carolina, those we spoke with emphasized the strong leadership the Community Care program has had over a long period of time. (“We’ve had the right visionary leadership. We don’t tell [a key leader] ‘no.’”) In Virginia, the state’s planned integrated care program began with strong gubernatorial support but anticipated gubernatorial turnover, in addition to stakeholder opposition and disinterest, led to the program’s ultimate demise. The Minnesota, Massachusetts, and Arizona programs have continued through multiple governors and agency heads but have benefitted from continuity and strong leadership from key agency managers.

**Early and concerted efforts to include all stakeholders (state agencies, plans, providers, beneficiary advocates) in discussions around program design and implementation are essential, and some buy-in is needed before moving ahead.** As one top state official put it, “Getting everyone coordinated and getting everyone’s input is the hardest part.” States that were unsuccessful in implementing their integrated care programs indicated that lack of stakeholder support was a major barrier to success. Stakeholders in Maryland were not supportive of the program in part because they were not engaged in design efforts. In addition to engaging stakeholders early, some buy-in from key stakeholders is needed before pushing a program forward, since without it political support for implementation may be limited. Providers, plans, and consumers in Virginia were not interested in an integrated program, and despite countless meetings, stakeholders remained uninterested or actively opposed, which contributed to the decision not to implement the program.

## Enrollment

**Building enrollment in integrated care programs for dual eligible beneficiaries has been a significant challenge in every state we looked at. Low enrollment in these programs results from lack of beneficiary awareness of the programs and their potential care coordination benefits, and from limits on states’ ability to require duals to enroll in the programs for their Medicare services.** Even in states such as Arizona and Minnesota, where a large number of dual eligibles were “passively enrolled” in SNPs in 2006 for their Medicare services, many duals are not enrolled in integrated SNPs, and enrollment is much lower in other states we looked at. States such as Arizona, Minnesota, and New Mexico that require dual eligibles to enroll in Medicaid managed care programs have built on that requirement, encouraging dual eligibles to enroll in SNPs for both their Medicaid and Medicare services in order to obtain better integration of their care. The encouragement usually takes the form of internal health plan marketing to their dual eligible enrollees, although states may assist by mailing information to all dual eligibles describing the benefits of enrolling in a single plan for both Medicare and Medicaid services. State and plan representatives told us, however, that the benefits of coordinated care are often difficult to describe in the abstract. Moreover, states have limited resources for mailings and other forms of communication with dual eligible beneficiaries. Once dual eligibles are enrolled in integrated care programs, we were told, they appreciate the benefits of coordination and disenrollment rates are low.

As noted, less than 30 percent of dual eligibles enrolled in Medicaid managed care plans in Arizona are enrolled in the same SNP for both Medicaid and Medicare services, and only about 5 percent of those in New Mexico. The percentage is higher for duals age 65 and over in Minnesota, where duals must choose between the mandatory MSC+ program and the voluntary MSHO program. As a result, about 75 percent of duals age 65 and over are enrolled in the integrated MSHO SNPs for both Medicaid and Medicare services. Where Medicaid managed care enrollment for duals is voluntary, as in Massachusetts, enrollment in integrated programs is lower; only about 11 percent

of duals age 65 and over are enrolled in the states' SCO program for Medicaid and Medicare services. In North Carolina, dual eligibles are required to enroll in the state's CCNC enhanced PCCM program for Medicaid services. If they receive Medicare services from a CCNC practice in the NC-CCN 646 demonstration, the state planned to enroll them automatically in that practice for Medicare services unless they opted out. As noted, however, CMS has expressed concerns about using this enrollment process for Medicare services, so that process is now on hold. NC-CCN demonstration officials told us that they expected to enroll about 10 percent of the state's full dual eligibles in the integrated program in its first two years, although that estimate predates suspension of the opt-out process for Medicare services.

## Financing

**States have been reluctant to establish integrated care programs for dual eligible beneficiaries because most of the potential savings from the programs, especially in the short term, accrue to Medicare rather than to Medicaid. In addition, many duals have costly accumulated health care needs that must be dealt with before savings from better care coordination can be realized.** In the short term, most of the savings from improved integration of care for dual eligibles will likely take the form of reduced inpatient hospital and emergency room services and more cost-effective use of prescription drugs, which are services that Medicare largely covers for duals. In addition, substantial investments in better care management and care coordination may be needed before Medicare acute care savings begin to materialize. Savings from more appropriate use of Medicaid long-term-care services will likely take even longer to achieve.

The states we looked at have developed or are considering several ways of benefiting from the shorter-term Medicare savings that are expected to result from better integration and coordination of care for dual eligibles, including:

- Contracting with SNPs that receive funding from both Medicaid and Medicare for duals, with the expectation that the savings associated with care coordination and management can reduce the state's Medicaid expenditures for duals in SNPs (Arizona, Minnesota, Massachusetts, and New Mexico)
- Contracting with a separate nonprofit entity that receives Medicaid funding for duals and that may receive future Medicare savings from care coordination, with the expectation that state Medicaid expenditures may be lower over time than they would otherwise be (North Carolina)
- Relying on the state to serve as a managed care entity that is responsible for both Medicaid and Medicare payments for dual eligibles, as Vermont and Massachusetts (for duals under age 65) are considering

From the perspective of states, achieving savings in these ways may look somewhat indirect and conjectural, potentially posing a barrier to gaining and keeping support for integrated care programs for duals.

## Care Coordination

**Better coordination of care for dual eligible beneficiaries is a major goal of all the integrated care programs we looked at. The programs exhibited several commonalities in their approaches to care coordination, but the overall structure of the programs varied, reflecting differences in the structure of the state Medicaid programs on which they are**

**based.** Common features in the care coordination initiatives we looked at include initial assessments of enrollee needs, with a corresponding allocation of care management resources; information systems that facilitate coordination of care; a team approach to care management; and a focus on transitions into and out of hospitals and nursing facilities. Several of the programs rely on physicians and physician-based medical homes as an important element in care coordination, but the programs supplement physicians with nurse practitioners, pharmacists, social service coordinators, behavioral health providers, and others who help with the complex medical, behavioral, and social problems faced by many dual eligibles. Several of the health plans described investments in information technology they have made to help frontline care managers make the “many touches” that are needed for effective care management, including cell phones, lap-top computers, and printers care managers can bring with them on home visits.

Minnesota, Massachusetts, and Arizona have built their SNP-based integrated care programs for dual eligibles on the states’ earlier capitated Medicaid managed care programs for Medicaid beneficiaries. New Mexico has operated Medicaid acute-care managed care programs for all Medicaid populations for many years, but the CoLTS program is the state’s first venture into coverage of long-term care services in managed care. Since the MCOs participating in the state’s existing Medicaid managed care program decided not to participate in CoLTS, the state contracted with SNPs new to the state. North Carolina’s 646 demonstration program for duals builds on the state’s long-standing Medicaid enhanced PCCM program, and Vermont proposes to build on its Medicaid Global Commitment and Choices for Care waiver programs. If Oklahoma decides to cover duals, it will build on the SoonerCare Choice enhanced PCCM program and the Health Management Program for high-cost Medicaid enrollees.

The states with SNP-based capitated programs have extensive provisions in their contracts with health plans for care coordination, including provider network requirements and a variety of structure, process, and performance measures. Most care coordination, however, takes place within the SNPs. The plan representatives we spoke with described their care coordination activities in considerable detail and provided written information on them, but we were not able to assess the actual effects of those efforts.<sup>15</sup> In North Carolina, the CCNC community networks that developed under the state’s Medicaid enhanced PCCM program provide many of the care coordination and care management services needed to supplement physician services. The SNPs we spoke with in Massachusetts and the community networks in North Carolina’s 646 demonstration networks are also addressing hospital and nursing facility transitions.

## Capitated and Non-Capitated Approaches

**Only a limited number of MCOs have experience and interest in operating integrated care programs for dual eligible beneficiaries, and only a limited number of states are experienced with capitated Medicaid managed care programs for populations with complex care needs. Accordingly, capitated approaches to integrated care are not likely to be a feasible option in all states.** As of January 2010, over 80 percent of total enrollment in dual eligible SNPs (outside of Puerto Rico) was concentrated in just 10 states, and nearly 65 percent of total dual

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<sup>15</sup> For a thorough and informative review of care coordination within several SNPs in Arizona and Massachusetts, see Burwell, Brian, Paul Saucier, and Lina Walker. “Care Management Practices in Integrated Care Models for Dual Eligibles,” Washington, DC: AARP Public Policy Institute, October 2010. Available at [<http://assets.aarp.org/rgcenter/ppi/health-care/health-dual0910.pdf>]. Accessed October 8, 2010.

SNP enrollment was concentrated in 10 companies.<sup>16</sup> Several multistate companies with extensive Medicaid managed care experience also operate SNPs and are generally interested in tapping new markets for dual eligibles.<sup>17</sup> States that have relied on capitated managed care in their Medicaid programs for ABD enrollees are likely to be especially attractive to MCOs that have an interest in integrated care programs for duals, so those states could have a number of MCOs to choose from if they decide to follow a capitated managed care approach.<sup>18</sup>

**States with limited or no availability of MCOs but with existing state-developed care management programs, such as North Carolina and Vermont, are implementing or considering integrated care options in which the state would assume some or all of the functions performed by MCOs.** North Carolina is using its well-established Medicaid enhanced PCCM program as the base for its new integrated care demonstration program, and Vermont is proposing to build its integrated care program on its existing state-run acute- and long-term care Medicaid waiver programs. Massachusetts, a state with an established MCO-based integrated care program for dual-eligible seniors, is considering whether the state could assume some MCO-like functions for the under-65 dual population. These models of integrated care could permit states to share more directly in some of the Medicare savings realized from improved coordination of care for duals. However, several issues related to funding, accountability, and measurement of savings and performance must be worked out between the states and CMS if the non-MCO models are to be feasible. As discussed below, the 2010 health care reform law authorizes CMS to test and evaluate new integrated care models for dual eligibles, including models in which states could have management and oversight responsibility for both Medicaid and Medicare funds for duals.

## Dual Eligibles Under and Over Age 65

**While disabled dual eligibles under age 65 have care coordination needs that are similar to those of duals age 65 and older, there are differences in the types of care and assistance needed, types of providers, and beneficiary and advocate expectations that have led Minnesota and Massachusetts to establish or consider establishing separate programs for duals under age 65.** Minnesota's experience with the MSHO/MS+ programs for seniors and with the MnDHO/SNBC programs for those under age 65 with disabilities highlights some of the differences between the two dual populations. Minnesota officials told us that seniors are most interested in coordination of medical services within a health plan while younger duals are interested in help with navigating the broader system on their own, including assistance in obtaining access to non-medical social and community services. The expectations of advocacy groups also differ, which

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<sup>16</sup> Mathematica analysis of CMS SNP Comprehensive Report for January 2010. The 10 states, in order of the number of dual-eligible SNP enrollees, were California, New York, Pennsylvania, Florida, Arizona, Texas, Minnesota, Alabama, Tennessee, and Oregon. The 10 companies, in order of the number of dual-eligible SNP enrollees, were UnitedHealthcare, Kaiser Foundation Health Plan, HealthFirst, Humana, HealthSpring, Bravo Health, WellCare, Gateway Health Plan, HealthNet, and University of Pittsburgh Medical Center.

<sup>17</sup> Companies that operate Medicaid health plans and SNPs in several states include AMERIGROUP, Centene, Molina, UnitedHealth, and WellCare.

<sup>18</sup> As of 2006, the following states had 20 percent or more of their ABD Medicaid beneficiaries in capitated MCOs: Arizona, California, Delaware, Florida, Maryland, Michigan, New Jersey, New Mexico, New York, Oregon, Pennsylvania, and Virginia. Mathematica and CMS, "Statistical Compendium: Medicaid Pharmacy Benefit Use and Reimbursement in 2006, United States," Appendix Table A.3. Available at [[http://www.cms.gov/MedicaidDataSourcesGenInfo/08\\_MedicaidPharmacy.asp](http://www.cms.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp)]. Accessed September 22, 2010.

has implications for stakeholder support. In Minnesota, the disabled community did not want to be included in a program with seniors. It believed that the models of care and care coordination that worked for seniors would not serve younger people with disabilities. The Massachusetts state agency and health plan representatives we spoke with agreed that the SCO model now used for the population age 65 and older might need to be modified to meet the needs and expectations of duals under age 65.

## Long-Term Care

**Since most state expenditures for dual eligible beneficiaries are for long-term care (nursing facility services and HCBS), it will likely be essential—but also difficult—to incorporate Medicaid long-term care services into integrated managed care programs for duals.** Nursing facility opposition to managed care proved to be a significant barrier for Maryland and Virginia, both of which ultimately failed to launch integrated care programs. North Carolina’s program does not include Medicaid long-term care, in part because long-term care is not included in the enhanced PCCM program on which it is being built, but also because of concerns about potential opposition from long-term-care providers. New Mexico, by contrast, has focused its integrated care program for duals heavily on Medicaid long-term care, with Medicare acute care services covered only for the limited number of duals who choose to receive them through CoLTS SNPs.

States such as Arizona, Massachusetts, and Minnesota with long-standing integrated care programs have included long-term care services and may therefore provide some lessons for other states:

- **Nursing Facilities.** Medicaid capitated rates paid to SNPs in these states have generally been sufficient to enable plans to pay nursing facilities rates the facilities view as adequate. In addition, the plans have sought to be timely and efficient payers. Nonetheless, there are still tensions around Medicare skilled nursing facility lengths of stay, since SNPs generally limit these lengths of stay more than Medicare does in traditional FFS. On the other hand, SNPs tend to encourage use of nursing facility services when that is a feasible alternative to inpatient hospital care, potentially benefiting nursing facilities.
- **HCBS Providers.** Providers of Medicaid HCBS are concerned that SNPs may reduce the services they provide for dual eligibles or the amounts they are paid. In Massachusetts, the state law that established the SCO program requires SCO SNPs to contract with these providers, and that has resulted over time in a generally productive relationship. In Arizona, capitated rates paid to ALTCS plans include pre-established shares for community and nursing facility services. Plans are rewarded for meeting or exceeding the community service percentage, leading to a substantial shift over time from nursing facility to community service use. Minnesota, Massachusetts, and New Mexico provide similar incentives for use of HCBS and related services in their SNP payment systems, thereby encouraging SNPs to develop and improve relationships with providers of these services. SNPs may also be used, as in New Mexico, to constrain the cost of state personal care assistance programs and improve the cost-effectiveness of HCBS waiver programs, which can lead to tensions with providers of those services.

## Behavioral Health

Since many dual eligible beneficiaries—especially those under age 65—have significant behavioral health needs and since Medicare’s coverage of behavioral health services is limited, many of the state agency and health plan representatives we spoke with stressed the importance of including these services in integrated care programs for duals, despite the obstacles to doing so that sometimes exist. Behavioral health providers, beneficiary advocates, and state agencies operating behavioral health programs may oppose the inclusion of behavioral health services in integrated managed care programs for dual eligibles, sometimes because of opposition to managed care in general and sometimes because they believe that existing behavioral health programs can provide better care. In Arizona and Massachusetts, for example, managed Medicaid behavioral health services are provided through separate systems. Behavioral health services were also carved out of New Mexico’s CoLTS program because there is a separate statewide behavioral health program that provides these services. In Maryland, opposition from behavioral health providers who did not want to deal with MCOs led the state to carve out developmentally disabled and mental health populations from the integrated care plan for duals that the state was seeking to develop. Minnesota and North Carolina, by contrast, include behavioral health services in their integrated care programs for duals.

## Barriers to Implementation and Expansion

States and health plans typically cited similar barriers to implementing and expanding integrated care programs for dual eligible beneficiaries, including opposition from providers, beneficiary advocates, and state agencies; Medicare beneficiary choice requirements; CMS Medicare marketing rules; limits on state resources for outreach and marketing; conflicting Medicare and Medicaid rules; limits on state ability to share in Medicaid savings; and concerns about upcoming MA/SNP payment reductions. States with more established programs and experienced health plans have managed to work through or around many of these barriers, but they all would welcome assistance from CMS in overcoming them. Three issues were noted as being of particular importance:

- **Medicare Beneficiary Choice Requirements.** The state agency and health plan representatives we spoke with recognized that dual eligibles cannot be required to enroll in MCOs for Medicare services. They suggested, however, a number of ways of encouraging duals to enroll in integrated Medicaid and Medicare programs that would still preserve beneficiaries’ ability to choose to receive their Medicare services in FFS Medicaid or from another MA plan. They pointed to arrangements (sometimes called passive or seamless enrollment) that tentatively assign duals to an integrated plan, with clear and timely information on other available Medicare choices and the ability for beneficiaries to opt out of the initial assignment for any reason. States and plans experienced with such approaches report that usually fewer than 10 percent of beneficiaries opt out. States and health plans also have been somewhat successful in relying on mailings, telephone calls, and other CMS-approved forms of marketing to encourage duals to enroll in integrated programs, but such efforts are resource-intensive, which can be especially problematic for states in today’s budget environment.
- **CMS Medicare Marketing Rules and Limits on State Resources for Outreach.** Most of the health plan representatives we spoke with expressed frustration with CMS marketing rules, many of which require duals to receive highly detailed information that does not account for the special characteristics of dual-eligible SNPs and other

integrated plans for duals, including the links between those plans and Medicaid. In some cases, we were told, the information CMS requires is misleading or inaccurate for integrated programs. The marketing materials, the plans said, are often unsuited to dual eligibles with low levels of education and literacy or limited facility in English or the other languages into which materials are translated. The CMS requirement that plans contact new enrollees by telephone or mail to confirm their intention to enroll—which is designed to prevent marketing abuse by sales agents—can pose a problem when duals lack a telephone or stable address, and may be confusing to some of those who are contacted. Both health plans and states noted that states could help substantially with outreach and marketing, since states have contact information for most dual eligibles and may be viewed as more credible and objective by potential enrollees, but state resources for such efforts are currently quite limited.

- **Upcoming MA/SNP Payment Rate Changes.** Many of the SNP and state agency representatives we spoke with acknowledged that the provisions in the new health care reform law aimed at reducing the general overpayment of MA plans would not have a unique impact on SNPs. They did argue, however, that SNPs have less ability to adjust for rate reductions by increasing enrollee cost sharing or amounts charged to purchasers, since there are strict limits on cost sharing for dual eligibles, and state Medicaid programs are facing serious budget constraints. SNPs in Minnesota and Massachusetts, which have had access to a special frailty adjuster for SNP rates, were concerned about whether the version of that adjuster that is in the new health care reform law will be available to them or otherwise adequate to reflect the special health care needs and costs of their dual-eligible enrollees.<sup>19</sup>

## Impact of Health Care Reform

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required that dual-eligible SNPs have a contract with Medicaid agencies in the states in which they operate to “provide [Medicaid] benefits, or arrange for benefits to be provided” by the end of 2010. States are not required to enter into such contracts, however.<sup>20</sup> PPACA extended the deadline for dual SNPs to meet this requirement to the end of 2012.<sup>21</sup> Dual SNPs without such state contracts will not be able to operate as dual SNPs in 2013 and later years.

Most of the state and health plan representatives we spoke with did not anticipate that this requirement that dual-eligible SNPs have contracts with state Medicaid agencies would have a significant impact on them. The SNPs in Arizona, Massachusetts, Minnesota, and New Mexico already have such contracts. State officials in North Carolina and Oklahoma told us they have had some preliminary discussions with dual SNPs that were interested in contracting with the state, but nothing firm has resulted at this point.

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<sup>19</sup> The frailty adjuster provision is in Section 3205(b) of Public Law 111-148.

<sup>20</sup> Public Law 110-275, Sections 164(c)(1) and (4).

<sup>21</sup> Public Law 111-148, Section 3205(d).

All the states and health plans we spoke with were enthusiastic and hopeful about the new Federal Coordinated Health Care Office established in CMS as part of health care reform.<sup>22</sup> Vermont, Massachusetts, and North Carolina were especially interested in how they might be affected by the authority for the new CMS Center for Medicare and Medicaid Innovation to test models that would give states authority to manage and oversee both Medicaid and Medicare funds in integrated care programs for dual eligibles.<sup>23</sup>

## MAJOR QUESTIONS THAT REMAIN OPEN

Our review of integrated care programs found some established programs that were working reasonably well, like those in Arizona, Massachusetts, and Minnesota, although each had challenges to face. Newer programs, like those in New Mexico and North Carolina, look promising but do not yet have a track record to assess.

Our review of these programs and recent efforts in other states indicated that several major questions regarding integrated care models for duals still remain open:

- Which approaches to care coordination and management have the most beneficial impact on dual eligibles, and on service use and expenditures in Medicaid and Medicare?
- Are there approaches to beneficiary enrollment in integrated programs that can provide the volume of enrollment needed to support effective care management, while still preserving the right of Medicare beneficiaries to choose how they would like to receive their Medicare services?
- Can ways be developed to enable states to share more directly in the savings to Medicare that may result from Medicaid support of care management for dual eligibles?
- What can CMS and states do to facilitate access by integrated care programs to the Medicaid and Medicare data needed to manage care effectively and measure performance?
- Can responsibility for some Medicare and Medicaid services be shifted from one program to the other in order to facilitate more effective coordination of care, and ease the system-navigation burden now borne by dual eligibles?

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<sup>22</sup> Public Law 111-148, Section 2602.

<sup>23</sup> Public Law 111-148, Section 3021(b)(2)(B)(x).

**SITE VISIT SUMMARIES**

## MASSACHUSETTS

We interviewed state agency officials, health plan representatives, providers, and consumer counselors during our August 16-17, 2010, visit to Boston. The state agency officials were from the Executive Office of Health and Human Services, including the Office of Medicaid (responsible for administering the state's Medicaid program, which is called MassHealth), the MassHealth Office of Long Term Care, and the Executive Office of Elder Affairs. Those offices are responsible for the state's Senior Care Options (SCO) integrated Medicare and Medicaid program for dual eligible beneficiaries age 65 and over. The Office of Medicaid has organized planning for a new program to extend integrated care to duals under age 65. The health plan representatives were from Commonwealth Care Alliance, Senior Whole Health, and Evercare, three of the four Special Needs Plans (SNPs) the state has contracted with for the SCO program.<sup>24</sup> We also spoke with representatives from nursing facilities (Massachusetts Senior Care Association), Aging Services Access Points (community service agency contractors responsible for care coordination, long term community support services planning and delivery, and information and referral), and the Serving the Health Insurance Needs of Elders (SHINE) consumer counseling program.

### Basic Features of State's Program for Dual Eligibles

The basic features of the SCO program are summarized in Table 1. The program began in 2004 as a CMS Medicare-Medicaid dual-eligible demonstration, following many years of planning and consultation with stakeholders. The SCO plans participating in the demonstration were required to become Medicare Advantage SNPs in 2006. SCO serves MassHealth members age 65 and over—most of whom are dual eligibles—and covers all Medicaid and Medicare services for duals, including long-term-care services (nursing facility and home- and community-based services). Enrollment in SCO is voluntary, but with limited exceptions those who choose to enroll must receive both their Medicare and Medicaid services through the SCO plan in which they are enrolled. Each plan has a small number of Medicaid-only enrollees, since the state allows over-65 Medicaid beneficiaries without Medicare coverage to enroll on a voluntary basis.<sup>25</sup>

The SCO plans operate in most areas of the state, except for Cape Cod and the more rural western part of the state. There are about 220,000 full dual eligibles in Massachusetts, and about 120,000 of them are age 65 and over and eligible for SCO if they live in a SCO service area.<sup>26</sup> As of

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<sup>24</sup> The fourth SNP is NaviCare, which is operated by Fallon Community Health Plan. NaviCare was not a SCO plan during the original demonstration period. It only recently began contracting with the state as a SCO plan and therefore is newer and smaller than the other three SCO plans.

<sup>25</sup> As of August 1, 2010, 6.3 percent of the enrollees in the four SCO plans were Medicaid-only. Senior Whole Health had the largest percentage of Medicaid-only enrollees (8.5 percent), while 6.8 percent of Commonwealth Care Alliance's enrollees were Medicaid-only and 3.8 percent of Evercare's. The most common reason that Medicaid beneficiaries age 65 and over lack Medicare coverage is that they are recent legal immigrants who have not paid into Medicare for the required 10 years.

<sup>26</sup> Holahan, John, Dawn M. Miller, and David Rousseau. "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005, Tables 2 and 3." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2009.

August 2010, there were just over 13,600 dual eligibles enrolled in the four SCO SNPs (out of 14,500 total enrollees), about 11 percent of the 120,000 full dual eligibles age 65 and older.<sup>27</sup>

Massachusetts is currently considering options that would extend integrated care to dual eligibles under age 65. The initiative to integrate care for younger dual eligibles is a response to a 2008 state law that requires development of “dual-eligible plans” for disabled dual eligibles under age 65.<sup>28</sup> The law is not specific about what these plans should look like, but it requires consideration of the clinical, administrative, and financial barriers to developing such plans and ways of removing those barriers. The law also requires public consultation with organizations representing seniors, disabled persons, health care consumers, and racial and ethnic minorities as well as with health delivery systems and health care providers.

## Plan and Provider Contracting

Massachusetts will contract in the SCO program with any organization that it considers qualified and that can meet program requirements. Commonwealth Care Alliance, Evercare, and Senior Whole Health have participated in the SCO program since its inception in 2004, and NaviCare began SCO enrollment in 2010. Each SCO plan has two contracts, one with MassHealth (Medicaid) for Medicaid benefits and requirements, and one with CMS as a dual-eligible SNP for Medicare benefits.<sup>29</sup>

The three SCO plans we met with have somewhat different approaches to building their provider networks. Commonwealth Care Alliance (CCA) focuses on developing relationships with primary care physician practices that are willing and able to implement the CCA approach to coordinating care for dual eligibles with complex care needs, and then builds their SCO network out from those practices, including hospitals, specialists, and other providers. Senior Whole Health (SWH) begins with the providers their SCO enrollees are already seeing, and seeks to bring those physicians, hospitals, and other providers into their SCO network. Evercare’s approach is more conventional. Since it is part of a national plan with a well-established presence in Massachusetts (UnitedHealthcare), it is able to cast a wider net in establishing its SCO network by building on its existing provider relationships, while still focusing on the providers most needed by its SCO enrollees.

The legislation that established the SCO program required the SCO plans to contract with Aging Services Access Points (ASAPs) to provide care coordination and counseling to SCO enrollees through their Geriatric Support Services Coordinators (GSSCs). GSSCs are social workers with geriatric expertise who assist with member assessments, care planning, non-medical support services, and linkages to community resources. They may have experience in working with a variety

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<sup>27</sup> As of August 2010, the Senior Whole Health SCO SNP had 5,994 enrollees, Evercare had 4,559, Commonwealth Care Alliance had 2,555, and NaviCare had 508. In addition, Evercare operates two chronic condition SNPs and two institutional SNPs in Massachusetts that are not part of the SCO program. See CMS. “Special Needs Plan Comprehensive Report.” August 2010. Available at [<http://www.cms.gov/MCRAdvPartDEnrollData/SNP/list.asp#TopOfPage>]. Accessed August 25, 2010.

<sup>28</sup> Chapter 305 of the Acts of 2008, Section 38.

<sup>29</sup> In the CMS dual-eligible SCO demonstration, there was a three-way contract that included the state, CMS, and the SCO plans that we were told substantially facilitated the operation of the SCO program. That arrangement ended on December 31, 2008, so SCO plans must now, at CMS’s direction, contract separately with the state and with Medicare.

of different populations and languages. The GSSCs work under contract with the SCO plans as part of plan care teams. The teams also include the enrollee, nurse care managers and member support staff employed by the plans, and the physicians who are caring for plan enrollees.

As discussed below under Care Coordination, SCO plans all rely on nurse care managers (usually nurse practitioners) to work directly with the physician practices in their networks. In some cases, if the practice is large enough and has enough SCO plan enrollees, the nurse care managers may be placed in the practice itself. More commonly, a nurse care manager works with several practices. These nurse care managers also work on transitions of SCO enrollees into and out of hospitals and nursing facilities.

## Financing and Payments

**State Payments to SCO Plans for Medicaid Services.** Massachusetts makes per member per month (PMPM) capitated payments to SCOs based on several factors, including geography (Boston or non-Boston), eligibility (dual eligible or Medicaid-only), care needs in the community (community well, Alzheimer's/dementia/chronically mentally ill [AD/CMI], and nursing facility clinically eligible in the community), and three levels within nursing facilities. In 2010, the rates for dual eligibles in Boston were \$165 PMPM for community-well enrollees; \$645 for AD/CMI; \$2,730 for nursing facility-eligible; \$4,457 for Tier 1 in a nursing facility; \$6,610 for Tier 2; and \$8,399 for Tier 3.<sup>30</sup> The PMPM payments cover all Medicaid services for dual-eligible SCO enrollees, including care coordination.<sup>31</sup>

To provide an incentive for SCOs to serve people in the community rather than in nursing facilities to the extent possible, the state pays the community nursing-facility-eligible rate for SCO enrollees' first 90 days in a nursing facility, and the Tier 1 nursing facility rate for 90 days after an enrollee moves from a nursing facility into the community.

While there are gradations in the state's capitated Medicaid payments to SCO plans, the plans told us that more fine-grained gradations would better reflect the actual care needs and costs of SCO enrollees. For example, a diagnosis-based risk adjustment system like the Chronic Disability Payment System (CDPS) used by many state Medicaid programs would be preferable for payments for enrollees in the community, they said. Similarly, they said that a nursing facility case-mix reimbursement system based on Resource Utilization Groups (RUGs) like that used by Medicare and many state Medicaid programs would provide a better basis for capitated payments to SCOs than the three-tier system now in place for SCO enrollees in nursing facilities.

**CMS Payments for Medicare Services.** The SCO plans have been paid by CMS for Medicare services in the same way as other Medicare Advantage plans are paid, with one exception. The SCO plans received an additional "frailty adjustor" during the dual-eligible demonstration period, but it

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<sup>30</sup> E-mail from Susan Ciccariello, Assistant Director, SCO, Massachusetts Executive Office of Health and Human Services, to Jim Verdier, September 23, 2010.

<sup>31</sup> For the small number of Medicaid-only enrollees in SCO, the Medicaid SCO payments are substantially higher, since they must cover the cost of services Medicare covers for dual eligibles. For Medicaid-only community-well enrollees, for example, the PMPM rate in Boston is \$1,006, compared to \$165 for a comparable dual. For a Medicaid-only enrollee in the community who is nursing facility eligible, the Boston SCO rate is \$7,351, compared to \$2,730 for a comparable dual.

was gradually phased down from 2006 to 2010. The 2010 health care reform law authorizes a new frailty adjuster payment for dual-eligible SNPs that are fully integrated with state Medicaid plans, which the SCO SNPs expect to be eligible for.<sup>32</sup>

**Plan Payments to Providers.** The SCO plans we met with told us that they generally pay providers according to the Medicare and Medicaid fee schedules, although they sometimes pay additional amounts for providers and services that are in short supply and/or are especially needed by their enrollees. The SCO plans also make some additional PMPM payments to physician practices to cover care coordination and management activities that may otherwise not be billable, and in some cases pay practices directly for the activities. The SCO plans generally pay the ASAPs on a capitated PMPM basis. Evercare said they did not require a three-day hospital stay as a pre-condition for Medicare skilled nursing facility (SNF) reimbursement, which results in higher SNF reimbursement in situations where there are shorter or no hospital stays.

Evercare said that it includes a small pay-for-performance element in its payments to nursing facility providers based on specific quality measures, such as influenza vaccination rates. The other SCO plans are also experimenting with extra pay-for-performance payments for providers in their networks, although this is currently a small element in current SCO provider reimbursement. The SCO plans were generally reluctant to provide specific details on their payments to providers, since they view this information as proprietary.

## Care Coordination

Each of the three SCO plans we met with devotes extensive resources to care coordination, including care teams made up of nurse care managers, GSSCs, and member services staff that work closely with physician practices to address the needs of specific enrollees. Enrollees are screened at initial enrollment to determine their care needs, and individual care plans are developed for each enrollee. Those with lower needs—the “community well,” for example—receive less focused ongoing attention than those with complex medical and behavioral health needs or who are clinically eligible for nursing facility care. SWH provided a copy of the 13-page “model of care” they submitted to CMS as part of their Medicare Advantage SNP application, which details SWH’s approach to care coordination. The CCA model of care was similar, but with more focus on working directly with selected physician practices.<sup>33</sup> Evercare did not provide a copy of their SNP model of care, since it is not company policy to do so, but the information they provided to us in writing and in our meeting with them indicated that their general approach to care coordination was similar to that of the other two plans.

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<sup>32</sup> Section 3205(b) of Public Law 111-148 authorizes CMS to apply a frailty adjustment similar to that used in the Program of All-Inclusive Care for the Elderly (PACE) for payments to fully integrated dual-eligible SNPs that have capitated contracts with states for Medicaid benefits that include long-term care, and that have similar average levels of frailty as the PACE program.

<sup>33</sup> For more detail on the CCA and SWH approaches to care coordination, see Brian Burwell, Paul Saucier, and Lina Walker. “Care Management Practices in Integrated Care Models for Dual Eligibles.” Research Report for the AARP Public Policy Institute, October 2010. Available at [<http://assets.aarp.org/rgcenter/ppi/health-care/health-dual0910.pdf>]. Accessed October 9, 2009.

Since the SCO program has been in operation since 2004, with a comprehensive Medicare-Medicaid benefit package and separate capitated payments from Medicare and Medicaid that the plans told us were generally adequate, the SCO plans have had the time and resources needed to develop and hone their care coordination programs. The plans are able to target their care coordination efforts to meet the varying care needs of different types of enrollees, and to address both their social and clinical needs. Nonetheless, the plans described some areas that have been challenging for them, and that other states considering programs for duals should take into account in their planning:

- **Relationships with ASAPs and GSSCs.** From the outset of the SCO program, the SCO plans have been required to contract with ASAPs and their GSSCs for care coordination and social service support. While some of the original tensions from this “arranged marriage” still remain (some ASAPs would prefer more autonomy in providing these services, and the SCO plans in some cases would prefer the flexibility to provide more of these services with their own staff), the SCO plans we met with generally expressed appreciation for the built-in expertise and networks that the ASAPs provide. The services provided by the ASAPs and GSSCs are a key element in the care coordination needed by the population served by the SCO plans, so the plans need this capacity in some form, and the current arrangements appear to be working in a reasonably satisfactory way for both the plans and the ASAPs. One ASAP representative we spoke with stressed the value of the increased communication between and among care managers, nurses, and beneficiaries as a result of SCO. “Some cases start out as train wrecks,” she said, “but the communication averts the wreck. It’s a well integrated system.”
- **Transitions into and out of Hospitals.** All the SCO plans highlighted the importance of doing a better job on these transitions and discussed some of the difficulties they have had in working with hospitals to reduce avoidable admissions and readmissions. The basic problem is that hospitals currently do not have sufficient incentives to focus resources or attention on activities that would reduce admissions, although the financial penalties for avoidable readmissions that hospitals will soon be facing may change that.<sup>34</sup> In the meantime, the SCO plans told us, they often do not have enough enrollees to give them the “clout” they need to persuade hospitals to work with them and their nurse care managers and physicians on this issue. The SCO plans are fully at risk for all Medicare services for their dual-eligible enrollees, so their role as the payer for Medicare hospital services gives them some leverage they would not otherwise have, but their use of any one hospital is usually not sufficient to enable them to have a significant impact on hospital behavior.
- **Reducing Avoidable Hospitalizations for Nursing Facility Residents.** In general, nursing facilities have substantial financial incentives to hospitalize dual-eligible residents who may need more intensive care than nursing facilities normally provide, since the cost of the care is then borne by the hospital (and Medicare), and the resident is usually eligible for a higher Medicare skilled nursing facility rate after returning to the facility

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<sup>34</sup> Beginning in October 2012, Medicare hospital payments will be reduced if hospitals have “excess readmissions.” See Patient Protection and Affordable Health Care Act of 2010, Public Law 111-148, Section 3025.

following a three-day hospital stay.<sup>35</sup> This is a bigger issue for Evercare than it is for the other two SCO plans, since 26 percent of Evercare’s SCO enrollees are in nursing facilities, compared to only 9 percent of SWH’s enrollees and 4 percent of CCA’s. Evercare has a well-developed model for reducing avoidable hospitalizations from nursing facilities, placing their own nurse practitioners in facilities to work with facilities and physicians to reduce hospitalizations, and making some extra payments to facilities that are successful in doing so. Since SCO plans are fully at risk for all hospital services for their enrollees, they can fund extra payments to nursing facilities out of savings from averted hospitalizations. Nonetheless, the fact that Evercare SCO residents are only a small percentage of the residents of most nursing facilities limits the scope of what Evercare can accomplish, and the two other SCO plans have even less leverage with nursing facilities, given the small number of their enrollees in these settings.

## Beneficiary Participation and Enrollment Practices

As noted earlier, enrollment in SCO plans is voluntary for both Medicaid and Medicare services. Dual-eligible beneficiaries who choose to enroll in a SCO plan must, however, receive all their Medicaid and Medicare services through the plan. Only about 11 percent of dual eligibles age 65 and over are enrolled in SCO, and enrollment growth for all four plans has been slow and incremental. Without greater enrollment, it is difficult to demonstrate to the state and others the benefits of managed care. A health plan representative sees enrollment as “an issue of critical mass. You have to get to a critical mass before the state realizes the savings from SCO programs.”

The SCO plans attributed part of their difficulty in increasing enrollment to CMS Medicare Advantage marketing guidelines that make marketing to individual dual eligibles resource-intensive and frequently confusing to enrollees, particularly those who do not speak English or have low levels of education and literacy.<sup>36</sup> One health plan representative explained that as a result of changes in MIPPA it is more difficult to have direct conversations with potential beneficiaries. “In the past you could find out who was eligible and now you can’t. It’s a marketing and privacy issue.” Even if a SCO plan can speak with potential enrollees, new CMS marketing guidelines require call-backs to newly enrolled beneficiaries to make sure they understand what they are signing up for. “We now have to call enrollees after they fill out the forms to make sure they want to join the program. We lose 10 people a month doing that. The rules make it out that we are all crooks. We complicate the process if we go to too many extremes to make sure people actually want to join.”

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<sup>35</sup> In most states, including Massachusetts, Medicaid also makes “bed hold” payments to nursing facilities to cover at least part of the facility’s cost of holding the bed until the patient returns. For a discussion of nursing facility financial incentives and their implications for dual eligibles, see James M. Verdier. “Coordinating and Improving Care for Dual Eligibles in Nursing Facilities: Current Obstacles and Pathways to Improvement.” Policy Brief. 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 October 1, 2010.

<sup>36</sup> In response to past marketing abuses by some Medicare Advantage plans, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires plans to use marketing materials with standard language approved by CMS and prohibits door-to-door solicitation and “cold calls” to potential enrollees. CMS-approved marketing materials may be mailed to dual eligibles, although it may be difficult to obtain accurate mailing addresses for dual eligibles. For details on the MIPPA marketing requirements, see 42 CFR Sections 422-2260 to 422-2274.

The SCO plan representatives also said that they have received relatively little outreach and marketing assistance from the state, even though the state has reasonably good contact information (addresses and telephone numbers) for dual-eligible beneficiaries. A health plan representative commented, “A simple part of enrollment is the role of the state. The state hasn’t been there building awareness in Massachusetts. The state knows who is eligible, but they aren’t there.” The state agency representatives we spoke with agreed that state assistance has been limited, attributing it to severely strained budget, staff, and administrative resources. State representatives told us the state mails postcards informing potential eligible enrollees about the SCO program at a rate of 4,000 a month and sends informational birthday cards to managed care enrollees turning age 65.

## Performance and Quality Monitoring

The SCO program has included extensive performance and quality monitoring requirements for participating health plans since its inception. The SCO plans submit the same HEDIS and CAHPS data to the state that they submit to Medicare, and also participate in the Medicare Health Outcomes Survey (HOS).<sup>37</sup> When Medicare began requiring SNPs to submit new structure and process measures in 2009, the state adopted that same requirement for the SCO SNPs.<sup>38</sup>

Plan representatives told us that there are no differences between the performance and quality measures that the state and Medicare require for SCO plans. Some of the plans suggested that measures be developed that better reflect the complexity of serving frail elderly duals, including measures focusing on hospital and nursing facility transitions, hospital readmissions, “treatment in place” in nursing facilities, behavioral health, social service assessments, use of HCBS, and hospice care. Plan representatives also said that both Medicaid and Medicare should be more mindful of the challenges in administering surveys such as HEDIS and HOS to persons with cultural and language differences and chronic medical and behavioral health conditions.

Massachusetts does not currently require the SCO SNPs to submit encounter data on the services they provide, nor does Medicare.<sup>39</sup> The state agency representatives we spoke with suggested that the state is working toward collecting encounter data from SCOs. SCO SNPs told us that they would be willing and able to submit such data if the state requested. Neither the plans nor the state agency representatives were specific about what kinds of encounter data might be involved, which could range from basic measures like hospital admissions and physician visits up to the full range of services included in FFS claims data.

The three SCO SNPs we spoke with all described similar efforts to monitor and improve the performance of providers in their networks, including comparisons of individual provider performance on a variety of measures to that of their peers, and work with providers on individual cases in which there appear to be access, care management, quality, or other problems. Evercare, for

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<sup>37</sup> HEDIS refers to the Healthcare Effectiveness and Data Information Set, which measures health plan performance on a variety of care and service measures. CAHPS refers to the Consumer Assessment of Healthcare Providers and Systems, which is a survey-based measure of consumer experiences with health care.

<sup>38</sup> For more detail on these SNP structure and process measures, see [<https://www.cms.gov/SpecialNeedsPlans/Downloads/SPMeasuresUpdate.pdf>]. Accessed August 26, 2010.

<sup>39</sup> Encounter data are service-specific records of the services rendered by providers. They are comparable to the claims for payment that providers submit to payers in FFS systems.

example, has a pay-for-performance program for nursing facilities that pays them additional amounts based on specific quality outcomes. SWH sends “quality of care” letters to individual providers when there are problems or unexpected outcomes with specific patients, such as falls while in a hospital or adverse reactions to medications. CCA sends quarterly reports to all of its primary care sites that compare that site’s performance to that of all other CCA practices on a variety of cost and quality measures. The SCO plans focus in particular on physician practices and other providers that serve a relatively large number of their members.

## Impact of Health Care Reform

The requirement that dual-eligible SNPs have a contract with state Medicaid agencies does not affect the SCO SNPs, since they all have such contracts already.<sup>40</sup>

Some of the SCO SNPs expressed concern that the new star rating and payment system for Medicare Advantage plans, which provides additional payments to plans based on ratings that use a variety of quality and performance measures, is not a good fit for plans that exclusively serve poor elderly dual eligibles.<sup>41</sup> One SCO representative said, “The HEDIS scores and star ratings don’t fit well with the geriatric population. That hurts us.” The SCOs suggested that star ratings and payments for SNPs should be based in part on the SNP structure and process measures developed by the National Committee for Quality Assurance (NCQA) and CMS, which the SCOs view as more appropriate measures of performance for plans like theirs.<sup>42</sup>

As noted, SCO SNPs are hopeful that they will qualify for the new “frailty adjuster” payments authorized in the health care reform law for dual-eligible SNPs that are fully integrated with Medicaid, but they had not received any definite word from CMS on this at the time of our visit.

All the SCO SNPs expressed concern about the scheduled reductions in reimbursement for Medicare Advantage plans, noting that plans serving exclusively low-income beneficiaries do not have the option of offsetting payment reductions with higher beneficiary premiums and cost sharing.<sup>43</sup> The for-profit SCOs expressed similar concerns about the premium tax on health insurance plans scheduled to take effect in 2014, which will have its greatest impact on for-profit plans.<sup>44</sup>

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<sup>40</sup> MIPPA required that dual-eligible SNPs have a contract with the states in which they operate by the end of 2010. The deadline was extended to the end of 2012 by Section 3205(d) of PPACA.

<sup>41</sup> For details on the star rating and payment provisions, see Sections 3201 and 3202 of Public Law 111-148 as modified by Sections 1102(b) and 1102(d) of the Health Care Education Reconciliation Act (Public Law 111-152).

<sup>42</sup> For details on these SNP structure and process measures, see: [<http://www.cms.gov/SpecialNeedsPlans/>]. Accessed October 13, 2010.

<sup>43</sup> Like all Medicaid Advantage plans, SNPs can offset payment reductions through administrative efficiencies and effective management of service utilization.

<sup>44</sup> Non-profit plans are partially exempt from the premium tax, and non-profit plans such as CCA that serve exclusively low-income, elderly, or disabled populations are fully exempt. See Sections 9010 and 10905 of Public Law 111-148, as amended by Section 1406 of Public Law 111-152.

## Barriers to Expansion

**Voluntary Enrollment.** The greatest barrier to expansion of the SCO program is the fact that enrollment is voluntary on both the Medicaid and Medicare side. Identifying and marketing to potential enrollees on a one-by-one basis is very costly and resource-intensive. In addition, as noted earlier, the state has not had the resources to assist the SCO plans with outreach and marketing. We were also told that some of those who counsel potential enrollees, such as the ASAPs and SHINE counselors, may have concerns about the appropriateness of managed care in general that could influence beneficiary choices. The ASAP and SHINE representatives we talked with during our visit spoke highly of the SCO program, however.

**Passive Enrollment.** There has been substantial discussion in the state over the years about whether “passive” enrollment in the SCO program should be instituted, with a very easy opportunity to opt out for those who preferred FFS or another health plan. We did not discuss in detail with the state or the plans how this might work. Beneficiaries could be required to enroll in SCO plans for their Medicaid benefits, for example, but current Medicare rules would not permit mandatory enrollment for Medicare benefits. SCO enrollees would then have the option of obtaining their Medicare benefits from a SCO plan, FFS Medicare, or from another Medicare Advantage plan. The hope of advocates for passive enrollment is that the exposure to the benefits of coordinated care for both Medicaid and Medicare benefits would lead most SCO enrollees to choose to receive their Medicare benefits from the SCO plan. As one SCO plan representative put it, “We assume if we have a time to get people in our program we can show them how great our program is and then they can opt out if they want to.”

CCA representatives, however, told us that they were opposed to any kind of passive enrollment in SCO plans since their coordinated care model depends heavily on beneficiary participation in and acceptance of their care coordination approach. SWH representatives suggested that many dual eligibles in Massachusetts are not enrolled in managed care simply because they are not aware of it: “They aren’t saying no; they just don’t know about it.”

**Nursing Facility Support for SCO.** In contrast to the experience in other states, nursing facilities in Massachusetts have generally supported the SCO program. The Massachusetts Senior Care Association, which is the trade association for nursing facilities, placed an ad in the *Boston Globe* in April 2010 praising the program.<sup>45</sup> A representative of the association told us, “We decided that these kinds of models are the future. . . . Our experience is generally very positive. . . . Consumers love it. . . . You get paid promptly with the SCO. . . . SCOs are cleaner, better payers. . . . SCOs are more successful [in preventing re-hospitalizations] because the nurse practitioners are in the nursing facilities. . . . The facilities feel more comfortable not sending patients to the emergency room.” He did express some concerns, however, related primarily to Medicare skilled nursing facility lengths of stay. “Length of stay with SCO is half of the length of fee-for-service,” he told us. “SCOs move them out faster.” When we asked him why enrollment in SCO plans is not higher, he said, “That’s their Achilles heel. Elderly people are reluctant to give up choice.”

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<sup>45</sup> Massachusetts Senior Care Association. “Better Managing the Care of Frail Seniors.” *Boston Globe*, April 13, 2010. The association represents more than 500 nursing and rehabilitation facilities, assisted living residences, residential care facilities, and continuing care retirement communities.

**CMS Marketing Restrictions.** As noted, all the SCO plans we spoke with expressed frustration with CMS and (to a lesser extent) with state marketing restrictions, pointing to substantial beneficiary confusion and, in some cases, unintended disenrollment. While plans can work with providers to help increase SCO enrollment, CMS rules prevent providers from “steering” patients to enroll in particular plans if the providers receive any financial benefit from doing so, making some providers uncertain about what they can and cannot do.<sup>46</sup>

**Medicare Advantage Member Communication Requirements.** The SCO plans also pointed to Medicare Advantage requirements for plan communication with members that are problematic for dual-eligible plans: “Most of the member materials speak only to Medicare. . . . Medicare requires that we use a generic model Explanation of Coverage [EOC] that contains language that does not apply to our members. . . . We are also required to talk about certain features as if they ‘may’ apply to our members, when all members are eligible due to the nature of our program. . . . Additionally, the benefit grid in the EOC is designed to reflect Medicare benefits, so all non-Medicare benefits for which members are eligible are not displayed in the same way.”

**Inconsistent and Conflicting Medicaid and Medicare Requirements.** The plans described inconsistent and sometimes conflicting state and CMS requirements for contracting and enrollment timelines, eligibility, enrollment and disenrollment, complaints and grievances, and monitoring and reporting. While the state and SCO plans have developed work-around solutions for most of these issues, the solutions are administratively burdensome. Full integration would be facilitated if more of these conflicts could be reduced or eliminated.

## Lessons Learned and Future Plans

**State Agency Representatives.** The state agency representatives we spoke with had several suggestions:

- “Lack of data in general is a problem. We aren’t collecting encounter data from the SCOs. We don’t require it from the SCOs, but we are moving toward requiring it. Lack of data from Medicare is also a problem.”
- “A lesson for other states is the importance of embracing consumer stakeholders in the process.”
- “The importance of support services to make us more efficient on the medical side is critical. . . . SCOs have a unique structure because of our ASAPs and legislative requirements. That particular relationship is unique to our state. It could be exported, but it depends on the environment.”

**Health Plans.** All the SCO plans we spoke with were pleased with the opportunities for improved integration of care under the SCO program, yet they were frustrated by conflicting Medicaid and Medicare rules and requirements:

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<sup>46</sup> The federal anti-kickback statute (42 USC Sec. 1320a-7b) makes any direct or indirect remuneration for such referrals illegal.

- “The dual regulatory oversight by both the state and CMS is fraught with challenges, including the complexity of a dual reporting relationship to both entities with its replication, duplication, inconsistencies, and conflicting requirements.”
- “There is limited awareness of the SCO program among potential members, families, providers, and policymakers. This poses a barrier to enrollment as well as under-publicizes the benefits of SCO that can certainly be described as a successful model in place today that is aligned with health care reform’s legislative intent to improve health care and financing models.”
- “The financing and benefit structure of Massachusetts Medicaid may be richer/broader than other state Medicaid programs, which may make it more challenging for other states to build a comprehensive SCO program off the Medicaid base model.”
- “You need a network in place in the community to allow your plan to work. You can’t just build the whole thing organically.”

**Future Plans.** State plans to extend integrated care options to dual eligibles under age 65 are still under development, but several of those we spoke with during our visit had views on how integrated care could be extended to the under-65 population. Most stressed the diversity in the under-65 dual eligible population in terms of their physical and behavioral health conditions, the types of non-medical supports and services that might be needed, and the adequacy of the Medicare benefit package and Medicare Advantage financing:

- [From a state representative] “For our new under-65 model, we are focusing on person-centeredness, care coordination, having a single accountable entity, and having financial integration where Medicare would share the savings with us. We would integrate Medicare and Medicaid funding at the state level. . . . We are not thinking of the under-65 initiative as an expansion program, but as a delivery system change.”
- [From a SCO plan] “We are well positioned to manage this population. We recognize and would be equipped to treat a potential varied disease burden such as beneficiaries with HIV, those with alcoholism, drug abuse and other mental health disorders, and those with physical disabilities.”
- [From another SCO plan] “A great idea, but without a revamping of the [Medicare risk-adjusted payment system], it will be underfunded. Behavioral health issues in this population are not accounted for in proportion to their prevalence in the current system. Part D is seriously flawed in bidding for this population.”
- [From an ASAP representative] “When we meet someone under 65, and they are frail, need care, and want to remain at home, we are very frustrated. I would embrace a model for the under 65.”

## NEW MEXICO

We interviewed state agency officials, health plan representatives, providers, and a consumer during our June 24–25, 2010, visit to Albuquerque and Santa Fe. The state agency officials were from the Human Services Department and the Aging and Long-Term Services Department, which jointly administer New Mexico’s Coordination of Long-Term Services (CoLTS) program for dual eligibles and other Medicaid beneficiaries. The health plan representatives were from Evercare and AMERIGROUP, the two plans the state has contracted with for the CoLTS program. We also spoke with nursing home and HCBS providers, and with a consumer receiving services in her home through Evercare.

### Basic Features of State’s Program for Dual Eligibles

The basic features of the CoLTS program are summarized in Table 1. The program began operation in August 2008 under a Medicaid Section 1915(b)(c) combination waiver. It covers primarily Medicaid long-term care services, including nursing facility, HCBS waiver, and Personal Care Option (PCO) state plan services. For non-dual Medicaid enrollees, it also covers Medicaid acute care services. Enrollment is mandatory for most Medicaid beneficiaries who meet nursing facility level-of-care requirements.<sup>47</sup> For dual eligible enrollees, it covers Medicare premiums and cost sharing and limited Medicaid acute care wrap-around services (vision, dental, transportation, and some other services not fully covered by Medicare). CoLTS managed care organizations (MCOs) also cover Medicare acute and long-term care services if the enrollee chooses to get those services through the Evercare or AMERIGROUP Special Needs Plan (SNP). CoLTS health plans are required to be Medicare Advantage SNPs. In most cases, however, dual eligible CoLTS enrollees choose to receive their Medicare services either in the traditional Medicare FFS system, or through one of the large Medicare Advantage plans in the state (Lovelace or Presbyterian).<sup>48</sup> Only 2 percent of AMERIGROUP’s 19,000 CoLTS enrollees receive their Medicare services through the AMERIGROUP SNP, and 6.5 percent of Evercare’s 18,500 CoLTS enrollees receive their Medicare services through Evercare’s SNPs.<sup>49</sup>

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<sup>47</sup> Beneficiaries receiving services in HCBS waivers for those with developmental disabilities, AIDS, or who are medically fragile are not required to enroll, nor are those enrolled in the Program of All-Inclusive Care for the Elderly (PACE). Dual eligibles not receiving long-term care services (“healthy duals”) are required to enroll for their Medicaid services.

<sup>48</sup> In 2010, over 75 percent of New Mexico’s 309,000 Medicare beneficiaries were in the traditional fee-for-service Medicare program. Out of the 74,000 enrolled in Medicare Advantage managed care plans, 38 percent were enrolled in a Lovelace plan, and 35 percent were in a Presbyterian plan. Marsha Gold, et al. “Medicare Advantage 2010 Data Spotlight,” Kaiser Family Foundation, June 2010, p. 11, available at [<http://www.kff.org/medicare/upload/8080.pdf>], accessed August 4, 2010. As of July 2010, AMERIGROUP’s New Mexico SNP had 458 dual-eligible enrollees, and Evercare’s SNP had 1,126, with another 3,072 in an Evercare SNP operating in both New Mexico and Texas. Evercare also has an Institutional SNP in New Mexico, with a July 2010 enrollment of 117. Centers for Medicare & Medicaid Services. Special Needs Plan Comprehensive Report, July 2010. Available at [<http://www.cms.gov/MCRAAdvPartDENrolData/SNP/list.asp#TopOfPage>]. Accessed August 4, 2010.

<sup>49</sup> Evercare representatives estimated in our June 25 discussion with them that approximately 1,200 of Evercare’s 18,500 CoLTS enrollees were also enrolled in Evercare’s SNPs for their Medicare benefits. AMERIGROUP representatives estimated that about 400 of their 19,000 CoLTS enrollees are enrolled in the AMERIGROUP SNP for their Medicare benefits.

## Plan and Provider Contracting

New Mexico selects MCOs that participate in its Medicaid managed care programs through competitive procurements that are scheduled periodically, usually every four years. New Mexico began developing what became the CoLTS program in November 2004 when it put out a request for proposals (RFP) seeking health plans to participate in the new program. The state hoped that MCOs participating in the existing Salud! Medicaid managed care program would be interested in participating in the new program, but in the end only two plans from outside the state—Evercare and AMERIGROUP—bid on the RFP and were selected to participate in development of the new program.

Now that the program has been established—and with the new requirement in federal law that dual eligible SNPs have a contract with state Medicaid agencies—New Mexico has been approached by additional plans seeking to participate in the CoLTS program. The next CoLTS procurement is not scheduled to take place until 2012, however, so the state has told these plans that they will not have an opportunity to participate until the RFP for that procurement is released.

Evercare and AMERIGROUP contract with providers in their networks on a FFS basis, generally following the payment methodology used by the state in the Medicaid FFS program. These Medicaid FFS methodologies are not always easy to replicate, however, especially for HCBS and PCO providers who have been paid in ways that are not as standardized as those used for physicians, hospitals, and nursing facilities.

Evercare and AMERIGROUP also do not necessarily pay providers the same amounts per service that the state would have in the Medicaid FFS system. The plans have the flexibility to pay more or less than these amounts as needed to assure that their provider networks and services meet their standards and those of the state for access and quality. As a practical matter, however, the plans say they must pay rates at least equivalent to the Medicaid FFS rates to obtain adequate provider participation, and often must pay more.

## Financing and Payments

**State Payments to Plans.** New Mexico's capitated payments to Evercare and AMERIGROUP are negotiated with the plans based on historic FFS expenditures. The actual rates remain confidential but differ for duals and non-duals, by geographic area, and by whether the enrollee meets nursing facility level-of-care (LOC) requirements. For duals, the rates cover Medicaid payments for Medicare cost sharing, the limited acute care benefits that Medicaid remains responsible for, and long-term care services. For non-duals, all Medicaid acute care services are included in the rates as well as the long-term care services for which non-duals are eligible.

The rates are not adjusted for risk based on health status or diagnoses. Since Medicaid enrollment is mandatory, however, and since there are only two health plans, the risk for plans of adverse selection based on health status is limited.

The rates for enrollees who meet nursing facility LOC standards are based on an assumption that some portion of those enrollees will be in nursing facilities, while the remainder will be in the community receiving HCBS or PCO services. If the plans are able to serve a greater number of their enrollees in the community rather than in nursing facilities, they will be able to retain a larger portion of the capitated rate as profit or for other purposes, since community care on average is less expensive than nursing facility care. Because the payment methodology provides incentives to keep

enrollees in the community, the state hopes it will lead to development of a more extensive community-based service network that will produce continued savings in the future.

**Plan Payments to Providers.** The two plans pay providers on a FFS basis, with Medicaid FFS rates as the starting point for negotiations. In areas with limited provider availability, such as many rural areas, the plans say they must often pay more than the Medicaid FFS rates to obtain provider participation.

As noted earlier, the HCBS and PCO Medicaid FFS payment methodologies have not always been easy for Evercare and AMERIGROUP to replicate, which has led to some confusion and delays in payment to providers, and some provider dissatisfaction with the plans and the CoLTS program. The state has addressed these payment issues by facilitating workgroups with PCO providers, nursing facilities, advocacy groups and the MCOs.

The plans indicated that the Medicaid FFS payment system for nursing facilities and PCO providers somewhat inhibited their ability to shift residents from nursing facility to community care. The nursing facility reimbursement system has only two payment tiers (high and low), which means that there are some nursing facility residents in an intermediate care-need category who may be difficult for plans to find and move into the community, especially if the nursing facility is receiving high-tier payments for them and wants to retain them in the facility. Despite this difficulty, the CoLTS MCOs have been successful in identifying and moving nursing facility residents back to their communities. During state fiscal year 2009, 236 residents were transitioned; in state fiscal year 2010, 212 residents were reintegrated into their community.

On the community side, Medicaid FFS payments to PCO providers have covered an extensive array of services in the past, which can result in community care being more expensive than low-tier nursing facility care for some beneficiaries, reducing the incentive for health plans to serve people in the community. However, updated assessments of enrollee needs by the MCOs and improved efforts at service coordination are helping to assure that the PCO services enrollees now receive are consistent with their needs and sufficient to enable them to live in the community when that is feasible.

## Care Coordination

The core premise of integrated care programs for dual eligibles is that having a single entity such as a SNP or some other type of MCO responsible for all Medicare and Medicaid benefits for individual beneficiaries leads to better care coordination and improved health outcomes. The CoLTS program facilitates coordination of Medicaid long-term care services (nursing facility, HCBS, and PCO services), but Evercare and AMERIGROUP are not able to coordinate Medicare services for duals in other than minimal ways unless beneficiaries enroll in one of those plans for their Medicare benefits. As noted, few currently do.

**Behavioral Health Carve-Out.** In addition, Medicaid behavioral health services in New Mexico are “carved out” of the managed care benefit package and provided through a separate statewide behavioral health organization (OptumHealth, a subsidiary of UnitedHealthcare). Evercare and AMERIGROUP must therefore coordinate with OptumHealth for behavioral health services for eligible CoLTS enrollees, many of whom need behavioral health services that are generally not available through Medicare.

**Service Coordinators.** Within these basic constraints, the health plans have sought to provide improved coordination for CoLTS enrollees by assigning service coordinators to all enrollees, as required by the CoLTS contract. The service coordinators have caseloads that vary in size, depending in part on the geographic area they are responsible for and the mix of care needs of the enrollees assigned to them. The state does not specify caseload sizes but does have guidelines and timelines for “touch points” such as initial needs assessments, re-assessments, care planning, visits, and telephone contact. Both health plans have established communication, tracking, and reporting systems that are aimed at increasing the efficiency and effectiveness of these service coordinators.

While we were not able to assess the impact of service coordinators in any systematic way, we did meet with one dual eligible consumer who was living in her home and enrolled in Evercare for her CoLTS services. She was extremely pleased with her service coordinator, saying:

*People used to be pushed into nursing facilities. I'm not even 50 years old yet. I want to be in my home. This program has opened up a lot for people with disabilities. Before Evercare, people were on their own.*

The service coordination model can identify both necessary and unnecessary services through the needs assessment process. By supplying preventive and supportive care/services, service coordination can potentially avoid the high cost of emergency care and/or nursing facility placement. Another interviewee provided the following example of what service coordination can accomplish:

*There was a guy living at home that couldn't leave because he had multiple sclerosis. He was on Medicaid. He never had any care coordination. Folks in the community brought him groceries. He only got care when something bad happened and he was taken to the ER. Service coordinators found people like this and helped them.*

One of the top state officials we met with summed up the benefits of the “intense care coordination” in CoLTS this way:

*This means families get help to find community-based care and higher levels of care if the community placement will not work for the member. I can't stress enough how important this is to families. This never existed in the system prior to CoLTS and people really struggled.*

Service coordination also has a cost, of course. It is probably too early in the program's implementation to determine the extent to which the cost of service coordination is outweighed by the savings from reduced use of more expensive services, but it is a key question.

**Lack of Information on Medicare Services.** The health plan representatives we spoke with underscored the difficulty of coordinating care for dual eligibles when the plan is not responsible for hospital, physician, or other services provided by Medicare. Hospitals are not required to inform the CoLTS health plans when one of their dual eligible enrollees is admitted to the hospital (unless the dual is also enrolled in the plan for Medicare services). Therefore, most of the time, the plans find out about hospitalizations through family members or not at all. Evercare estimated that about 25 percent of the time it does not know that its dual eligible members are in the hospital. Since avoiding unnecessary hospitalizations and readmissions is one of the major ways in which care coordination can reduce costs and improve quality, the limited number of CoLTS dual eligible enrollees who choose to obtain Medicare services from Evercare or AMERIGROUP poses a significant obstacle to full care coordination for dual eligibles in the CoLTS program.

## Beneficiary Participation and Enrollment Practices

Both New Mexico and the CoLTS health plans described a variety of outreach and education efforts that they have undertaken to increase enrollment in CoLTS. With enrollment mandatory on the Medicaid side for most beneficiaries, the major challenge lies in convincing dual eligibles to enroll in Evercare or AMERIGROUP for their Medicare benefits. Nearly a third of the state's population lives in rural areas (twice the national average), and a large Native American population lives in the rural areas. Outreach to beneficiaries in rural communities is especially important to creating a statewide program. The state currently collaborates with the health plans on a joint marketing and outreach plan, but state budget constraints place significant limits on what the state can do.

In terms of health plan outreach and marketing, Medicare marketing guidelines can be problematic, according to the health plans. What can and cannot be said to potential enrollees can be confusing, they said. It is sometimes difficult to use the language that CMS requires, especially when dealing with Native American populations (“It’s hard to translate their words into Navajo.”). One health plan representative said that sales people struggle to get through a CMS-approved sales program because too much information must be conveyed. (“Where’s the cutting point to make sure people have informed consent?”) Another said, “It would be good for CMS to adjust some of those requirements so states and health plans have some flexibility in marketing.”

Another marketing issue, we were told, is “outbound verification.” “Once you make a sale,” a health plan representative said, “you have to chase it with a phone call to make sure that the client understands what they are signing up for. We need to explain that there is no cost sharing and that clients don’t have to pay out of pocket for the MCO.” Verification is not always easy when potential enrollees do not have reliable phone numbers or face language barriers.

## Performance and Quality Monitoring

New Mexico’s contracts with the CoLTS health plans include standard quality monitoring requirements such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, but the measures fall short in reporting health plan effectiveness in the CoLTS program, we were told. The health plans pointed to the need for measures targeted to long-term care and noted that holding plans accountable for services for duals provided through Medicare is not appropriate unless the plans are directly responsible for those services. As one health plan representative stated:

*In terms of performance measures, we are measuring a lot of things that aren’t giving us enough information. We are measuring the wrong things. We are trying to do HEDIS [Healthcare Effectiveness Data and Information Set] when we don’t have Medicare data. There are some requirements that CMS asks states to collect and then the states ask MCOs to collect and it doesn’t make sense for us to collect. More performance measures around HCBS are needed. We need to get smarter about what we are looking at and need more alignment in performance measurements.*

The state is currently working with the Hilltop Institute in Maryland to develop quality measures appropriate for both dual and non-dual populations.

**Reports for CMS.** In May 2010, New Mexico submitted a report to CMS on the HCBS 1915(c) waiver portions of CoLTS that focused primarily on Evercare’s and AMERIGROUP’s compliance with contractual and regulatory requirements with respect to member education, provider networks, quality management, coordination of services, submission of encounter data, member grievances,

reporting, services for members with special health care needs, transitions of care, and fraud and abuse.

The New Mexico Medical Review Association, the state's external quality review organization (EQRO), completed an initial "compliance audit" report on the CoLTS program in June 2010, which the state provided to us. Designed to determine a baseline level of compliance with state regulations and contract requirements, the audit focused primarily on health plan policies and procedures, information systems capability, and medical records and case files rather than on broader performance and quality issues.

## Impact of Health Care Reform

The requirement that dual eligible SNPs have a contract with state Medicaid agencies by 2013 has not had an impact on the Evercare and AMERIGROUP dual eligible SNPs in New Mexico, since both plans already have such contracts. Other health plans have approached the state about participating in the CoLTS program but have been told that they will not have an opportunity to do so until the CoLTS reprocurement, currently scheduled for 2012.

The state agency representatives we met with told us that they are pleased with the attention that CMS is now giving to coordinating care for duals; they think that the new Federal Coordinated Health Care Office in CMS will increase that attention even further. They also expressed the hope that CMS will be able to provide a greater degree of support and technical assistance for states such as New Mexico that are trying to develop and enhance integrated care programs for dual eligibles.

The state agency representatives voiced concern that the scheduled reductions in Medicare Advantage rates (including those for SNPs) under health care reform could make SNPs less financially viable in New Mexico. While health care reform makes an additional "frailty adjuster" rate enhancement available for dual eligible SNPs that are fully integrated with state Medicaid programs, it is not clear at this point which SNPs in which states will be eligible.

## Barriers to Expansion

**Reimbursement and Administrative Problems.** The CoLTS program has experienced the kinds of problems that are common in Medicaid when there is a transition from FFS to capitated managed care. Providers are accustomed to being paid directly and usually quickly by the state's fiscal agent. In New Mexico, the same fiscal agent (ACS) has been in place for more than 12 years, so reimbursement and communications systems are well-established and familiar to providers. The CoLTS program changed all of that, so now providers are paid by either Evercare or AMERIGROUP, who are also responsible for authorizing and reviewing services. As a result, we heard many complaints from providers about timeliness of reimbursement and administrative problems in dealing with the health plans. If the health plans are able to improve their performance in these areas over the next year, it should not be a significant obstacle to further expansion of the CoLTS program, but it does bear watching.

**Personal Care Option Utilization and Cost Trends.** A related issue that should be monitored closely is how the health plans deal with the PCO program. When the PCO program was first started in 1999, the state estimated that total enrollment would be about 1,800. It is now over 14,000, with an average annual cost per person of almost \$20,000. The rapid expansion of this personal care services program was one of the factors that led to the establishment of CoLTS. CoLTS program designers hoped that better management and monitoring of the PCO program, and

better coordination between PCO, HCBS, and nursing facility services, would lead to a more cost-effective Medicaid long-term care program in the state. It will therefore be important for the state and the health plans to track the type, volume, intensity, and cost of the services provided in the PCO program as CoLTS develops, as well as the impact of those services compared to other options.

**Service Coordinator Effectiveness.** Service coordinator caseloads also warrant continued monitoring. Some service coordinators serve upward of 100 to 200 clients. A consumer we spoke with was thankful for her “advocate” (service coordinator) and did not feel in any way neglected even though the service coordinator had a heavy caseload. Not all CoLTS members require substantial attention, however. As one interviewee noted, “Case management used to only be provided to waiver individuals. Now CoLTS is open to everyone. A case worker might have a 150-person load, but 50 are healthy duals.” Since the service coordination/care management function is crucial to the success of any integrated care program, caseload size and service coordinator effectiveness will be important for the state and health plans to track over time.

**Limited Alignment with Medicare Services.** Perhaps the largest obstacle to the development of CoLTS as an integrated care program for dual eligibles is the fact that most duals enrolled in the program do not get their Medicare services through the CoLTS health plans. Since enrollment of Medicare beneficiaries in managed care is voluntary, New Mexico currently has limited options to deal with this issue. Further outreach and marketing efforts by the state and the health plans may help to persuade more dual eligible beneficiaries to enroll in CoLTS health plans for their Medicare benefits. As noted earlier, the state is currently working with the CoLTS health plans to develop a joint marketing and outreach program. The current enrollment of duals in large and well-known Medicare Advantage plans like those operated by Presbyterian and Lovelace may limit the potential impact of this kind of marketing, however. Focusing on duals who receive their Medicare services through the Medicare FFS system may be more effective. State officials said they currently provide the plans with a list of duals so they can communicate with them. It is also possible that the new CoLTS procurement in 2012 may attract health plans that will be more successful in marketing to Medicare beneficiaries than Evercare and AMERIGROUP have been.

**State Budget and Staffing Constraints.** New Mexico’s budget constraints have limited the staff available to develop and expand CoLTS. Budget pressures have also led to reimbursement limits for providers and MCOs, which may limit their willingness to participate in Medicaid in general and CoLTS in particular. While the CoLTS program may serve to limit the growth in Medicaid long-term care expenditures, and thus help with the state’s budget problems, the potential financial benefit to the state from having the CoLTS MCOs cover more Medicare services for duals through their SNPs is, at best, indirect. Yet coverage of those services is essential to making CoLTS a truly integrated program for dual eligibles.

## Lessons Learned and Future Plans

**State Officials.** The state officials we spoke with had several suggestions for other states seeking to develop integrated programs for duals:

- “Change is always difficult, especially with big programs like CoLTS. There are issues with the new claims system that do drag down providers. Providers complain about another layer that they have to go through.”
- “Getting everyone coordinated and getting everyone’s input is the hardest part.”

- “For big picture things, direction comes from the top down. Governor Richardson is big into getting everyone in his cabinet to agree. It’s nice that there’s agreement coming from the top. It’s about collaboration. Effective communication between departments is essential.”
- “Access has gone up, but it’s expensive. Warn Congress that if they want greater access, then they need more money.”
- “It would be smart for [other states] to find a grant or a foundation or other resources to help with staff and funding. We don’t have enough staff. States need qualified staff to make integrated care work. The states don’t have time to apply for grants, especially with health reform happening. We don’t have the resources to put a good proposal together. A helpful thing would be a pool of experts that states could draw from for advice.”
- “For further integration we need to go around more and explain to people around the state what we are doing. It is all still very new. When I talk to Minnesota, they spent years telling people about their plan and now families know how to get care coordinated. People here don’t have the education about that yet. We don’t have the resources to do that yet.”

**Health Plans.** Health plan representatives also had advice for states, health plans, and CMS:

- “Barriers to growing SNP coordination include (1) inability to locate members and (2) people who are already enrolled in a general MA [Medicare Advantage] plan. We are trying to show members and providers the value of SNPs. Having something that concretely links the two programs together—for example, through benefit design—would help. One approach would be to have SNPs pay co-pays only if the person is enrolled in the SNP for both Medicare and Medicaid. If you can figure out the benefit that will really entice someone and get the programs to link, then it can work. You need carrots to provide incentives for people.”
- “I would like to work with the state and CMS to do some joint materials for sales. A sales representative goes out on the Medicare side and sells the SNP, but there’s nothing in writing about opportunities for coordination with Medicaid. If there’s a way to have a piece that shows what is covered by Medicare and Medicaid, that would help when talking about SNPs. Administrative barriers are confusing to the client at the end of the day.”

**Future Plans.** Both the state and the health plans expressed support for the goal of moving toward fuller integration of Medicare services into CoLTS. The new CoLTS procurement in 2012 will provide an opportunity to address a variety of program design and modification issues, and will likely attract a range of health plan bidders that will increase the options available to the state.

New Mexico is the only state we interviewed or visited that began their integration program with a primary focus on Medicaid long-term care services, responding in part to the perceived need for better management of community-based services. How the state moves toward fuller integration of Medicare services for dual eligibles will be important for other states and national policymakers to watch and analyze.

## NORTH CAROLINA

North Carolina's Medicare 646 Demonstration Program for dual eligible beneficiaries builds on the state's long-standing Medicaid enhanced primary care case management (PCCM) program, which is called Community Care of North Carolina (CCNC).<sup>50</sup> The demonstration is being operated by North Carolina Community Care Networks (NC-CCN), a non-profit 501(c)(3) organization.

During our visit to Raleigh and Charlotte on August 12–13, 2010, we met with core leadership and staff from CCNC and NC-CCN, administrative staff for one of eight networks participating in the demonstration, providers from network practices, and a representative of the Program of All-Inclusive Care for the Elderly (PACE). At NC-CCN, we spoke with staff involved in developing the demonstration and leading integration and coordination activities for dual eligibles. At Southern Piedmont Community Care Plan, a local network participating in the 646 demonstration, we spoke with administrative staff and with providers from organizations that are members of the network (Cabarrus Family Medicine and Carolinas HealthCare System/Carolinas Physician Network). Provider representatives included family medicine physicians, psychiatrists, pharmacists, and a nursing home medical director.

### Basic Features of State's Program for Dual Eligibles

The 646 Demonstration Program began operating in January 2010 after four years of development. Like the CCNC program, the 646 demonstration focuses mainly on acute care rather than on long-term care. It is designed to function as a medical home model for dual eligibles supported by a community-based care management system. An important goal of the demonstration is to determine whether its approach to care management will result in Medicare savings that the federal government can then share with NC-CCN. In the first two years of the five-year demonstration, NC-CCN and its participating community networks will cover approximately 30,000 dual eligibles, using essentially the same care management approach the state now uses for CCNC's Medicaid-only aged, blind, and disabled (ABD) enrollees. Beginning in year three, approximately 150,000 Medicare-only beneficiaries who are being served by the practices participating in the demonstration will be added. The basic features of the demonstration program are summarized in Table 1.

In 2005, CCNC leaders and CMS central office staff determined that Section 646<sup>51</sup> was the only authority that would allow the state's community-based networks to serve as the medical home for duals and share in accrued Medicare savings. Although CCNC includes 14 community care networks, CMS asked CCNC to limit the 646 demonstration to 8 of the networks. As of January 2010, the 8 networks in the demonstration represented 925 individual providers in 197 practices. They mainly manage acute and primary care services for duals, and initiatives to integrate behavioral health services are underway. Long-term support services such as nursing facility and home and

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<sup>50</sup> For additional information on Community Care of North Carolina, 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 October 1, 2010.

<sup>51</sup> Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which authorized Medicare Health Care Quality demonstration programs.

community-based services (HCBS) have not been formally integrated into the demonstration, although the state hopes that the medical home and care management features of the demonstration will result in some savings in those Medicaid-funded services.

As of August 2010, the state estimated that there were 280,478 dual eligibles in North Carolina, 80,485 of whom were enrolled in CCNC, and 19,923 were enrolled with a 646 practice.<sup>52</sup> Although CCNC enrollment is voluntary, the state Division of Medical Assistance (DMA) uses an opt-out process for the Medicaid ABD population, including duals. Under the opt-out process, DMA assigns ABD beneficiaries to a CCNC practice if they are treated by a provider in that practice, but they can choose a different practice if they wish or—if they are duals—they can choose not to participate in CCNC. North Carolina sought to use this same opt-out system for Medicare services for duals in the 646 demonstration, but CMS expressed concern that it may not be consistent with Medicare freedom-of-choice requirements, so implementation is on hold for now. As noted above, the demonstration will extend its medical home and community-based care management model to all Medicare patients served by providers participating in the demonstration in the third year of the demonstration, which should substantially increase enrollment.

NC-CCN did not receive any upfront demonstration funds to cover its administrative and care management functions and instead relies on the Medicaid per member per month (PMPM) payments it receives from the CCNC program on which the 646 demonstration is built. As discussed below, Medicaid pays local community care networks \$3.72 PMPM for most Medicaid enrollees and \$13.72 PMPM for ABD enrollees. Almost all duals fall into the ABD category. Ongoing negotiations with CMS are addressing how NC-CCN and the eight participating networks will share savings from the management of dual eligibles and eventually the management of all Medicare patients in the networks.

## Plan and Provider Contracting

**Providers.** NC-CCN is not a payer and thus does not enter into contracts with providers. Rather, it is the organizational structure under which the local community care networks organize, make decisions on quality improvement (QI) initiatives, support QI, provide data through the Informatics Center (described later), and assess progress. While the networks exhibit commonalities—all are non-profit and primary care based and are made up of physicians and other providers, hospitals, and local health and social services departments—the culture and characteristics of each are distinctive, reflecting community needs and resources. Affiliated practices receive the benefit of additional supports provided by their local networks and NC-CCN, including information on practice performance; assistance with practice planning and redesign; workforce resources such as care managers, pharmacists, and psychiatrists hired by the networks; and an Informatics Center that provides practices with information on costs and quality outcomes. In return, practices are required to treat Medicaid patients and participate in their local community care networks to improve identified quality measures. Provider participation has been good, we were told, because North Carolina's Medicaid program pays well and providers trust their local networks.

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<sup>52</sup> Hewson, Denise Levis. "North Carolina's 646 Quality Demonstration." Presented at the National Academy for State Health Policy (NASHP) 23rd Annual State Health Policy Conference, New Orleans, October 5, 2010.

NC-CCN and CCNC representatives told us that being a provider-based network helps with physician participation and engagement. Physicians accept integration of the model into their practices, they said, because local physician leaders organize the networks, select the quality measures, and work with the practices to change the way they manage care. The data sharing is perceived as non-threatening because it is part of a physician-to-physician review of practices.

*“There is a lot of participation and loyalty, and there [is] an interest in keeping the connection and not having an intermediary come between the provider and the state.” (NC-CCN official)*

About 90 percent of the doctors in CCNC are primary care physicians, and 10 percent are specialists. The number of specialists grew in 2009 as networks began reaching out and building relationships with specialists who were seeing dual eligibles. Ultimately, a cardiologist or gynecologist who sees a patient most frequently for primary care could be considered that patient’s medical home as long as the specialist agrees to assume medical home responsibilities and expectations as part of the network.

We were told that network care management efforts are more likely to succeed when networks manage the care for a large portion of a practice, as is common in the Medicaid CCNC program. Depending on how enrollment develops under the 646 demonstration, a smaller portion of a practice may participate in a network and thus give rise to somewhat less successful care management.

The number of patients enrolled in the nearly 1,400 practices affiliated with CCNC ranges from less than 100 to more than 10,000, with about 44 percent of practices having 101 to 500 enrolled CCNC patients. Almost 65 percent of the over one million patients in CCNC are enrolled in the 19 percent of practices with more than 1,000 patients each.<sup>53</sup> Although the practices involved in the 646 demonstration are a subset of CCNC practices, the distribution of practices is similar in terms of size and number of enrollees.

Representatives of NC-CCN believe that dual eligibles under age 65 will be similar in their characteristics and care needs to the Medicaid-only ABD population, whose care is already managed in the CCNC program. However, as the number of dual eligible enrollees over age 65 grows, networks will have to reach out to providers of long-term supports and services (LTSS)—nursing facilities, home health agencies, and HCBS providers—to strengthen the continuum of care for the older population. A long-term care pilot project within the 646 demonstration is currently underway (described below).

How the local networks evolve to incorporate affiliated practices and providers is determined at the local level, with support from NC-CCN. NC-NCC measures network and provider performance and provides data to the networks, which are then responsible for the performance of providers in their networks. Innovations developed in one network are shared through NC-CCN meetings and conferences and reviewed for adaptability to other networks. NC-CCN leaders recognize that networks must develop their own expertise at local levels, with support from NC-CCN.

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<sup>53</sup> Dubard, Annette, M.D., M.P.H. “Informatics Center Overview.” Presented to site visit team, August 12, 2010.

*“To be innovative, you have to have the infrastructure to meet the innovation at the community level.” (NC-CCN official)*

**Health Plans.** Even though two Medicare Advantage Special Needs Plans (SNPs) for dual eligibles operate in North Carolina (Evercare and Southeast Community Care-DualPlus), they have so far not approached NC-CCN or the state about contracting with them, perhaps because of uncertainty on both sides about how the CCNC and NC-CCN care models would mesh with SNP care models.

*“[NC-CCN/CCNC networks] are community-based, so if partnership makes sense for the community and patients, we would be open to that.” (NC-CCN official)*

## Financing and Payments

**State Payments to Networks and Providers.** As noted, the CCNC programs pay each participating network \$3.72 PMPM for most Medicaid enrollees and \$13.72 PMPM for ABD enrollees to cover administrative and care management responsibilities. Participating providers receive \$2.50 PMPM for most Medicaid enrollees and \$5.00 PMPM for ABD enrollees to provide a medical home and participate in disease management and quality improvement activities. Medicaid’s relatively generous payments to physicians in North Carolina (95 percent of Medicare) have helped garner provider participation.<sup>54</sup>

**Demonstration Payments to NC-CCN.** Since CMS did not provide upfront funds for the 646 demonstration, NC-CCN plans to use Medicaid PMPM payments to the participating networks (\$13.72 for ABD enrollees and \$3.72 for non-ABD enrollees) to cover upfront administrative and care management expenses. In addition, NC-CCN plans to use the shared Medicare savings that may be achieved in the demonstration’s first two years to fund the new Medicare-only population beginning in year 3. The NC-CCN Board of Directors, which includes the leaders of all 14 CCNC networks, will determine how the savings will be used for various purposes, subject to CMS’s approval. NC-CCN currently expects that a portion of the shared savings will fund additional services for the Medicare-only demonstration population, physician quality performance incentives, information technology, and research and development.<sup>55</sup> A portion of any shared savings award may also be held as a reserve to support ongoing operations during the demonstration. At the conclusion of the demonstration, all remaining shared savings held in reserve will be disbursed to participating networks.<sup>56</sup> Negotiations with CMS on the method for determining savings are ongoing, but it appears that NC-CCN may receive 50 percent of total savings.<sup>57</sup> Currently, the participating 646 demonstration networks return a portion of their Medicaid PMPM payments to NC-CCN to fund staff, informatics, training, program development, and technical support. The budget for NC-CCN is approved by the NC-CCN Board.

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<sup>54</sup> Zuckerman, Stephen, Aimee Williams, and Karen Stockley. “Trends in Medicaid Physician Fees, 2003-2008.” *Health Affairs*, Web Exclusive, pp. w510-w519, April 28, 2009. Available at [<http://content.healthaffairs.org/cgi/reprint/28/3/w510>]. Accessed September 14, 2010.

<sup>55</sup> “Community Care’s 646 Demonstration Waiver,” June 1, 2010, summary, p. 4.

<sup>56</sup> “NC-CCN Demonstration Protocol,” November 24, 2009, draft, p. 7.

<sup>57</sup> “Community Care’s 646 Demonstration Waiver,” June 1, 2010, pp. 3-4.

**Pay-for-Performance Initiative.** NC-CCN intends to design an incentive program to recognize and encourage participating practices' improvements in identified performance measures. A portion of the shared savings from the demonstration will be placed in a pay-for-performance (P4P) incentive pool for payments above and beyond the normal FFS payments and the CCNC payments for care management (\$2.50 or \$5.00 PMPM) now received by providers. The details of the incentive design are still in development, but the distribution of payments may be "based on the number of patients attributed to a practice and the practice's composite performance score on a basket of quality indicators."<sup>58</sup> In keeping with an organizational structure that allows local networks to deal directly with affiliated providers in regard to performance, the networks may receive their share of P4P savings for further distribution to providers.

## Care Coordination

NC-CCN views the incorporation of dual eligibles into the population of patients cared for by community care networks as a natural extension of existing infrastructure and the activities involved in managing Medicaid's ABD population, with the important difference that Medicare provides most acute care services for dual eligibles (physician, inpatient hospital, prescription drugs).

*"It is an extension of what we are doing with ABD enrollees. The interventions are the same, and it's the logical step to building out the system to manage the Medicare population." (NC-CCN official)*

To the extent that Medicare acute care service providers overlap with CCNC Medicaid ABD providers, use of the CCNC care coordination/medical home model for duals will be facilitated. However, the inclusion of dual eligibles introduces population needs that require adjustments and additions to existing NC-CCN care models and interventions, especially for duals age 65 and older who are generally not served through the current CCNC model. Under-65 duals, by contrast, have characteristics and care needs that are similar to those of the under-65 Medicaid ABD population that is currently served in CCNC. The medical and socioeconomic complexities that come with providing care for dual eligibles have implications for the types of services that need to be incorporated into the medical home and the training needs of care team members.

**Risk Stratification and Identifying the Target Population.** To identify enrollees who can most benefit from targeted care management interventions, NC-CCN and its participating networks rely on a grouping system based on Medicaid claims data. The system uses several variables to assign a score to enrollees, including two or more chronic conditions, an inpatient admission in the past six months, three or more emergency room visits in the past six months, eight or more prescriptions over the past month, three or more outpatient provider visits over the past six months, no primary care provider visit in the past year, and two or more limits on activities of daily living (ADLs) requiring hands-on assistance. About 5 percent of patients are assigned to a high-risk group, and another 15 to 20 percent are flagged for additional screening. Those with lower scores receive care management assistance on a less intensive, as-needed basis. Data analysis is ongoing, so patient scores may change over time. NC-CCN is also exploring the use of other risk stratification systems, such as the Clinical Risk Group system developed by 3M Health Information Systems.

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<sup>58</sup> "NC-CCN Demonstration Protocol," November 24, 2009, draft, p. 8.

**Care Managers.** The care coordination activities offered by NC-CCN networks and providers primarily focus on creating a medical home for enrollees, and care managers are central to that effort. The primary care providers are the medical home, but care managers are often the face and connection to the medical home for patients. Care managers become an integral part of the team, helping practices identify patients with high-risk conditions or needs, assisting providers with disease management education and followup, and helping patients coordinate their care or access needed services.<sup>59</sup> Large practices with a high number of patient enrollees may employ a full-time care manager (embedded), whereas smaller practices with fewer enrollees may share a care manager (co-located). Currently, CCNC has approximately 500 care managers, for a ratio of 1 care manager for every 4,000 patients.<sup>60</sup> Caseloads are lower for the ABD population than for women and children. The networks continue to recruit care managers and hope to reduce by half the care manager-to-patient ratio.

Care managers are nurses, social workers, mental health social workers, and nutritionists, all with bachelor's degrees and some with master's degrees. The skills involved in managing the whole patient, rather than just one disease, require flexibility and critical thinking. NC-CCN leaders expect that duals entering the demonstration will pose a management challenge in view of their several chronic conditions, relatively low level of educational attainment, and low literacy level. In response, NC-CCN is creating a learning collaborative around motivational interviewing for care managers and, eventually, providers. Motivational counseling aims to help patients change their attitudes and behavior in ways that may enable them to participate effectively in their own care.

Everyone is part of the larger medical home care team, and a team effort is stressed. For example, in some cases a mental health care manager and a medical care manager conduct home visits jointly and then decide who should be the primary care manager and who should be the secondary, with each collaborating and consulting with the other.

*“Rather than being competitors, everyone is brought into the same room and are deployed together rather than have people go out and drum up their own business.” (Cabarrus administrator)*

**Transitional Support.** Managing a patient's transition between hospital and community helps ensure that information from the patient's medical home (primary care practice) informs decisions made within the hospital and that information from the hospital returns to the patient's medical home for follow-up care. Transitional support is particularly important for dual eligibles, who tend to be high users of emergency and hospital services compared to other Medicare beneficiaries.

*“When a patient comes into the hospital, they don't know their medications. The ED [emergency department] providers make a best guess on medications, the hospitalists write the best medications they can, and hospitals use substitutions on medications based on their own formulary. So by the discharge phase, you have no idea what should be happening with the patient.” (NC-CCN physician)*

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<sup>59</sup> For details on care coordination in CCNC, see Verdier et al. “Enhanced Primary Care Case Management Programs in Medicaid,” pp. 16-17, cited earlier.

<sup>60</sup> These numbers apply to the entire CCNC. The number of care managers for the subset of eight networks involved in the 646 demonstration is smaller.

NC-CCN is working on a transitional support intervention that relies on care managers to represent the medical home in the hospital, participate in discharge planning, perform medication reconciliation, coordinate community resources and services, and conduct home visits to high-risk patients. To the extent possible, care managers work with hospitals to help with connectivity between the medical home and hospital. They speak with hospitalists within 24 hours of a patient's admission and with hospital pharmacists to ensure no changes in important medications. They also assist with discharge planning, making sure that discharge information is uploaded to NC-CCN databases that track and manage patients. Such collaboration works most effectively when hospitals are part of NC-CCN networks and treat a large number of CCNC and NC-CCN enrollees. Care managers are being embedded in large tertiary hospitals to facilitate screenings and assessments and to participate in discharge planning. As noted, hospital transitions can be especially problematic for dual eligibles in that Medicare, not Medicaid, is the primary payer.

Cabarrus Family Medicine (a major physician group in one of the local networks) is testing the use of a nurse practitioner (NP), rather than a care manager, to provide transition support once a patient returns to the community. Cabarrus wants to see if the involvement of an NP can help reduce hospital readmissions. Cabarrus is developing a method to distinguish high-risk patients who may need an NP during transition from low-risk patients who could be seen by a care manager. The NP can perform a clinical assessment and, unlike care managers, make medication changes if needed. In addition, the NP makes home visits to discharged patients, performs medication reconciliation, updates the NC-CCN database with discharge information and follow-up notes (for example, reason for hospital admission, current situation), and communicates with either the assigned medical home provider within Cabarrus or the discharge physician if problems require a physician's attention.

The NP pilot has been running since October 2009 but has so far not measurably reduced hospital readmissions, perhaps because the NP's patient volume was low at the outset. The pilot is obtaining additional hospital admission data and will continue to assess effects. The home visits have, however, identified several medication errors, even when the patient has received home health care. Although Medicaid covers NP home visits, the network loses money on them.

*"Patients love [NP home visits] because someone is checking on them at home, and the PCP [primary care provider] has a lot of stuff already done for them by the time the patient comes in [for an office visit]."*  
(Cabarrus physician)

**Mental Health Integration.** NC-CCN leaders told us that, in hindsight, they would have incorporated mental health organizations and agencies into the core organizations participating in the networks. They recognize that integration of mental health services into the medical home is critical. Particularly for dual eligibles with neurocognitive problems such as dementia, NC-CCN launched a community care initiative to help networks develop mental health resources to increase evidence-based practices in primary care offices (for example, improved mental health screening). By the end of summer 2010, NC-CCN planned for all local networks to hire network psychiatrists to support practices and to identify local psychologists to be mental health services champions. As of our site visit on August 12, 2010, two-thirds of networks had mental health professionals in place, others were recruiting, and others were struggling to recruit. Mental health providers will educate practices on available mental health resources, train care managers in how to access mental health resources, and educate all providers on how they can share information without violating patient confidentiality rules.

*“There is a lack of information in the primary care world, and providers believe that there is a lack of mental health services available. [They] believe that there are no services out there, but there are a lot of services available, you just have to know how to access them.” (NC-CCN psychiatrist)*

Beyond the addition of mental health resources at the network level, psychologists are now part of the medical home care team. Currently, 40 co-location practices include a behavioral health provider who works within the practice. In January 2009, Cabarrus Family Medicine added three full-time psychologists to the clinic, and they were readily integrated into the medical home care team. The integration has improved behavioral health service access and effectiveness for patients. Because a patient can be assessed while at the clinic for a medical appointment, the patient sees that the mental health service is part of their overall care, and is thus more likely to follow through with recommended treatments. In addition, co-location improves communication between primary care and mental health staff.

*“It’s worked very well, and we got busy much faster than we thought we would. Psychologists have been in the medical settings for years, usually in specialty medicine. In the past year, there’s been a movement to put psychologists in primary care, which makes sense because primary care sees everything.” (Cabarrus psychologist)*

**Pharmacy Integration.** NC-CCN recently added pharmacists to the medical home care team. Local networks have clinical pharmacists on staff to support affiliated practices, and some practices and hospitals employ on-site pharmacists. Southern Piedmont Community Care Plan’s clinical pharmacist reviews care manager notes from home visits to identify drug problems and then communicate any concerns to PCPs. She also oversees the care manager’s work in medication reconciliation and reaches out to pharmacists in the community to help manage difficult patients.

Cabarrus Family Medicine employs a full-time pharmacist who sees patients referred to her by providers within the practice. She speaks with patients to help them understand why they are taking medications, identifies barriers to compliance, and finds solutions to overcome those barriers. Another staff pharmacist runs group visits for patients with diabetes to assist them with self-management.

*“Patients do better when they truly understand their disease. They are more compliant with medications when they understand what they are. I’ve found that they get nervous with physicians and nod their heads a lot, but when I talk with them, I know they don’t get it. The most important part of my job is taking the time to explain things to patients and educate them—things physicians don’t have the time to do.”(Cabarrus pharmacist)*

**Long-Term Care Pilot Project.** NC-CCN is piloting a long-term care service model that centers on physician practices dedicated to serving nursing homes. The goal of the pilot is to limit the number of unnecessary ED admissions and unplanned hospitalizations occurring from nursing homes, enhance patient care with practice guidelines and an increased medical presence, expand the number of residents with advance directives, improve the information flow from hospital to nursing home, and support network physicians involved in long-term care. The pilot is developing its formal evaluation plan and is in the process of recruiting nursing facilities.

Under this new model, the nursing home—rather than the physician’s office—is the medical home. Moreover, with physicians dedicated to nursing facilities, facility staff “hungry to improve their medical care” are able to deliver the services they are trained to deliver. In keeping with NC-CCN’s “ground up” approach to innovation, implementation of the model differs in each of the

four communities participating in the pilot. One practice of 15 to 20 physicians left a “bricks and mortar practice” to work in 35 nursing homes. A physician and physician assistant (PA) take turns visiting participating nursing homes to deal with acute and other problems. A practice called Extended Care Physicians operates in three locations, providing services to more than 60 nursing homes. A care team—a physician, care coordinator, clinical nurse liaison, social worker, and clinical pharmacist—works with the nursing homes to institute a “treatment in place” model to care for patients within the nursing home as appropriate rather than relying on hospitalization. Funding care teams on a continuing basis may be problematic, however, unless NC-CCN networks can tap Medicare savings from reduced hospitalizations.

The pilots must also contend with the financial incentives for nursing homes to send patients to the hospital that exist within the current Medicare and Medicaid payment structure. Nursing facilities are able to obtain Medicare skilled nursing facility daily payment rates that are higher than the Medicaid daily rates for dual-eligible Medicaid residents who spend three or more days in a hospital, and then return to the nursing home. Unlike most states, North Carolina Medicaid does not pay nursing homes to hold beds open while Medicaid residents are in the hospital, so that somewhat diminishes the nursing home’s net financial benefit from hospitalizations. Until these underlying financial incentives are better aligned, the majority of nursing homes will likely have limited interest in this NC-CCN initiative. Nursing homes within a larger hospital-based medical system that is willing to subsidize nursing home losses rather than leave a higher-paying hospital bed unfilled may be more inclined to participate. We were told that some stand-alone hospitals support the program, knowing that their census may decline but that their payer mix will improve if lower-paying Medicaid patients can be cared for in nursing homes.

*“Given proper opportunities, this is a trend that will spread the way hospitalists did. . . . The primary care physician will hand over a patient to the nursing home physicians when it’s time for a patient to enter the nursing home.” (Physician participating in the demonstration)*

**Informatics Center.** Three user applications developed and maintained by NC-CCN’s Informatics Center—the Case Management Information System (CMIS), Pharmacy Home, and Provider Portal—support much of the care coordination performed by managers and the quality improvement initiatives supported by local networks. Care managers use CMIS to track patients and identify and prioritize at-risk and highest-cost patients for care management (for example, people on several medications and people who have visited the ED or have not seen a PCP). CMIS also offers health assessment and screening tools for use by care managers. Clinical pharmacists use the Pharmacy Home to reconcile and manage patient medications. The Provider Portal, launched by the Informatics Center in mid-August, will be available to all providers willing to sign a data-use agreement with NC-CCN, not just providers in their local networks. The portal will permit all providers involved in patient care to share information on enrolled patients.

Currently, NC-CCN databases are primarily populated by Medicaid claims and administrative data, although the database also includes data from 26,000 chart audits on participating practices and data provided by hospitals affiliated with the networks. NC-CCN has finalized an agreement with Surescripts, the predominant vendor for claims adjudication for the nation’s pharmacies, to provide additional medication data essential for managing duals. The Medicaid prescription drug data are uploaded regularly, with about a two-week lag; data from chart audits are available annually; and the Surescripts data uploads occur in real time. NC-CCN is also awaiting Medicare claims and Part D data from CMS, but long delays have hindered progress. Medicaid PMPM payments to networks, along with foundation money, have funded much of the database development.

**New Provider Portal.** Annette Dubard, M.D., of the NC-CCN Informatics Center demonstrated the new Provider Portal during our visit and provided the following description:

*“Through a secure web portal, treating providers in the primary care medical home, hospital, or emergency room will be able to access a Medicaid patient health record that includes patient information, care team contact information, visit history, pharmacy claims history, and clinical care alerts. Other entities involved in the coordination of care for Medicaid recipients, such as mental health Local Management Entities, public health departments, and state mental health facilities, may also access the Provider Portal. Importantly, the use of Medicaid claims data provides key information typically unavailable within the provider chart or electronic health record. For example, providers are able to see encounter information (hospitalizations, ED visits, primary care and specialist visits, laboratory, and imaging) that occurred outside of their local clinic or health system. Contact information for the patient’s case manager, pharmacy, mental health therapy provider, durable medical equipment supplier, home health or personal care service provider is readily available. Providers can discern whether prior prescriptions were ever filled and what medications have been prescribed for the patient by others. Built-in clinical alerts appear if the claims history indicates the patient may be overdue for recommended care (e.g., diabetes eye exam, mammography).*

*The Provider Portal also contains key resources for assisting providers in the management of Medicaid patients, such as a compendium of low-literacy patient education materials, and practice tools for risk assessment and disease management. Through a seamless link into a licensed service maintained by an outside partner, providers can retrieve medication information for patients in multiple languages, in video or print format. Medical home providers will be able to directly access population management reports for their CCNC-enrolled Medicaid patients, such as ED and inpatient utilization reports and disease registries with care gap alerts. Quarterly and annual reports provide practice-level performance feedback on CCNC quality measures related to diabetes, asthma, heart failure, cardiovascular disease, and pediatric and adult preventive services.”*

Since NC-CCN does not have claims data for Medicare services, however, the Provider Portal is more limited in the information it can provide for dual eligibles.

## **Beneficiary Participation and Enrollment Practices**

NC-CCN administrators currently estimate that, during the demonstration’s first two years, the eight participating networks will manage approximately 30,000 dual eligibles out of a total statewide dual-eligible enrollment of approximate 280,000.<sup>61</sup> As noted earlier, the state’s Division of Medical Assistance (DMA) currently uses an opt-out enrollment process for the ABD population (including duals) in the Medicaid CCNC program. Under the opt-out process, DMA assigns ABD beneficiaries to a CCNC practice if they are being treated by a provider in that practice, but they can choose a different practice if they wish. Dual eligibles can also choose to opt out of participation in CCNC. DMA sends a letter to beneficiaries telling them that they will be enrolled in that provider’s practice as their medical home unless they respond otherwise. We were told that six percent of the dual eligible beneficiaries enrolled in this way called to disenroll because they wanted the flexibility to see whomever they choose, did not want “government in their business,” or simply did not want change.

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<sup>61</sup> Denise Levis Hewson, NASHP conference presentation, October 5, 2010.

The state was planning to use this opt-out process to enroll dual eligibles in the 646 demonstration, but CMS has expressed concern about using this process when Medicare services are involved, so implementation of the process in the demonstration is now on hold.

Enrollment of more beneficiaries depends on educating patients on the benefits of a medical home. Local networks are partnering with Aging Resource and Disability Centers to help with this. Having care managers in the hospitals who can have a face-to-face interaction with patients and reinforce the concept of the medical home also helps.

In the demonstration's first two years, NC-CCN will focus on dual eligibles, but starting in the third year it plans to expand enrollment to all Medicare beneficiaries receiving services from providers participating in the demonstration. NC-CCN administrators estimate that 150,000 Medicare-only beneficiaries will be added in the third year.

## Performance and Quality Monitoring

**Reports for CMS.** In each demonstration year, NC-CCN will provide CMS with an annual performance plan that identifies the quality measures NC-CCN proposes to track during the performance period. The measures will provide the basis for determining the shared savings award to NC-CCN as well as the performance incentives for networks and participating practices. After NC-CCN and CMS agree on the measures, NC-CCN will complete a mid-year progress report and an annual performance improvement report with results for each identified performance measure for NC-CCN as a whole and for individual networks and practices. An annual financial report will account for use of the shared savings award.<sup>62</sup> For the demonstration's first year, NC-CCN has proposed four diabetes care measures, five congestive heart failure measures, three ischemic vascular disease measures, one hypertension measure, one diabetes and hypertension measure, one post-myocardial infarction measure, and one transitional care measure.<sup>63</sup> In the first year, 50 percent of the potentially available Medicare savings will be contingent on meeting quality measures; by year five, the percentage of savings dependent on quality measures will rise to 80 percent. Performance measures may be modified and expanded during the demonstration.<sup>64</sup>

**Evaluation of the 646 Demonstration.** The formal CMS evaluation of the 646 demonstration is in its early stages, with the comparison groups selected but an evaluation design still in development.<sup>65</sup> In discussions with CMS and the demonstration evaluator, NC-CCN stressed the importance of selecting comparison groups from outside the state. Since the NC-CCN and CCNC networks operate throughout the state, NC-CCN argued that it would be difficult to locate comparison groups within North Carolina that have not been influenced by Community Care activities. In the current evaluation design, the evaluator has selected counties in Georgia, Kentucky, South Carolina, Tennessee, and Virginia for purposes of comparison to the NC-CCN counties.

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<sup>62</sup> "NC-CCN Demonstration Protocol," November 24, 2009, draft, p. 36.

<sup>63</sup> Hewson, Denise Levis. NASHP conference presentation, October 5, 2010.

<sup>64</sup> "Community Care's 646 Demonstration Waiver," June 1, 2010, summary, pp. 2-4.

<sup>65</sup> The Research Triangle Institute has been the CMS contractor for the initial stages of the North Carolina demonstration.

**Network Performance Monitoring.** Within CCNC, local networks have always received monthly, quarterly, and annual reports on their performance on identified quality metrics based on state Medicaid claims and administrative data as well as on annual audits of medical charts. Representatives from local networks then visit each practice to provide practice-level information. The purpose of the reports has been to help providers improve care; as a result, feedback often comes with assistance organized through the local networks. Examples of assistance could include the provision of specific data on patients from chart audits to help target interventions and consultant services for practice redesign. As NC-CCN develops a P4P system to disburse shared savings from the demonstration, performance on quality metrics could be tied to additional monetary rewards such as increased PMPM payments.

*“[CCNC] provides a lot of quality metrics. We’ve always taken the state data and given networks data. The networks then give information to providers. We give data so that networks and providers can compare themselves.” (NC-CCN official)*

## Impact of Health Care Reform

The requirement that dual-eligible SNPs have a contract with state Medicaid agencies by 2013 has not had an impact on NC-CCN activities. As noted earlier, the two dual eligible SNPs operating in the state (Evercare and Southeast Community Care) have so far not approached the state or NC-CCN about contracting for Medicaid services.

## Barriers to Implementation and Expansion

**Lack of Medicare Data.** NC-CCN administrators emphasize that the demonstration’s success relies heavily on receiving Medicare claims data for dual eligibles. The databases that drive and facilitate active management of enrolled patients—for example, CMIS and Pharmacy Home—currently lack the Medicare data needed to create a full picture of Medicare patients. NC-CCN has extensive Medicaid data on these patients, but Medicaid data provide only limited information on use of Medicare services by duals (mainly through “crossover” claims for Medicare beneficiary cost sharing). The demonstration began in January 2010 and, eight months into the effort, NC-CCN still cannot say when Medicare data will be forthcoming. In particular, Part D drug data are critical. As it awaits Medicare data, the Informatics Center is working on methods to plug data holes. For example, it has entered into an agreement with Surescripts to provide the center with medication data for the demonstration’s duration and is working on similar arrangements with LabCorp and Thomson Reuters for data on laboratory test results and inpatient hospital admissions. Without Medicare claims data, NC-CCN does not know which provider should be considered the medical home for particular dual eligibles. The Informatics Center is attempting to use its existing Medicaid data to deduce patients’ medical homes by, for example, relying on Medicaid cost-sharing payments for Medicare physician visits to identify the physicians seen by dual-eligible enrollees.

*“For us, being successful with the Medicare population requires having access to data to find interventions that may make a difference. Right now, we are kind of working blindly.” (NC-CCN representative)*

*“Just getting Medicare Part D to give information to the states would be a huge help.” (NC-CCN pharmacist)*

**Issues with Billing.** As the medical home model grows to include providers like pharmacists and psychiatrists/psychologists, issues have arisen with billing. One concern relates to same-day billing and the generation of two medical bills. At Cabarrus Family Medicine, primary care

physicians and psychiatrists have started co-therapy sessions with patients. When both the physician and the psychiatrist participate in a face-to-face meeting with the patient, both can bill, but when one meets with the patient and the other is consulted but does not see the patient, only the one meeting with the patient can bill.

**Cross-Network Communication and Management.** As the transitional support intervention spreads, NC-CCN faces the challenge of facilitating cross-network communications. For large tertiary hospitals, many hospitalized patients come from providers outside the local network. Devising a system for a care manager in one network to connect and communicate effectively with providers from another network is a logistical challenge. The new Provider Portal should help with this.

**Multiple but Siloed Programs for Duals.** While there are PACE, SNPs, and HCBS waiver programs in North Carolina that aim to treat, manage, and support dual eligibles, those programs have not been incorporated into the NC-CCN demonstration. No current plan appears to exist for coordinating services among the various programs aimed at managing dual eligibles, which could lead to service duplication and patient confusion. According to NC-CCN leadership, SNPs are health-plan based and HCBS programs are agency-based, making it difficult to integrate them into the community-based NC-CCN system. Without some level of collaboration, however, dual eligibles may very easily be confused by the services being offered to them from different sources. For example, they may be contacted by a care manager from HCBS, a care manager from NC-CCN, and care manager from a SNP. Enrollment in PACE plans is currently low (126 enrollees in two plans in August 2010), but enrollment in SNP dual-eligible plans is substantially higher (7,458 in Evercare and 638 in Southeast Community Care in August 2010), and enrollment in the aged and disabled HCBS waiver program is also sizable (14,670 in 2006).<sup>66</sup> These coordination issues may therefore loom larger as enrollment in the 646 demonstration expands.

**Promoting Use of Available Data.** The database applications created by NC-CCN's Informatics Center are impressive and, if used, could greatly improve the management of care for dual eligibles. However, uptake and meaningful use by intended users is often a challenge for any program implementing health information technology, particularly among busy physicians who are important intended users of NC-CCN's Provider Portal.

## Lessons Learned and Future Plans

NC-CCN leaders and providers offered advice and comments that may be useful for other states looking to develop integrated programs for duals. Several comments focused on the special features of the North Carolina model:

- “Community Care is like a virtual ACO [accountable care organization]. We are not an insurance plan. . . . Because we are the provider. . . we are already a business partner. That’s why it’s easy for networks to get data from their hospitals.”

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<sup>66</sup> Ng, Terence, Charlene Harrington, and Molly O’Malley Watts. “Medicaid Home and Community-Based Service Programs: Data Update, Table 5.” Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2009.

- “Some networks have forged relationships with hospitals by managing some of their uninsured. They do this so [it is clear that] the network is meeting more of [the hospitals’] needs. The hospitals would have loved to have us manage everyone; we couldn’t do that, but we did do more with the uninsured.”
- “With Community Care, providers are part of a delivery system that is holding them accountable. We have an infrastructure in place, so if a practice is performing poorly, they are being brought forward locally so everyone knows.”
- “Ninety percent of physicians want to do the right thing. Our task is to go to offices and help them do the things they want to do that are right for patients.”
- “There is ownership in the quality metrics because the doctors approved them.”
- “The physician really needs to lead this. It’s still the physician-patient relationship that I feel needs to be most sacred. . . . It’s a patient-centered team, but the physician still needs to be the leader. In some teams, individual people want to be leaders of their own piece, and that doesn’t work as well.”
- “We are most focused on preserving primary care in North Carolina. We are providing practices the tools [they need]. We want to support primary care so patients can have medical homes.”
- “Give flexibility for local health systems to develop themselves. . . . We have to go back to our principles—flexibility, play to your strengths, non-profit, and local.”
- “Top down doesn’t work. It’s the local buy-in and the local leadership that works.”

A number of comments were more broadly applicable:

- “If I had the power to decide where to spend our health dollars, I would look at where the interactions are happening with patients and let spending be patient-driven. Then organizations that are paying the professionals would have more flexibility to recruit the right people. If you look at where most patient encounters happen, 90 percent are outside of hospitals, but most of our health dollars are spent in the hospital.”
- “Changing a practice to be a medical home is a huge investment that will take years. The only constant in the universe is change, but by God it gets old after a while. . . . We do this because it is the right thing to do.”
- “How do you get everyone together to talk? As long as everyone is at the table, the enemy of my enemy is my friend, so you are more likely to create a Switzerland-type program.”
- “There would be a lot of pharmacists who would be capable and willing to do a clinical position in a nursing home if they could make a change in their career and could be reimbursed competitively. You would have more pharmacists in the pot.”
- “Bring the medical home to the home [with home visits by care managers and nurse practitioners].”
- “If you can do it for the duals, you can do it for anybody.”
- “We’ve had the right visionary leadership. We don’t tell [Dr. Dobson] ‘no.’”

**Future Plans.** Only just launched, North Carolina’s 646 demonstration will run for five years. Given that the demonstration is focusing thus far on acute and primary care services, it will be informative for other states to see how the networks deal with the long-term care needs of older duals. The NC-CCN model currently does not include nursing facility and HCBS, but dual eligibles’ heavy use of these services will inevitably require some coordination with providers of these services. Also of interest will be the program’s move from a non-financial model for driving improvements in quality to a P4P strategy focused on quality measures. Much of what is yet to emerge from the demonstration will be of great interest to other states and federal policymakers looking for lessons and strategies for integrating care for dual eligible beneficiaries.

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