FEASIBILITY OF CARE COORDINATION FOR PERSONS DUALLY ELIGIBLE FOR MEDICAID AND MEDICARE

Prepared for:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Submitted by:

PACIFIC HEALTH POLICY GROUP

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PHPG

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TABLE OF CONTENTS

Executive Summary **1**

Section 1: Introduction **7**

Who are Dual Eligibles? 7

Service Delivery is Fragmented 9

Overview of Report 10

Section 2: Dual Eligibles in Oklahoma **12**

Demographics 12

Health Care Needs 13

Current Care Coordination Program and Initiatives 18

Section 3: Medicare Managed Care in Oklahoma **21**

Background 21

Oklahoma Market 23

Care Coordination Activities in Other States 31

Section 4: Other States' Models **32**

Overview 32

Integration of Medicare and Medicaid 32

Managed Long-Term Care Programs 37

Differences among State Dual Initiatives 38

Selected State Profiles 40

Section 5: Options/Considerations **42**

Introduction 42

Enrollment Groups 42

Care Coordination Options 44

Potential Medicaid Savings 53

Appendices

Appendix A: Medicaid Expenditures and Utilization by Dual Eligible Population and Chronic Condition

Appendix B: Integrated Care Activities in Other States by MA Plans in Oklahoma

Appendix C: Select State Profiles

EXECUTIVE SUMMARY

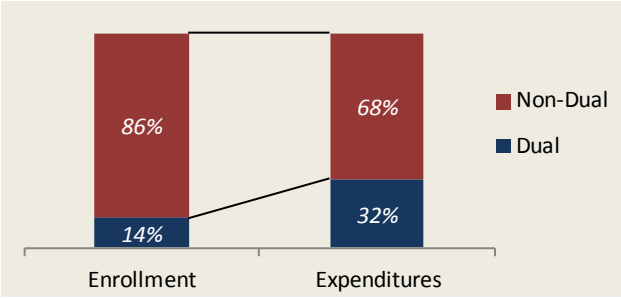
Senate Bill 272 directed the Oklahoma Health Care Authority (OHCA) to "conduct a feasibility study of current and potential care coordination models for persons who are dually eligible for Medicaid and Medicare that may be implemented in the State; and explore options for cost containment and delivery alternatives for those persons, that are consistent with the mission of the agency."

The Pacific Health Policy Group (PHPG) was retained by the OHCA to assist in performing the tasks outlined in SB 272. PHPG specializes in the development and evaluation of coordinated (managed) care programs for publicly-funded populations, including Medicaid and Medicare. In the past three years, PHPG has assisted public or private sector clients in the states of Arizona, Florida, Kansas, New Mexico, Texas, and Vermont to develop or administer coordinated care programs for dual eligibles.

Over 109,000 Oklahomans are enrolled in both Medicare and Medicaid (SoonerCare in Oklahoma). Medicare is financially responsible for most primary and acute care service costs, while Medicaid largely funds long-term care, including nursing facilities, intermediate care facilities for persons with intellectual/developmental disabilities and home- and community-based services.

Dual eligibles account for only 14 percent of SoonerCare enrollment but 32 percent of expenditures (Exhibit ES-1). This disproportionate spending is driven by significantly higher rates of chronic conditions, disabilities, and long term care placements than other SoonerCare populations.

Exhibit ES- 1: Distribution of Oklahoma Medicaid Enrollment and Expenditures by Medicare Eligibility (2012)

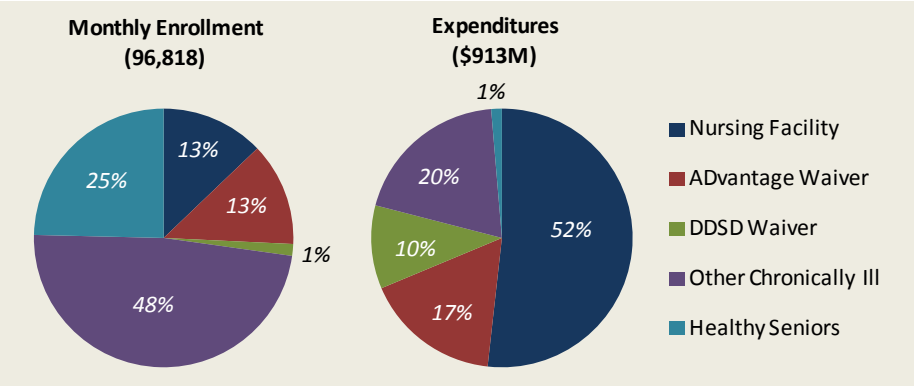


Despite their overall higher costs, the health care needs of dual eligibles vary considerably. In general, dual eligibles can be categorized into three populations based on need (see Exhibit ES-2 for distribution of enrollment and expenditures by population):

- **Frail elders and persons with physical disabilities receiving long-term care**, either in a nursing facility or through a home- and community-based services (HCBS) waiver (e.g., the ADvantage waiver). These duals account for 26 percent of the dual population but 79 percent of expenditures. Dual eligibles also account for over 90 percent of Medicaid long-term care recipients.

- **Persons with intellectual or development disabilities (I/DD) receiving long-term care**, either in an intermediate care facility for the intellectually disabled (ICF-ID) or through an HCBS waiver (e.g., the Community waiver or Homeward Bound waiver). Only about one percent of duals are I/DD but account for 10 percent of expenditures.
- **Other dual eligibles residing in the community**, including healthy seniors and adults with chronic physical and/or mental health needs. The healthy portion of this population constitutes 25 percent of the dual population but only one percent of expenditures. Other duals with chronic health needs represent 48 percent of the population and 20 percent of expenditures.

Exhibit ES-2: Distribution of Medicaid Enrollment and Expenditures for Dual Eligibles by Population (2012)



Historically, Medicare and Medicaid have lacked the policy vehicles and financial incentives to coordinate care between the two programs. As a result, service delivery for dual eligibles nationally has been marked by fragmentation of care and duplication of services, resulting both in wasteful spending and poor health outcomes. For example in 2005, it was estimated that for all dual eligibles nationwide requiring long-term care, 39 percent of hospitalizations were avoidable, representing nearly $4.15 billion in unnecessary spending ($3.6 billion for Medicare; $550 million for Medicaid) in current dollars.[1]

A small number of states pioneered coordinated care strategies for dual eligibles, including long-term care recipients, in the 1980s and 1990s. However, most states, including Oklahoma, are in the process of planning or implementing coordinated care initiatives under the auspices of CMS integrated care demonstration grants. Private managed care organizations (MCOs) also have accelerated adding capacity to serve this population through acquisitions and product/program development.

Other states' coordinated care models vary most notably in the following areas:

- How medical services are paid for (i.e., capitated or fee-for-service);
- Who has primary care coordination responsibilities (i.e., state staff, state contractors, providers, or MCOs);

[1] Walsh, et al., "Potentially Avoidable Hospitalizations of Dually Eligible Medicare and Medicaid Beneficiaries from Nursing Facility and Home- and Community-Based Services Waiver Programs," March 2012.

- What populations are included/excluded (e.g., long-term care, chronically ill, I/DD); and
- What services are covered (e.g., all Medicaid and Medicare services vs. only Medicaid long-term care).

In addition, the specific policy objectives of each program and the type(s) and scope of models used in each state are determined by a variety of factors, including but not limited to, the demographic characteristics of the dual eligible population; geographic characteristics of the state; maturity of the Medicaid and Medicare managed care markets; and other state programs or initiatives implemented or being developed.

CARE COORDINATION OPTIONS

As Oklahoma considers options for expanding care coordination for dual eligibles, two key decisions will need to be made: (1) what populations/enrollment groups should be targeted, and (2) under what model(s) should coordinated care be implemented. These decisions will determine the structure and ultimate impact of the State's coordinated care strategy.

Potential Enrollment Groups

- *Frail elders/physically disabled receiving long-term care, including nursing facility and HCBS waiver participants*

  This population is responsible for the majority of Medicaid spending on behalf of dual eligibles and should be part of any coordinated care strategy.

- *Persons with intellectual or developmental disabilities (I/DD) requiring long-term care, including institutional and HCBS*

  The primary needs of this group often are non-medical in nature but instead are habilitative and oriented toward strengthening life skills. These services often are provided by smaller, non-profit providers who solely serve the I/DD community. Traditional MCOs often lack expertise in delivering such services. As a result, only a small number of states are chosen to include the I/DD population in their coordinated care initiatives; however, some states have enrolled the I/DD population in MCOs for acute care only.

- *Other dual eligibles in the community*

  This group consists of healthy seniors and those with chronic conditions not requiring long-term care. "Other duals" account for a small portion of total Medicaid spending but are still appropriate for inclusion in coordinated care. Early intervention and care coordination has the potential to improve health outcomes and forestall the need for long-term care, thereby

reducing future state expenditures for nursing facility or home- and community-based services. Integration of Medicare and Medicaid services is essential for this group, since most its costs are covered by Medicare.

Potential Models

- *Enroll dual eligibles in a capitated program through contracts with MCOs*

  The majority of states implementing coordinated care have done so through a capitated model, not only for dual eligibles but other populations as well. Oklahoma does not currently have a private Medicaid MCO infrastructure and the state's Medicare MCO enrollment is relatively small and concentrated in metropolitan areas. However, if structured properly, and given sufficient time to expand, the MCO model would offer a number of advantages over a purely unmanaged system, including:

  - ✓ Leveraging expertise of national organizations
  - ✓ Platform for integrations of Medicare and Medicaid
  - ✓ Fiscal/budget predictability

- *Build on the State's existing community-based infrastructure*

  As an alternative to the MCO model, Oklahoma could pursue a managed fee-for-service (MFFS) model through expansion of initiatives already underway for SoonerCare dual eligibles. This would involve direct contracts with provider and care management organizations under FFS, risk-sharing, or full-risk arrangements. The MFFS model offers several potential advantages, including:

  - ✓ Lower administrative expenses
  - ✓ Retention of savings by the State for program reinvestment or reduction in general fund needs
  - ✓ Larger choice of providers
  - ✓ Faster program expansion, particularly in rural areas
  - ✓ Greater potential for targeting high cost members through partnerships with provider organizations
  - ✓ Greater flexibility for implementing and replicating successful innovations (direct action vs. through a third party)

Oklahoma is not limited to one model or the other. For example, the State could evaluate options for risk-based managed care for the long-term care population, while continuing to expand community-based programs and initiatives for all other duals.

Other Considerations

Regardless of the model(s) Oklahoma decides to pursue, there are important considerations for a successful implementation:

- *Establish realistic timeframes* – Implementation can take two years or longer, depending on the program's design;

- *Involve stakeholders in planning and program design* – Inclusion will result in a more resilient care coordination structure;

- *Emphasize person-centered care and appropriate physician role* – Front-end assessments, interdisciplinary care teams, rigorous care planning, real-time service monitoring, and system-wide quality monitoring; and

- *Define opportunities for nursing facilities* – If Oklahoma's strategy includes the long term care population, the result will be a continued reduction in nursing facility utilization, even as these facilities continue to place an essential role in caring for frail elders and others with physical disabilities. Nursing facilities should be given the opportunity to benefit from program reform through assistance in repurposing portions of their facilities to other uses (e.g., adult day care) and sharing of savings associated with successful transition of residents back to the community.

Potential Medicaid Savings

PHPG analyzed historical paid claims data for dual eligibles in Oklahoma to develop a savings model for the different enrollment groups and two models of care coordination. Each model/population was subjected to a "high" and "low" scenario, which respectively assumed more or less (a) rebalancing of the long-term care program and (b) savings due to reduction in utilization due to service delivery reform.

Detailed tables by population are presented in the body of the report. As the summary table below illustrates, there is a significant potential for savings over time, with frail elders and persons with physical disabilities receiving long term care representing the greatest opportunity for improved quality of life and cost reduction (Exhibit ES-3).

Under managed long-term care, sustainable savings occur over time, as new members living in the community receive the necessary supports to forestall placement in a costlier nursing facility. Over the first 24 to 36 months, the placement mix will begin to shift (or rebalance) in the direction of home-based care and savings will result.

Exhibit ES-3: Summary of Projected Potential Savings Scenarios for Populations of Dual Eligibles Five-Year Outlook: 2015 – 2019

	Long-Term Care	I/DD	Other Dual Eligibles	All Dual Eligibles
Baseline Expenditures	$ 4,933,357,817	$ 741,083,803	$ 1,533,511,525	**$ 7,207,953,145**
Percent of Total	68%	10%	21%	**100%**
MCO/Capitated Model				
Low Scenario				
Savings	$ 230,829,330	$ (33,348,771)	$ (69,008,019)	**$ 128,472,540**
Percent of Baseline	4.7%	-4.5%	-4.5%	**1.8%**
High Scenario				
Savings	$ 790,308,344	$ 15,335,115	$ 15,335,115	**$ 820,978,574**
Percent of Baseline	16.0%	1.0%	1.0%	**11.4%**
Community-Based/MFFS				
Low Scenario				
Savings	$ 427,679,359	$ 15,933,302	$ 32,970,498	**$ 476,583,159**
Percent of Baseline	8.7%	2.2%	2.2%	**6.6%**
High Scenario				
Savings	$ 945,188,698	$ 54,099,118	$ 111,946,341	**$ 1,111,234,157**
Percent of Baseline	19.2%	7.3%	7.3%	**15.4%**

Conclusion

Oklahoma has multiple feasible pathways to implementing coordinated care for dual eligibles, particularly frail elders and persons with physical disabilities receiving long-term care, as well as other community-based dual eligibles. Coordinated care has the potential to rebalance services in a manner that improves member quality of life and health outcomes and yields significant savings, particularly with respect to the same long-term care recipients.

Whatever strategy is adopted, it should be the result of careful and inclusive planning that involves all major stakeholders. It also should be undertaken with realistic expectations about the amount of time necessary for implementation and achievement of sustainable savings.

SECTION 1: INTRODUCTION

Senate Bill 272 directed the Oklahoma Health Care Authority (OHCA) to "conduct a feasibility study of current and potential care coordination models for persons who are dually eligible for Medicaid and Medicare that may be implemented in the State; and explore options for cost containment and delivery alternatives for those persons, that are consistent with the mission of the agency."

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WHO ARE DUAL ELIGIBLES?

Dual eligibles are individuals enrolled in both Medicare and Medicaid (SoonerCare in Oklahoma). There are over 10 million dual eligibles nationwide,[2] including 109,000 in Oklahoma.[3] Dual eligibles account for approximately 17 percent of Oklahoma Medicare beneficiaries and 14 percent of SoonerCare members.[4,5]

Individuals are eligible for each program based meeting the following criteria:

Medicare		**Medicaid**
• 65 years of age or older, *OR* • Under age 65 and disabled, *OR* • Have End Stage Renal Disease	**AND**	• Low income, *AND* • Limited financial assets

In addition to full Medicare benefits, dual eligibles qualify for at least one of three types of Medicaid benefits. Dual eligibles are categorized as "full" or "partial" duals based on which Medicaid benefits they receive.

"Full duals" are eligible to receive three types of Medicaid benefits: all Medicaid covered services; reimbursement for Medicare premiums; reimbursement for Medicare cost sharing obligations (i.e., copays, deductibles, and coinsurance). "Partial duals" are not eligible for Medicaid services.

[2] Medicare-Medicaid Coordination Office (MMCO), "Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011," February 2013.
[3] OHCA Enrollment Fast Facts for September 2013
[4] *Ibid.*
[5] Based on number of eligibles from monthly CMS Medicare Advantage State/County Penetration file September 2013.

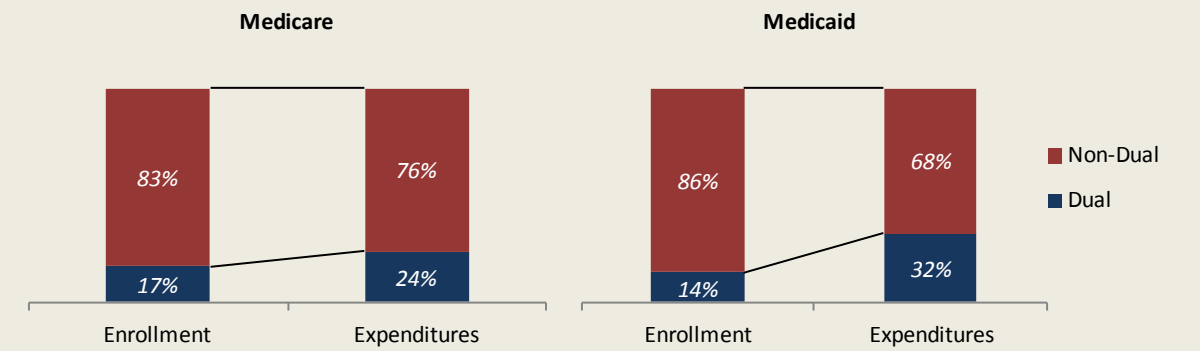
Nearly 80 percent of dual eligibles in Oklahoma are "full duals".[6] These individuals also account for the great majority of dual eligible Medicaid expenditures and would be the focus of any coordinated care strategy in Oklahoma, as they are in other states with coordinated care programs (Exhibit 1-1).

Exhibit 1-1: Medicaid Benefit Types for Dual Eligibles

Medicaid Benefits (Eligibility Category[7])	Full Duals	Partial Duals
1. Reimbursement for Medicare Part A or B premiums (SLMB, QI, QDWI)	✓	✓
2. Reimbursement for Medicare deductibles and copays (QMB)	✓	✓
3. All Medicaid covered services	✓	
Percent of dual eligibles in Oklahoma (2012)	*78%*	*22%*

Combined Medicare and Medicaid spending on Oklahoma's dual eligibles in 2011 exceeded $3 billion and is projected to nearly double to over $5.9 billion by 2021.[8] While dual eligibles are a relatively small portion of Medicare and Medicaid enrollment, they are some of the costliest beneficiaries, accounting for 24 percent of Medicare and 32 percent of Medicaid spending in the state (Exhibit 1-2).[9]

Exhibit 1-2: Medicare/Medicaid Enrollment and Spending in Oklahoma by Dual Status (2011)



While Medicare and Medicaid both spend significant dollars on dual eligibles, the nature of the expenditures is very different. Medicare takes precedence over Medicaid as a payer and therefore is responsible for most of the cost of services that are covered under both programs, such as physician visits and hospital admissions ("acute care") and prescription drugs. (Medicaid typically only pays for

[6] Based on an analysis of paid claims data.

[7] Duals eligibles receive their Medicaid benefits for Medicare premiums/cost sharing through the Medicare Savings Program (MSP). MSP eligibility groups are provided in parentheses. SLMB = Specified Low-Income Medicare beneficiary; QI = Qualifying Individual; QDWI = Qualified Disabled Working Individual; QMB = Qualified Medicare Beneficiary. For more information, visit www.Medicare.gov.

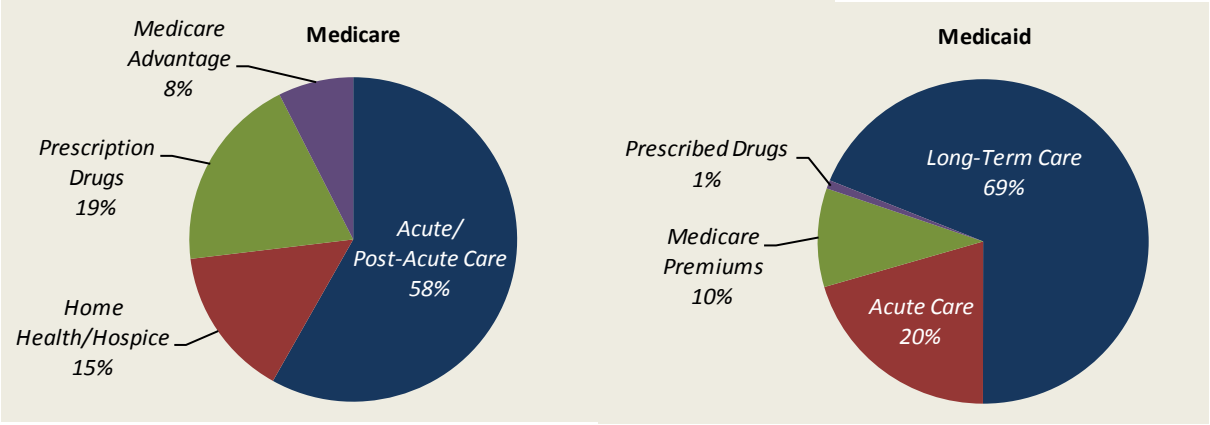
[8] Special Needs Consulting Services (SNCS), "Achieving Optimal Care Coordination for Medicaid/Medicare Dual Eligibles," August 2011. Includes all Medicare and Medicaid services, including Medicare premiums and cost sharing paid by Medicaid, and Medicare Part D prescription drug costs.

[9] PHPG estimates based on data from or estimates by SNCS, 2011 (total spending for dual eligibles by program, including Medicare Part D prescription drugs) and the Kaiser Family Foundation and Urban Institute (total Medicaid spending, Medicare spending per beneficiary, and annual growth in Medicare spending per beneficiary).

member cost sharing, such as deductibles and co-payments, for these services. Medicaid also covers some mental health and transportation service costs.)

However, Medicare provides only a limited benefit for long-term care (LTC) services. Once the Medicare benefit is exhausted, Medicaid becomes the primary payer for nursing facility and home- and community-based services (HCBS), which are some of the costliest benefits provided to dual eligibles (Exhibit 1-3).

Exhibit 1-3: Distribution of Medicare/Medicaid Spending for Dual Eligibles in Oklahoma[10]



SERVICE DELIVERY IS FRAGMENTED

Without the proper incentives in place, Medicare and Medicaid historically have not effectively coordinated care for dual eligibles. For example, states do not stand to reap significant financial benefits for managing inpatient costs for these members, as most of the savings due to reduced hospitalizations would be realized by the Medicare program. The same holds true in reverse for Medicare and appropriate LTC utilization.

In the absence of integrated or coordinated care, patients, families, caregivers, and providers have been left to self-navigate the complex web of different and often conflicting rules, requirements, programs, and services. The result at the individual level is service delivery fragmentation. A dual eligible member may have a primary care physician through traditional Medicare, receive home- and community-based services through Medicaid, and prescription drugs through a Medicare Part D plan.

Coordinated, or managed care, if done properly, offers the potential to re-align incentives, improve health outcomes, and increase member and provider satisfaction, while also better controlling costs.

[10] Medicaid spending in 2010 according to the Kaiser Family Foundation. "Acute care" includes Medicaid payments for Medicare cost sharing and Medicaid services not covered by Medicare. Medicare spending in 2009, estimated based on Medicare eligibility and FFS data obtained by PHPG (excludes prescription drugs) for Oklahoma dual eligibles. Prescription Drug spending based on national average as calculated by the Congressional Budget Office (CBO) for full duals as a percent of total Medicare spending per beneficiary. Acute/post-acute includes hospital, physician, carrier, and durable medical equipment.

There has been significant coordinated care activity for dual eligibles in recent years at both the federal and state level, as well as within the managed care industry.

While a few states have enrolled dual eligibles in coordinated care programs for many years (e.g., Arizona since the 1980's), there has been an upsurge in activity more recently, in part due to the availability of federal demonstration grants for states seeking to test new approaches for integration of services and funding.

The various initiatives, both within and outside of Oklahoma, vary in terms of the specific dual eligible populations being targeted and the manner in which financial risk is structured. When evaluating what is feasible going forward for Oklahoma, the issue of who to cover and under what model (MCO risk arrangement or other) will be two key decision points. In addition, the State must consider how well any potential strategy fits within Oklahoma's existing environment and how well it performs with respect to:

- Integrating Medicare and Medicaid service delivery and financial incentives;
- Building on successful existing strategies and associated infrastructure;
- Minimizing implementation timelines/costs and ongoing administrative burden;
- Offering coordinated care statewide, including in rural Oklahoma;
- Improving service accessibility, quality of care, and quality of life for members;
- Offering opportunities to providers to participate in a meaningful way; and
- Contributing to the financial sustainability of the SoonerCare program.

OVERVIEW OF REPORT

Section two of the report contains detailed demographic, utilization, and expenditure data for dual eligibles in Oklahoma. The section also reviews the Oklahoma Health Care Authority's (OHCA) current programs and planned initiatives to better manage the care delivered to SoonerCare dual eligibles.

Section three describes the Medicare managed care organization (MCO) market in Oklahoma, including enrollment, service areas, provider networks, benefits, and rates.

Section four presents information on care coordination models for dual eligibles being pursued across the country and includes profiles of select states undertaking these initiatives.

Section five draws upon the information in the prior sections to identify feasible care coordination options for Oklahoma and potential savings associated with expansion of coordinated care for the State's dual eligible population.

Concurrent with this feasibility study, the OHCA released a Request for Information seeking recommendations for care coordination models to serve Oklahoma's dual eligible population. The OHCA received responses from six organizations, all of which serve dual eligibles directly, or through affiliated

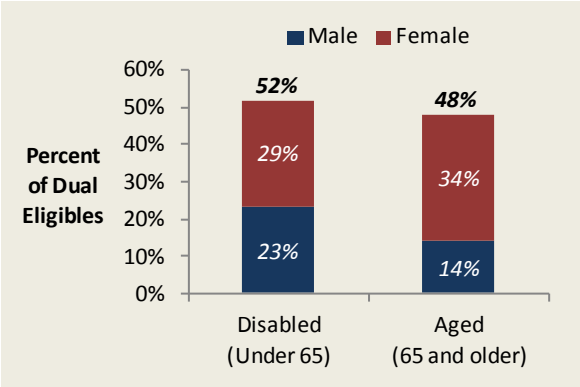
companies, in various Medicare and Medicaid managed care programs around the country. The OHCA is evaluating the responses as part of its information gathering to meet SB 272 mandates. PHPG also reviewed the responses and has included relevant information in the discussion of care coordination options in section five of the report.

SECTION 2: DUAL ELIGIBLES IN OKLAHOMA

DEMOGRAPHICS

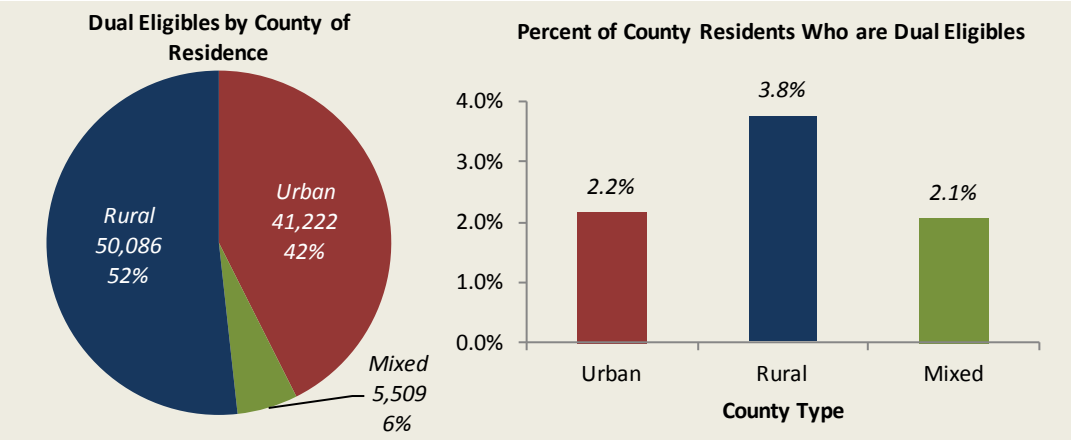
The dual eligible population in Oklahoma is roughly evenly split between those who are age 65 and older (48 percent), and those who are under age 65 and disabled (52 percent). Most dual eligibles are female (63 percent) and females age 65 and over outnumber their male counterparts nearly 2.5 to 1 (Exhibit 2-1).

Exhibit 2-1: Age and Gender Distribution of Dual Eligibles in Oklahoma (2012)



Dual eligibles are almost evenly divided between rural counties (52 percent) and urban/semi-urban (i.e., mixed) counties (48 percent). However, residents in rural counties are nearly twice as likely to be dual eligibles as those living in other counties, reflecting the reality that the residents of rural Oklahoma are, on average, lower income and older than their urban counterparts (Exhibit 2-2).[11]

Exhibit 2-2: Geographical Distribution of Dual Eligibles in Oklahoma (2012)



[11] Estimates for county population from OHCA Enrollment Fast Facts September 2013

Dual eligibles are slightly less likely to be of a minority race or ethnicity (27 percent) compared to the overall Oklahoma population (32 percent). African Americans are somewhat overrepresented, while younger Hispanic and Native American populations are underrepresented (Exhibit 2-3).

Exhibit 2-3: Race and Ethnicity of Dual Eligibles in Oklahoma (2012)[12]

Race/Ethnicity	Dual Eligibles	Statewide Population
White, non-Hispanic	**73%**	**68%**
Minority Race/Ethnicity	**27%**	**32%**
Black/African-American	13%	8%
Hispanic	4%	9%
Native American/American Indian	6%	9%
Multiple/Other	4%	6%

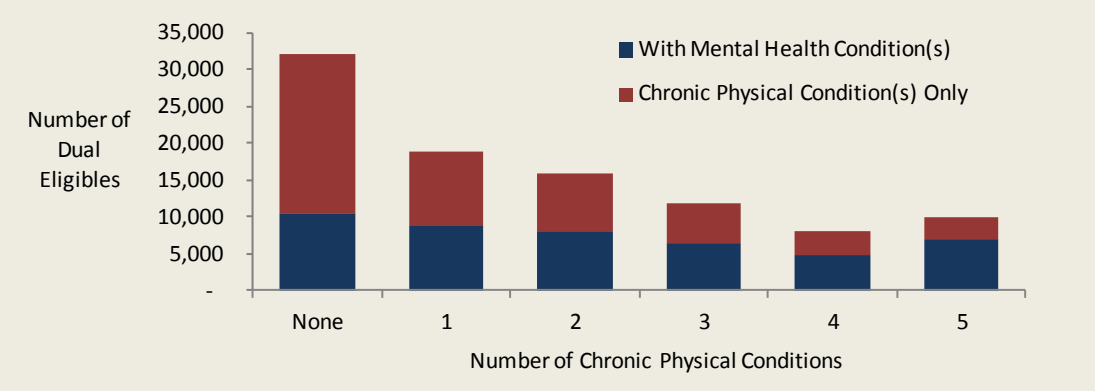
HEALTH CARE NEEDS

The health care needs of the dual eligible population span a wide range of physical and mental health conditions, requiring both acute and chronic care services. Overall, dual eligibles have greater needs than beneficiaries enrolled in only Medicaid or Medicare. The Congressional Budget Office (CBO) found in 2009 that over half of duals initially gained Medicare eligibility due to a disability, as compared to 17 percent of non-dual Medicare beneficiaries. Duals also were twice as likely to have three or more chronic conditions, and three times more likely to have a mental health condition.[13]

In Oklahoma, about 67 percent of dual eligibles have a chronic physical health condition and 47 percent have a mental health condition, either acute or chronic (Exhibit 2-4, following page).[14] The prevalence of mental conditions also increases as the number of chronic physical health conditions increases. The comorbidity rate for individuals with one physical health condition is 46 percent; the rate for individuals with five or more physical health conditions is 70 percent. Overall, over half (54 percent) of dual eligibles with a chronic physical condition also exhibit some type of mental health condition.

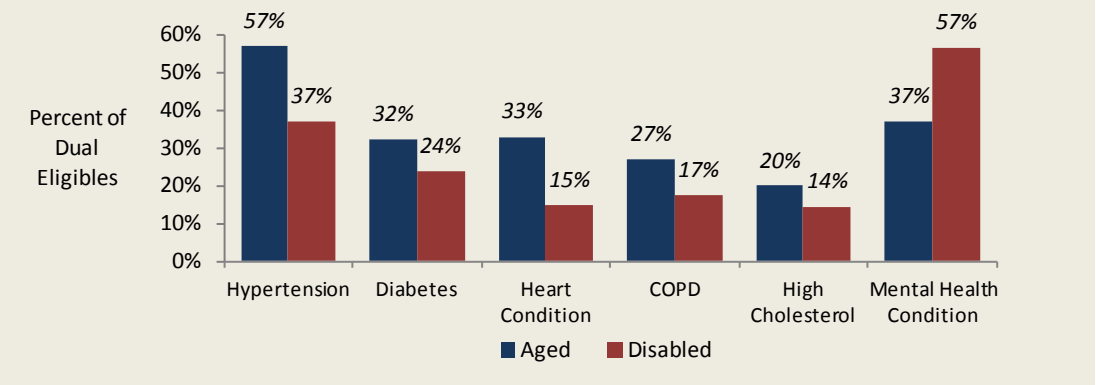
[12] Statewide figures from 2010 U.S. Census.
[13] Congressional Budget Office (CBO), "Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies," June 2013.
[14] "Chronic conditions" defined as those identified by MEDai predictive analytics software used for the SoonerCare Health Management Program, including: asthma, cerebrovascular accident/stroke, chronic obstructive pulmonary disease (COPD), congestive heart failure, coronary artery disease, depression,* diabetes, HIV/AIDS, hyperlipidemia (high cholesterol), hypertension, lower back pain, migraines, multiple sclerosis, renal failure, rheumatoid arthritis, and schizophrenia.* Conditions with an asterisk (*) are not include when "chronic physical conditions" are referenced.

Exhibit 2-4: Frequency of Chronic Physical Conditions and Mental Health Comorbidities among Dual Eligibles in Oklahoma (2012)



The top chronic physical conditions for Oklahoma's dual eligibles are hypertension, diabetes, heart disease (includes congestive heart failure and coronary artery disease), chronic obstructive pulmonary disease (COPD), and high cholesterol. The physical health conditions are more prevalent among dual eligibles age 65 and older, particularly hypertension and heart ailments. In contrast, disabled dual eligibles under the age of 65 have a significantly higher rate of mental health conditions (Exhibit 2-5).

Exhibit 2-5: Top Chronic Conditions among Aged and Disabled Dual Eligibles in Oklahoma (2012)



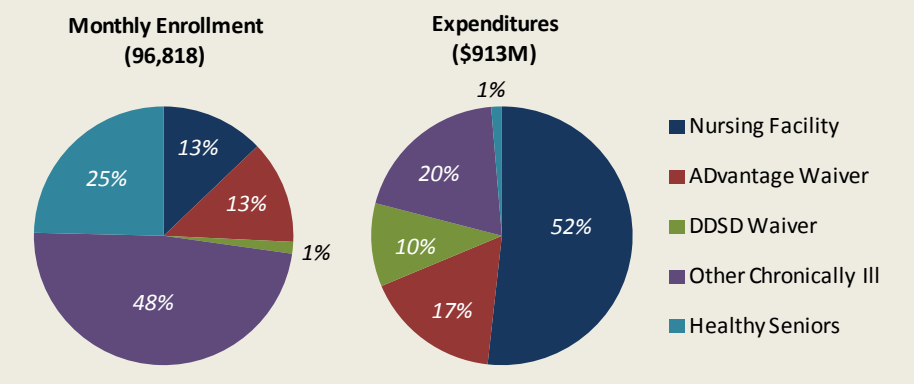
In general, dual eligibles can be grouped into five categories, based on their health care needs and service use:

- Frail elders and persons with physical disabilities residing in nursing facilities;
- Frail elders and persons with physical disabilities receiving home- and community-based services (HCBS), such as the ADvantage waiver, in lieu of nursing facility care;
- Persons with intellectual/developmental disabilities requiring long term care (regardless of setting);
- Persons living in the community with one or chronic conditions, but not requiring long term care; and
- "Healthy seniors" who have no chronic physical or mental health conditions.

N.B. *For the purposes of the analysis in this report, the I/DD population was identified in paid claims and eligibility data as dual eligibles receiving care through the Developmental Disabilities Services Division (DDSD) waiver. Recipients of long-term care in the home or community were identified as dual eligibles receiving care through the ADvantage waiver program. Medicaid expenditures exclude Medicare premiums paid by OHCA on behalf of dual eligibles.*

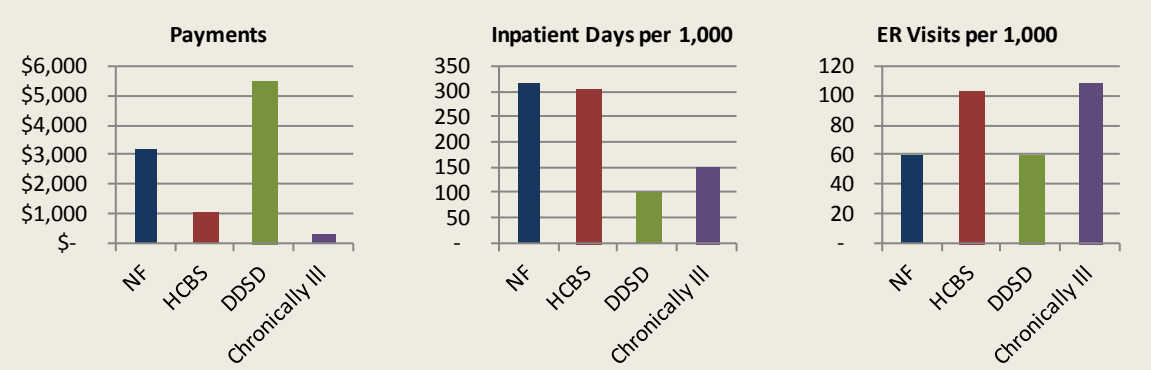
Individuals requiring long-term care account for only 27 percent of dual eligibles but 79 percent of total Medicaid expenditures.[15] Individuals with chronic conditions account for nearly all of the remaining spending; only one percent of total expenditures go toward services for healthy seniors, even though they comprise 25 percent of the population (Exhibit 2-6).

Exhibit 2-6: Enrollment and Medicaid Expenditures for Dual Eligibles by Population in Oklahoma (2012)



Consistent with aggregate expenditures, the long-term care population has the highest per member per month (PMPM) costs and incurs the greatest number of hospital days per member. Persons with chronic illnesses visit the emergency room (ER) at similar or even higher rates than long-term care dual eligibles; however, Medicaid PMPM payments for this group are low, given that Medicare is primary payer for inpatient and ER services (Exhibit 2-7). (Healthy seniors were excluded from the exhibit due to minimal utilization by these members.)

Exhibit 2-7: Medicaid PMPM Payments and Utilization for Dual Eligibles by Population (2012)



[15] All Medicaid expenditure data is combined state and federal, unless otherwise noted.

PHPG analyzed Medicaid payments and utilization rates for each population of dual eligibles across various chronic conditions. Data for major chronic conditions are presented below (Exhibit 2-8). Some key trends identified in the data include:

- The DDSD waiver population is the most costly population for Medicaid, at approximately double what nursing facility residents cost.
- The ADvantage waiver population is only 34 percent as costly as the nursing facility population.
- Other chronically ill dual eligibles cost Medicaid, on average, about $3,847, or $321 per month.

Additional data on chronic conditions by population is presented in Appendix A.

Exhibit 2-8: Annual Medicaid Costs and Utilization for Dual Eligibles with Major Chronic Conditions (2012)

Chronic Condition	Nursing Facility				ADvantage Waiver			DDSD Waiver			Other Chronically Ill		
	Annual Medicaid Costs	Nursing Facility Days	Inpatient Days per 1,000	ER Visits per 1,000	Annual Medicaid Costs	Inpatient Days per 1,000	ER Visits per 1,000	Annual Medicaid Costs	Inpatient Days per 1,000	ER Visits per 1,000	Annual Medicaid Costs	Inpatient Days per 1,000	ER Visits per 1,000
Asthma	$37,170	235	7,594	1,535	$14,394	5,988	2,263	$76,723	3,297	1,289	$ 4,567	3,367	2,595
Congestive Heart Failure	$36,154	233	6,360	1,148	$14,732	6,508	1,842	$75,216	5,308	1,058	$ 4,951	5,626	2,098
COPD	$36,005	230	6,654	1,166	$13,985	5,059	1,593	$72,731	4,041	1,135	$ 3,667	3,205	1,772
Coronary Artery Disease	$35,027	223	6,851	1,323	$14,001	5,373	1,890	$71,111	6,334	1,117	$ 3,513	3,305	1,791
Diabetes	$36,517	238	5,542	1,015	$13,921	4,629	1,544	$69,368	1,713	1,099	$ 3,796	2,310	1,431
Hypertension	$36,169	237	5,142	962	$13,757	4,782	1,586	$70,558	2,376	1,040	$ 3,206	2,356	1,498
Average, All Conditions	**$38,012**	**253**	**3,800**	**727**	**$13,098**	**3,865**	**1,270**	**$66,285**	**1,300**	**727**	**$ 3,847**	**1,816**	**1,305**

PHPG also performed an analysis to estimate total expenditures for dual eligibles, including both Medicare and Medicaid payments. Based on PHPG estimates, total Medicare and Medicaid expenditures for dual eligibles in Oklahoma in 2012 was over $2.2 billion, with 33 percent ($731 million) going toward hospital costs (i.e., inpatient and outpatient), only six percent ($41 million) of which was

funded by Medicaid. Spending on nursing facility, hospice, and home health services accounted for another 46 percent of total spending, with 65 percent of these services funded by Medicaid (Exhibit 2-9).

Exhibit 2-9: Medicare and Medicaid Payments for Dual Eligibles, in millions (2012)[16]

Category of Service	Nursing Facility	ADvantage Waiver	DDSD Waiver	Other Chronically Ill	All Other	Total
Medicaid						
Inpatient	$5.5	$7.7	$0.2	$14.8	$0.1	$28.3
Outpatient	$1.1	$2.6	$0.1	$8.3	$0.7	$12.7
Physician	$5.8	$8.9	$1.4	$24.8	$1.6	$42.4
Nursing Facility	$379.5	$1.1	$0.0	$2.7	$1.0	$384.4
Other Institutional	$67.1	$0.0	$13.2	$0.3	$0.0	$80.7
Home Health	$2.4	$69.0	$50.5	$66.3	$2.6	$190.8
DME	$3.1	$15.3	$1.1	$5.5	$0.3	$25.3
Other	$8.0	$51.6	$27.9	$56.6	$4.3	$148.5
Total	**$472.6**	**$156.1**	**$94.4**	**$179.3**	**$10.6**	**$913.0**
Medicare						
Inpatient	$83.1	$72.9	$7.6	$312.6	$46.2	$522.5
Outpatient	$26.6	$22.1	$2.0	$100.2	$16.9	$167.7
Physician	$30.7	$29.5	$2.8	$122.6	$18.0	$203.6
Nursing Facility	$16.7	$14.5	$0.6	$51.2	$8.3	$91.4
Other Institutional	$18.5	$12.7	$0.6	$43.9	$13.3	$89.0
Home Health	$26.8	$26.4	$2.0	$109.9	$12.6	$177.8
DME	$8.7	$7.1	$0.9	$34.5	$4.6	$55.6
Other	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Total	**$211.0**	**$185.3**	**$16.5**	**$775.0**	**$119.9**	**$1,307.6**
Medicare & Medicaid						
Inpatient	$88.7	$80.7	$7.8	$327.4	$46.3	$550.9
Outpatient	$27.7	$24.6	$2.1	$108.5	$17.6	$180.5
Physician	$36.5	$38.3	$4.2	$147.4	$19.6	$246.0
Nursing Facility	$396.2	$15.6	$0.6	$54.0	$9.4	$475.8
Other Institutional	$85.6	$12.8	$13.8	$44.2	$13.3	$169.6
Home Health	$29.2	$95.4	$52.5	$176.2	$15.2	$368.6
DME	$11.7	$22.4	$2.0	$40.0	$4.9	$80.9
Other	$8.0	$51.6	$27.9	$56.6	$4.3	$148.5
Total	**$683.6**	**$341.4**	**$110.9**	**$954.3**	**$130.5**	**$2,220.7**

[16] Excludes Medicare premiums, Part D (prescription drug) costs, and Medicare Advantage payments (estimated at . Medicaid payments are actual payments, including Medicare crossover claim payments. Medicare payments were not available for 2012; figures presented are 2010 payments adjusted to 2012 levels based on trends in Medicare crossovers between 2010 and 2012. "Other Institutional" includes Hospice, I/DD, and other institutional costs.

In addition to the major categories of dual eligibles shown above, approximately 120 adults in 2012 were enrolled in the Cherokee Program of All Inclusive Care for the Elderly (PACE) program, located in Tahlequah[17]. The PACE model, which exists nationally, fully integrates Medicare and Medicaid services, with both programs providing a capitated payment to the PACE contractor; in Tahlequah this is Cherokee Elder Care.

The PACE contractor is responsible for furnishing all medically necessary acute and long term care services, including HCBS and nursing facility care. In federal fiscal year 2012, Cherokee Elder Care reported $2.4 million in revenue from Medicaid and $3.8 million in revenue from Medicare.

The PACE model has proven to be an effective platform for integrating services and the OHCA is in the process of developing additional PACE sites around the State, patterned after Cherokee Elder Care. However, because of historical constraints in its design, PACE should be considered a supporting initiative, rather than a primary vehicle for integration of services for Oklahoma's dual eligible long term care population.

First, the model is limited to frail elders (age 55 and older) eligible for long term care, which excludes most dual eligible members, including younger adults with physical disabilities and seniors who do not require long term care services. Second, PACE has historically operated on a small scale, although there are efforts underway nationally to increase enrollments at PACE sites. (See also Exhibit 2-10 on the following page.)

CURRENT CARE COORDINATION PROGRAMS AND INITIATIVES

SoonerCare has a number of existing care coordination programs and planned initiatives to serve both dually- and non-dually eligible members with chronic health conditions. These programs and initiatives are similar to those offered by private MCOs, consistent with the OHCA's strategy of implementing managed care principles in collaboration with community-based partners.

[17] The program also enrolls a handful of Medicaid-only members.

A summary of these existing programs and planned initiatives is presented below in Exhibit 2-10.

Exhibit 2-10: Existing Programs and Planned Initiatives for Oklahoma Dual Eligibles

Program/Initiative	Program Description	Model Characteristics
Existing Programs		
SoonerCare Health Management Program (HMP)	Chronic care/ disease management program	• EXCLUDES DUAL ELIGIBLES • Members identified as high risk are provided health coaching to improve self-management skills • Practice facilitators target providers with high needs patients to improve health outcomes and efficient service delivery
SoonerCare Population Care Management	Care coordination for high cost members	• Targets members with complex medical and mental health needs, including high-risk pregnancies, breast and cervical cancer, hemophilia, and at-risk infants • Care coordinators direct members to available SoonerCare programs that meet their needs; assist with coordination of out-of-state care; coordinate bilingual services; arrange referral for support services; and conduct some in-home assessments • Addresses both medical and behavioral health needs, including coordination of efforts for members with medical/behavioral co-morbidities
Systems of Care	Community support for children with mental illnesses	• Focus on reducing hospitalizations • Care team includes the member, care coordinator, family support provider, child welfare worker, counselor, teachers, and others. • Care team develops care plans, which include weekly visits by the care coordinator and family support provider; the whole team meets once per month
*AD*vantage Waiver Program	Home- and community-based services	• Targets frail elderly and adults with disabilities, excluding those with intellectual/development disabilities • Services include but are not limited to: case management, transition management, personal care, and home health, therapies, durable medical equipment, skilled nursing, and home-delivered meals
Cherokee Elder Care PACE	All Medicare and Medicaid services, including long term care	• Fully integrates Medicare and Medicaid services under capitation • Targets frail elders (age 55 and older) • Model historically has seen limited growth in participants; Cherokee Elder Care membership stands at approximately 120 adults
Developmental Disabilities Services Division (DDSD) Waiver Program	Home- and community-based services	• Targets individuals (age 3 and older) with intellectual and/or developmental disabilities who otherwise would require placement in an institutional setting, and has needs that cannot be met through the In-Home Supports waivers • Services include but are not limited to: adult day care, therapies, agency companion, transition services, counseling, home health, respite, supported employment, transportation, and psychological services

Program/Initiative	Program Description	Model Characteristics
Planned Initiatives		
SoonerCare Silver (managed fee-for-service)	Coordination of Medicare and Medicare services	• Care coordinator will serve as "bridge" between Medicare and Medicaid programs and providers • Interdisciplinary care team will develop and implement a member-specific action plan
Health Homes (managed fee for service)	Care coordination and planning for persons with chronic mental illnesses	• Partnership between SMHA and ODMHSAS • Focuses on adults and youth with serious emotion disturbance (SED) or who are seriously mentally ill (SMI) • Nurse care manager coordinates with a care team of professionals • Health Homes will be anchored by community mental health centers and their satellite locations
Integrated Care Sites (capitated)	Model similar to PACE	• Member receives care at single site, overseen by an interdisciplinary care team, including member, physician, nurse, and social worker • Provider receives blended capitation rate from Medicare and Medicaid • Flexibility for provider to provide services not covered by Medicare or Medicaid, including nurse practitioner services • Member does not have to require nursing facility level of care, but must have two or more complex and chronic conditions, including functional limitations

SECTION 3: MEDICARE MANAGED CARE IN OKLAHOMA

BACKGROUND

Medicare Advantage

Since 1997, Medicare beneficiaries have had the option to enroll either in the traditional fee-for-service Medicare program or a private plan offered by a managed care organization (MCO), such as a closed network plan (also sometimes referred to as health maintenance organization [HMO]) or preferred provider organization (PPO), in what is known as the Part C program. In 2003, in addition to creating the Medicare Prescription Drug (Part D) program, the MMA (Medicare Prescription Drug, Improvement and Modernization Act) made some changes to Part C, which became known as the Medicare Advantage (MA) program. MA plans have become increasingly popular in recent years, with enrollment growing by 3.3 million (30 percent) since 2010 and one million (10 percent) in the past year. Currently, over 14 million beneficiaries nationwide, or 29 percent of the Medicare population, are enrolled in some type of MA plan.[18]

The majority of MA participants nationally (64 percent) are enrolled in a closed network MCO. Another 29 percent are enrolled in a local or regional PPO, and four percent are enrolled in a private fee-for-service (PFFS) plan. The types of plans differ mainly on their monthly premium costs; provider network restrictions; requirements for primary care physicians and specialist referrals; and the availability/cost of prescription drug and other benefits not offered by traditional Medicare (Exhibit 3-1).

Exhibit 3-1: Summary of Medicare Advantage Plan Types and National Enrollment Distribution

Plan Type	Percent of MA Participants (National, 2012)	Out-of-Network Providers	Primary Care Physician Required	Referrals Required for Specialists	Drug Coverage Available	Extra Benefits Available	Premium
MCO – Closed Network	64%	Not allowed	Yes	Yes	Yes	No	Lower
PPO	29% Local-22% Regional-7%	Allowed, but will cost more	No	No	Yes	Yes	Higher
PFFS	4%	Providers may choose not to treat	No	No	Yes, but can charge a premium	Yes, but can charge a premium	Lower

[18] Gold, M., Jacobson, G., Damico, A., and Neuman, T., "Medicare Advantage 2013 Spotlight: Enrollment Market Updates. Kaiser Issue Brief," June 2013.

The availability of and participation in MA plans varies between metropolitan and non-metropolitan areas. While enrollment continues to grow in both areas, 80 percent of MA-eligible beneficiaries live in metropolitan areas, 30 percent of whom enroll in a MA plan, compared to 18 percent in non-metropolitan areas.

The distribution of enrollees by plan type also is different. Currently closed network MCO plans account for a much larger share of enrollees in metropolitan areas (70 percent) than non-metropolitan areas (32 percent), while other plans have a larger share (62 percent) of enrollment in non-metropolitan areas.

Geographical differences in MA enrollment and plan availability/selection are due to a variety factors. For example, forming closed provider networks is easier in metropolitan areas, and these areas also have a longer history with managed care. To illustrate, the market share of PFFS plans in non-metropolitan areas has been on the decline since 2011, the year when MIPPA (Medicare Improvements for Patients and Providers Act of 2008) required these plans to have networks of providers in most counties.[19]

Special Needs Plans (SNPs)

SNPs are MA closed network MCOs or PPOs that serve only specific types of Medicare beneficiaries. Approximately 1.6 million Medicare beneficiaries are enrolled in a SNP nationally, an increase of 11 percent over last year. The three types of SNPs include the following: [20]

- *D-SNP* – Enrolls only beneficiaries dually eligible for Medicaid. D-SNPs account for 82 percent of SNP enrollment. Nationwide, 12 percent of dual eligibles were enrolled in D-SNPs as of 2013, up 10 percent from 2012. However, D-SNP enrollment varies considerably across states. In nine states (AL, AZ, FL, HI, MN, OR, PA, TN, and UT), 20 percent or more of all dual eligibles are enrolled in D-SNPs, with the highest being Hawaii (55 percent). By contrast, 14 states have no D-SNP enrollment.
    - *FIDE-SNP (Fully Integrated Dual Eligible SNP)* – Created by the Affordable Care Act (ACA) in 2010, these plans are a type of D-SNP that fully integrates Medicare and Medicaid financing and service delivery but combining benefits for both programs, including Medicaid long-term care, within a single MCO. FIDE-SNPs currently are available for dual eligibles in seven states.
- *C-SNP* – Enrolls only beneficiaries with a specific chronic or disabling disease(s)/condition(s), e.g., diabetes. Multiple diseases/conditions can be covered under the same SNP.

[19] Gold, M., Jacobson, G., Damico, A., and Neuman, T., "Medicare Advantage 2013 Spotlight: Enrollment Market Updates. Kaiser Issue Brief," June 2013.
[20] Mathematica Policy Research/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2006-2013.

Approximately 90 percent of C-SNPs target chronic heart failure, cardiovascular disease, and/or diabetes. Enrollment in C-SNPs has grown by 31 percent over last year to approximately 252,000.

- *I-SNP* – Enrolls only beneficiaries requiring treatment in an institutional setting. I-SNPs account for only three percent of total SNP enrollment. The I-SNP market is predominantly composed of plans offered by UnitedHealth Group and SCAN Health Plan, which account for 67 and 13 percent of I-SNP enrollees, respectively.

SNPs offer the potential for significant improvement in the coordination of care for dual eligibles. In addition to their contracts with the Centers for Medicare and Medicaid Services (CMS) to deliver Medicare-financed services, SNPs can enter into formal relationships with state Medicaid agencies so that the delivery of Medicare benefits is coordinated with state-administered Medicaid benefits. These formal relationships can take several forms, including separate Medicaid capitation payments or non-risk based agreements to share clinical and/or utilization information. To date, most SNPs have coordinated with state Medicaid programs under a capitated Medicaid managed care program.

Exhibit 3-2 summarizes currently SNP enrollment nationally and in Oklahoma.

Exhibit 3-2: Number of SNP Plans and Total Enrollment Nationally (September 2013)[21]

Type of SNP	National			Oklahoma	
	Number of States[22]	Number of SNPs	Total Enrollment	Number of SNPs[23]	Total Enrollment
Institutional	30	68	49,178	1	141
Chronic	36	214	245,501	0	0
Dual Eligible (regular and FIDE)[24]	43	362	1,311,679	0	0
Total	**46**	**644**	**1,606,358**	**1**	**141**

OKLAHOMA MARKET

Nearly 626,000 Oklahomans currently are enrolled in Medicare, with 53 percent living in urban counties, 40 percent in rural counties, and the rest in semi-urban, "mixed" counties. This means one out of five residents of rural counties and one out of seven in urban counties is eligible for Medicare.[25] In 2013, PHPG projects that Medicare will spend over $7.2 billion in Oklahoma.

[21] CMS SNP Comprehensive Report September 2013.
[22] "States" includes District of Columbia.
[23] Oklahoma's one SNP, an I-SNP called Tribute in the greater Ardmore metropolitan area.
[24] 40 of the 362 D-SNP plans are FIDE-SNPs located in seven states.
[25] OSU Center for Rural Health, "Oklahoma Rural Health Brief: Medicare Reimbursement Rate Cuts," July 2008.

Approximately 16 percent, or 101,000 Medicare beneficiaries, in Oklahoma were enrolled in an MA plan in September 2013 (Exhibit 3-3). The penetration rate in urban counties was 23 percent, significantly below the national average of 30 percent. The penetration rate in rural counties was only nine percent, or one-half the national average of 18 percent

Exhibit 3-3: Oklahoma MA Penetration by Region and Urban/Rural Geography (September 2013)[26]

Region (high to low enrollees)	Plans with Enrollees	Total Medicare Beneficiaries	County Geography				MA Penetration	Avg. Enrollees per Plan
			All	Urban	Mixed	Rural		
Tulsa	9	119,071	32,686	28,382	3,561	743	27.5%	3,632
OKC	8	131,083	26,372	23,836	0	2,536	20.1%	3,297
East	9	152,904	15,262	0	0	15,262	10.0%	1,696
Northwest	6	130,249	15,019	0	9,194	5,825	11.5%	2,503
Southwest	4	92,287	11,244	6,610	546	4,088	12.2%	2,811
Total	**12**	**625,594**	**100,583**	**58,828**	**13,301**	**28,454**	**16.1%**	**8,382**

Plan Availability

Based on CMS enrollment data as of September 2013, twelve plans currently serve MA enrollees in Oklahoma, including nine national plans and three local (other plans may be licensed in Oklahoma, but had no enrollees). Exhibit 3-4 on the following page summarizes membership by plan and county type, and includes the number of counties in which each plan has enrollees (plans may be licensed in additional counties).

The exhibit also presents the average market share for each plan in the counties in which they have enrollment, as well as their overall market share in Oklahoma. Of the 12 plans with MA members, the top three in market share account for 89 percent of all enrollment: UnitedHealth Group, Inc. (38 percent), CommunityCare Managed Healthcare Plans of Oklahoma, Inc. (28 percent), and Humana, Inc. (23 percent).

As the exhibit further illustrates, there are no MA plans with enrollment in all 77 counties. Humana has members in 73 counties[27], followed by United with members in 38 counties. Most of the plans have members in fewer than 10 counties each.

[26] Regions were modeled on Oklahoma's five federal congressional districts.
[27] Four counties with no Humana enrollment are Cimarron, Harper, Payne, and Roger Mills.

Exhibit 3-4: Service Area, Market Share, and Enrollment of Oklahoma MA Plans (September 2013)[28]

Plan (high to low enrollment)	Service Area by County Geography (counties with enrollees)				Avg. Market Share	Total Market Share	MA Enrollment			
	All	Urban	Mixed	Rural			All	Urban	Mixed	Rural
UnitedHealth	38	3	5	30	41.1%	37.7%	37,924	25,793	5,601	6,530
Community Care	6	1	2	3	66.5%	28.3%	28,439	19,312	5,133	3,994
Humana	73	4	5	64	23.0%	23.0%	23,143	7,223	1,737	14,183
Universal	23	4	4	15	7.7%	6.4%	6,397	4,282	425	1,690
Aetna	25	4	3	18	2.1%	1.8%	1,829	1,305	152	372
Ardent	8	2	1	5	2.3%	1.5%	1,472	793	253	426
CIGNA	7	0	0	7	26.0%	1.1%	1,152	0	0	1,152
Cherokee Nation	1	0	0	1	13.4%	0.1%	94	0	0	94
Highmark	3	2	0	1	0.1%	0.0%	41	28	0	13
OKC Clinic	1	1	0	0	0.1%	0.0%	40	40	0	0
BCBS	2	2	0	0	0.1%	0.0%	38	38	0	0
WellPoint	1	1	0	0	0.1%	0.0%	14	14	0	0
				Total MA Enrollees			**100,583**	**58,828**	**13,301**	**28,454**
				Total Medicare			**625,594**	**253,370**	**36,664**	**335,560**
				MA Penetration			**16.1%**	**23.2%**	**36.3%**	**8.5%**

According to the Kaiser Family Foundation, almost all (89 percent) Oklahoma Medicare beneficiaries have access to a locally coordinated care plan (i.e., local PPO or closed network MCO), with over half (55 percent) having access to three or more plans, though these plans may be offered by the same MCO. For example, Humana may be the only MCO present in a county but may offer three plans, i.e., a closed network MCO, PPO, and MFFS Plan.

Exhibit 3-5 on the following page below summarizes MA enrollment in Oklahoma by region and plan type. As of September 2013, 69 percent of MA enrollees in Oklahoma were enrolled in a closed network MCO, 24 percent in a local PPO, and the remaining eight percent in a PFFS plan. These percentages are essentially on par with national averages.

[28] Average market share refers to the unweighted average of the plan's market shares in each county in which it has enrollees.

Exhibit 3-5: Oklahoma MA Enrollment by Plan Type (September 2013)[29]

Region (high to low enrollees)	Plans with Enrollees	Total Medicare Beneficiaries	Plan Type				MA Penetration	Avg. Enrollees per Plan
			Total	MCO (closed network)	PPO (all local)	PFFS		
Tulsa	9	119,071	32,686	27,613	4,738	335	27.5%	3,632
OKC	8	131,083	26,372	21,376	4,815	181	20.1%	3,297
East	9	152,904	15,262	5,717	6,142	3,403	10.0%	1,696
Northwest	6	130,249	15,019	9,373	4,028	1,618	11.5%	2,503
Southwest	4	92,287	11,244	5,143	4,019	2,082	12.2%	2,811
Total	**12**	**625,594**	**100,583**	**69,222**	**23,742**	**7,619**	**16.1%**	**8,382**

Payment Rates

CMS pays MA plans a monthly capitation rate for each enrollee they serve in exchange for providing all Part A (inpatient) and Part B (outpatient and physician) benefits, plus any additional, value-added benefits the plan elects to offer (e.g., preventive dental cleanings or eyeglasses). Plans may also provide Part D (prescription drug) benefits, although these rates are developed and paid separately.

The rate each plan is paid is based on the historical Medicare fee-for-service (FFS) experience for enrollees in that county/area, known as the "benchmark," adjusted for the case mix of the plan's enrollees (age, disability, diagnoses, etc.), and including any quality bonuses for the plan's star rating (see Star Ratings section). Plans must submit a bid rate before the rate setting process beings; if the rate bid by the plan is above the benchmark, enrollees choosing that plan will be required to pay a premium, which CMS also adjusts for the plan's case mix to arrive at a single, fixed premium to be paid by all the plan's enrollees.[30]

According to the 2012 MA benchmarks published by the Kaiser Family Foundation, the average Medicare enrollee in Oklahoma is slightly more costly (seven percent) than the national average. Unweighted benchmark rates (i.e., not adjusted for enrollment in the various types of MA plans) average $806 for Oklahoma counties, and range from $715 (Woodward) to $983 (Choctaw). On average, urban enrollees ($815) are more costly than rural enrollees ($794), and enrollees in mixed counties are the most costly ($850).

[29] Oklahoma's I-SNP (enrollment of 141) is included in the HMO enrollment figures for the Southwest region.
[30] "Medicare Advantage Program Payment System," Medicare Payment Advisory Committee (MedPAC), Revised October 2012.

As mentioned previously, the benchmark rates are adjusted based on the case mix of enrollees, which includes an upward adjustment of as much as 50 percent for dual eligibles.[31] For example, an MA plan would receive around $1,183 per month per dual eligible enrollee residing in Tulsa city limits, compared to $789 for the average Medicare enrollee.

Exhibit 3-6 below presents the average MA county benchmark by region and county type (urban, mixed, rural), both for the average Medicare enrollee and dual eligible. These rates do not include, among other adjustments, any monthly premiums required to be paid by the enrollee/SoonerCare, which vary depending on the plan and benefits offered (see next section).

Exhibit 3-6: Medicare Advantage Benchmarks for Oklahoma (2012)

Region	Average Medicare Beneficiary				Average Dual Eligible Beneficiary			
	Average	Urban	Mixed	Rural	Average	Urban	Mixed	Rural
Tulsa	$ 786	$ 789	$ 841	$ 732	$ 1,179	$ 1,183	$ 1,261	$ 1,098
OKC	$ 846	$ 855	n/a	$ 795	$ 1,270	$ 1,282	n/a	$ 1,193
East	$ 811	n/a	n/a	$ 811	$ 1,216	n/a	n/a	$ 1,216
Northwest	$ 787	n/a	$ 852	$ 768	$ 1,180	n/a	$ 1,277	$ 1,152
Southwest	$ 790	$ 765	$ 852	$ 807	$ 1,185	$ 1,147	$ 1,278	$ 1,210
Statewide	**$ 806**	**$ 815**	**$ 850**	**$ 794**	**$ 1,208**	**$ 1,222**	**$ 1,275**	**$ 1,191**

Note: Benchmarks for the Average Medicare Beneficiary are the MA local unweighted benchmarks (i.e., not adjusted for MA enrollment by plan type), weighted by number of beneficiaries in each region and county. Benchmarks for the Average Dual Eligible Beneficiary were calculated by multiplying the Average Medicare Beneficiary benchmark by 1.5. Rates do not include premiums paid by enrollees, rebates, or quality bonuses.

Benefits

PHPG performed a comparison of plan benefits in six counties for all MA products to see if there was any variation in premiums and benefits by geography (i.e., rural, mixed, urban) or by health plan. Select counties included the following: Seminole (rural, Oklahoma City region), Texas (rural, Texas region), Logan (mixed), Canadian (mixed), Tulsa (urban), and Oklahoma (urban).

Following is a summary of benefit information for the counties and plans that were sampled. The only key differences in geography were the number and types of plans offered (e.g., there were no closed network MCOs in the rural counties sampled) and some of the premium and copay ranges, which are discussed below.

- Closed network MCOs have the lowest monthly premiums ranging from $0 to 42; the higher range was found in urban counties;

[31] Congressional Budget Office (CBO), "Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies," June 2013.

- Monthly premiums for Local PPOs range from $33.50 in urban counties to $69 in all counties; monthly premiums for Regional PPOs range from $0 to $167 (all regions); and monthly premiums for PFFS plans range from $15 to $162 (all regions).
- Primary Care Provider (PCP) Office visits ranged from $0 copay to $35 copay with the higher range noted among closed network MCOs in urban counties ($35) versus a low of $10 in mixed counties (closed network MCOs and Local PPOs); PFFS plans use a range of $20 copay per PCP visit up to a 20% coinsurance rate per PCP visit;
- Office visits for Specialists ranged from $35 to $50 (all plan types except PFFS); PFFS plans use a range of $40 copay per Specialist visit to 20% coinsurance range;
- Closed network MCOs require the use of their contracted providers; Local and Regional PPOs enable enrollees to go out of network but for additional costs; and PFFS enrollees can go to any provider that accepts the plan's terms and conditions of payment.
- The Maximum Out Of Pocket (MOOP) for closed network MCOs ranged from $4,500 to $6,700 (highest being in urban counties) and from $3,400 to $6,700 for Local and Regional PPOs. PFFS plans do not have a MOOP;
- Closed network MCOs had the lowest copays for prescription drugs ranging from $0 to 10 for Preferred Generic Drugs and from $39 to 50% coinsurance for Preferred Brand Drugs. Local PPOs ranged from $1 to $6 for Preferred Generic Drugs and from $39 to 15% coinsurance for Preferred Brand Drugs; Regional PPOs with a $0 premium did not offer a Part D benefit and PPOs with a premium offered a Part D benefit and used a 25% coinsurance; PFFS plans with a $15 premium did not offer a Part D benefit and plans with a premium offered a Part D benefit and used a $7 Preferred Generic copay and a $43 Brand copay.
- All plans offered supplemental benefits in all counties. Most included dental, vision and hearing. Other plans also included Health Club memberships, over-the-counter items, Health Education, Nursing Hotline, and a meal program.
- Two plans offered Value-Added-Benefits (VAB) in the counties they served, which included an Optional Supplemental Package for Dental (United) and discounted dental, hearing, complementary and alternative medicine, vision discounts, Nutrisystem discount, Lifeline Medical Alert Systems, Walmart hearing discount, and Lifecard plans (Humana).

Exhibit 3-7 on the following page summarizes the Medicare Advantage Benefits offered in Oklahoma County for all plan types.

Exhibit 3-7: Oklahoma City County Medicare Advantage Benefits Summary

Premiums/Benefits	Closed Network MCOs (6)	Local PPOs (4)	Regional PPOs (2)	PFFS Plans (2)
Monthly Premium	$0-$42	$33.50-$68	$0-$167	$15-$162
Office Visit for PCP	$5-$35 copay	$5-$20 copay	$15 copay	$20-20% coinsurance
Office Visit for Specialist	$35-$50 copay	$35-$50 copay	$35 copay	$40-20% coinsurance
Network	Must use network providers	Can use providers in and out of network	Can use providers in and out of network	Can go to any provider that accepts the plan's terms and conditions of payment
Out of Pocket Limit	$4,500-$6,700	$3,400-$6,700	$3,400	N/A
Part D - Prescription Drug Coverage	$0-$10 Preferred Generic; $39-50% coinsurance Preferred Brand	$0-$6 Generic; $39-15% Coinsurance Preferred Brand	$0 premium plan has no Part D; other plan has 25% coinsurance	$15 premium plan has no Part D; other plan has $7.00 Generic copay and $43 Brand copay
Supplemental Benefits	Dental cleaning, exam and x-ray(s); Diagnostic and Routine Hearing exam and supplemental aid(s); Vision Exam, Lenses and Frames; Health Club Membership/Fitness Classes, Well Dine Inpatient Meal Program; OTC Items	Dental cleaning, exam and x-ray(s); Diagnostic and Routine Hearing exam and supplemental aid(s); Vision Exam, Lenses and Frames; Health Club Membership/Fitness Classes, Nutritional Benefit, Health Club Membership and Nursing Hotline	Dental cleaning, exam and x-ray(s); Diagnostic and Routine Hearing exam and supplemental aid(s); Vision Exam, Lenses and Frames; Health Education; Additional Smoking and Tobacco Use Cessation Visits; Health Club Membership/Fitness Classes; Nursing Hotline; OTC items	SilverSneakers® fitness center; Tools for tracking your physical activity
Value Added Benefits	Discount dental, hearing, complementary and alternative medicine, vision discount, Nutrisystem discount, Lifeline Medical Alert Systems, Walmart hearing discount, Lifecard Plans; Optional Supplemental Package for Dental (United)	Discount dental, hearing, complementary and alternative medicine, vision discount, Nutrisystem discount, Lifeline Medical Alert Systems, Walmart hearing discount, Lifecard Plans	Discount dental, hearing, complementary and alternative medicine, vision discount, Nutrisystem discount, Lifeline Medical Alert Systems, Walmart hearing discount, Lifecard Plans	Discount dental, hearing, complementary and alternative medicine, vision discount, Nutrisystem discount, Lifeline Medical Alert Systems, Walmart hearing discount, Lifecard Plans

Provider Network

MA plans must demonstrate that they are able to provide adequate access to existing and new enrollees through a contracted network of providers and facilities. All new applicants and existing MA contractors seeking to expand a service area are required to demonstrate network adequacy through the submission of Health Services Delivery (HSD) Tables. Access to a given provider/facility is considered "adequate" when the following criteria are met:

- *Minimum Number of Providers/Facility* – MA applicants must demonstrate that their networks have sufficient numbers of providers/facilities to meet minimum number requirements[32] and allow adequate access for beneficiaries/potential enrollees. Specialized and pediatric/children's hospitals as well as providers, facilities and services not specifically contracted by the applicant for its Medicare Advantage product are not counted toward the numbers needed to meet HSD criteria.

- *Maximum Travel Time/Distance* – MA organizations must demonstrate that their networks do not unduly burden beneficiaries in terms of travel distance and time to network providers/facilities. These time and distance metrics speak to the access requirements pertinent to the approximate locations of beneficiaries, relative to the locations of the network provider/facilities. MA applicants must demonstrate that 90 percent of beneficiaries (or more) have access to at least one provider/facility, for each specialty type, within established time and distance requirements.

Due to the proprietary nature of each plan's HSD tables, PHPG was unable to access the networks that Oklahoma's MA submitted to the CMS. As a result, information on each plans' MA network in Oklahoma is not part of this report. In the absence of comprehensive network data, PHPG reviewed the major Centers of Excellence (COEs) in Oklahoma that have affiliations with some of the MA plans in the State as well as Medicaid plans. Exhibit 3-8 on the following page highlights the MA plans that have these major providers in their network.

[32] Although the minimum number requirement for each facility specialty is one (with the exception of Acute Inpatient Hospital Beds), applicants may need to submit evidence of contract with more than one of each facility type to satisfy time and distance requirements.

Exhibit 3-8: MA Plans Associated with Centers of Excellence

MA Plan	University of Oklahoma Medicine	University of Oklahoma Physicians	St. John Health System	Integris	Oklahoma Weight Loss Options	Oklahoma Pain Management	Oklahoma State University Medical Center & Physicians	Neurological Associates of Tulsa
Aetna	✓	✓	✓	✓	✓	✓	✓	✓
Ardent								
Blue Cross Blue Shield	✓	✓	✓	✓	✓	✓	✓	✓
Cherokee Nation								
CIGNA	✓	✓			✓	✓	✓	✓
Community Care		✓	✓	✓		✓	✓	✓
Highmark							✓	
Humana	✓	✓		✓		✓	✓	✓
The Oklahoma City Clinic								
United	✓	✓	✓	✓	✓	✓	✓	✓
Universal							✓	
WellPoint								

CARE COORDINATION ACTIVITIES IN OTHER STATES

National plans currently serving Medicare beneficiaries in Oklahoma have considerable experience with providing care coordination to dual eligible and long-term care populations in other states. This experience is described in detail in Appendix B.

SECTION 4: OTHER STATES' MODELS

OVERVIEW

Until recently, most states' Medicaid managed care models excluded individuals who are dually eligible. Coordinated care models for individuals who are dually eligible present a unique set of challenges:

- Responsibility for payment is shared across Medicare and Medicaid and development of effective coordinated care models requires enhanced cooperation across the two programs.
- While long term care represents the majority of Medicaid spending on behalf of dual eligibles, private health plans' experience with provision of long-term care has been limited as compared to acute care services.

Both states and the federal government have recognized the importance of improved coordination across Medicare and Medicaid to improve care delivery and reduce program expenditures. The Affordable Care Act (ACA) created the Medicare-Medicaid Coordination Office (MMCO) within CMS with the specific charge to develop new models for integrating Medicare and Medicaid services. The ACA also created the Center for Medicare and Medicaid Innovation (CMMI), charged with development of innovative payment and service delivery models for individuals participating in Medicare, Medicaid and the Children's Health Insurance Program (CHIP). CMS and several states have collaborated to develop innovative alignment models to improve service delivery for individuals who are dually eligible.

As coordinated care models have matured and long-term care expenditures have placed additional pressure on state budgets, more states have developed managed long-term care (MLTC) models in recent years. While only eight states had MLTC programs ten years ago, about one-third of the states (16 as of July 2012) have such programs today, and that number is expected to grow to 26 by 2014.[33]

The remainder of this section provides an overview of coordinated care models that have been developed to integrate Medicare and Medicaid services as well as a summary of models serving individuals with long-term care needs.

INTEGRATION OF MEDICARE AND MEDICAID SERVICES

For dual eligibles not requiring long-term care, Medicaid provides mostly cost sharing assistance as well as Medicaid services not provided by Medicare, most notably mental health services. Absent integration of care, Medicaid is not the primary payer for acute care services and has limited

[33] Truven Health Analytics, "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update," July 2012.

opportunities to improve service delivery. Some steps states have taken to integrate Medicare and Medicaid service delivery are outlined below.

Special Needs Plans (SNPs)

Some states are leveraging the Medicare Advantage (MA) program to encourage integration and coordination of care for dual eligibles. As discussed in Section 3, SNPs are MA plans designed to provide targeted care to individuals with special needs, including dual eligibles, beneficiaries with chronic conditions, and beneficiaries receiving care in an institutional setting.

Being limited to a specific, high-need population, SNPs can provide more focused and specialized care coordination services to enrollees, including providing value-added services that are tailored to the specific needs of the population. SNPs also have more care management and performance reporting requirements.

Since enrollment in MA plans, including SNPs, is voluntary, states have sought to increase enrollment by leveraging their purchasing power and requiring MCOs who offer an MA or Medicaid managed care plan in a given county to also offer a SNP product. The most popular SNP model is the D-SNP, with over one million enrollees nationwide.

However, D-SNPs generally only provide a subset of Medicaid services. As a result, true integration is not being achieved. The ACA created a new type of SNP, called a Fully Integrated Dual Eligible SNP, or "FIDE-SNP." As discussed in the Section 3, FIDE-SNPs cover most or all Medicaid services, including long-term care, i.e., FIDE-SNPs are truly integrated at both the financial and service delivery levels. These FIDE SNPs take a significant step toward addressing the financial disincentives between the Medicare and Medicaid programs. Currently seven states offer FIDE-SNPs to dual eligibles: Arizona, California, Hawaii, Massachusetts, Minnesota, New York, and Wisconsin.

As states pursue SNPs for coordinating care for dual eligibles, it should be noted that in March 2013, the Medicare Payment Advisory Committee (MedPAC) issued recommendations to Congress regarding the reauthorization of SNPs. MedPAC recommended that:

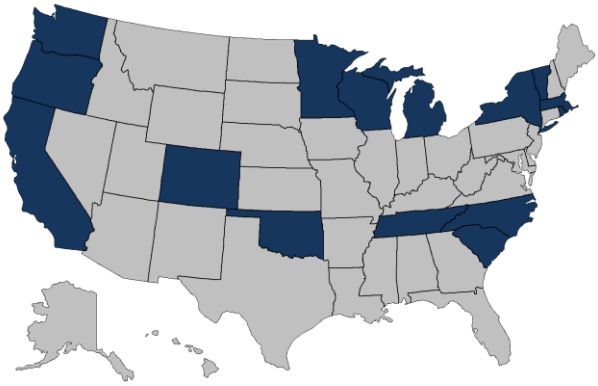
- Both D-SNPs and C-SNPs not be reauthorized, due to lack of integration and performance;
- I-SNPs be permanently reauthorized, as these SNPs demonstrated an ability to reduce avoidable hospitalization rates for institutionalized dual eligibles; and
- FIDE-SNPs also are permanently authorized.

Financial Alignment Demonstrations

In April 2011, CMS awarded grants to 15 states, known as State Demonstrations to Integrate Care for Dual Eligible Individuals, to develop approaches to coordinate and integrate care for dual eligibles across

primary, acute, mental health, and long-term care services. Each state, including Oklahoma, received up to $1 million to design and implement a program with the goal of identifying and validating delivery system and payment coordination models that can be replicated in other states.

Exhibit 4-1: States Awarded Design Grants to Integrate Care for Dual Eligibles



In addition, in October 2011 37 states (which include the 15 states above) submitted letters of intent to participate in the Medicare and Medicaid Coordination Office's (MMCO) financial alignment initiative to address the financial misalignment between the Medicare and Medicaid programs. In May 2012, 26 of the states, including all 15 states above, submitted demonstration proposals.[34]

As part of this Demonstration program, CMS will test two models of care and share Medicare savings with states under both:

- **Capitated Model** – The capitated model is based on a three-way contract signed by states, CMS, and health plans that will provide comprehensive, integrated Medicare and Medicaid services and align administrative functions between the two programs.

- **Managed Fee-for-Service (MFFS) Model** – Under the MFFS model, states sign an agreement with CMS to manage an enhanced FFS program that integrates primary, acute, mental health, and LTSS for dual eligibles and may incorporate other care coordination models introduced in the Affordable Care Act (ACA), such as Health Homes or Accountable Care Organizations (ACOs).

The timing of the financial alignment demonstration projects is uncertain because the approval process has progressed more slowly than anticipated by CMS. In their applications, two states proposed starting their projects in 2012, 13 states in 2013, and 11 states in 2014. As of May 2013 however, only six states (CA, IL, MA, OH, VA, and WA) had memorandums of understanding (MOUs) from CMS approving their plans for the demonstration projects, with planned implementation dates ranging from July 2013 to early 2014.

[34] Kaiser Commission on Medicaid and the Uninsured, "State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS," October 2012.

As of May 2013, seven of the 26 applicants (AZ, HI, MN, NM, OR, TN, WI) had withdrawn from the financial alignment demonstration or were working on alternative demonstration projects to coordinate care for full dual eligibles, as they determined that the financial models offered through the initiative were not viable options within their programs.[35]

Capitated Models

Under a capitated model, MCOs received capitation payments to provide integrated Medicare and Medicaid services to enrollees. The majority of states pursuing alignment demonstrations are opting for capitated models. As of October 2013, seven out of eight demonstrations approved by CMS are based on a capitated model, which translates into over 1.1 million dual eligibles receiving care through a capitated program.[36]

States relying on capitated models vary with respect to the dual eligible populations included in the demonstrations (e.g., over age 65, all adult duals, only duals requiring long-term care, or only high-cost/high-need duals); however, while these groups may require a different mix of services, many of the care coordination elements and activities used by MCOs are similar. Below is a list of common care coordination elements used by MCOs to serve dual eligibles:

- Health Risk Assessment (HRA) – assess patient risk for costly services including hospitalization, Emergency Room, and Institutionalization;
- Assignment of members to an acuity level (risk group) for care coordination;
- Development of an individualized and person-centered plan of care that factors in all Medicare, Medicaid, and community support services as well as member goals and preferences;
- Interdisciplinary Care Teams – includes care managers and member's providers;
- Regular contact with the member through ongoing monitoring – the type and frequency based on member acuity;
- Medication Management – reconciling medications to ensure they are taken and understood by the member;
- Transitional Care –Some programs use nurses to monitor and manage their enrollees' care in hospitals and have nurses visit members both during and after the hospital stay. Medication reconciliation, home visits to high-risk members, and reassessment are key components of transitional care. Care managers often coordinate a member's medical appointments, follow up to make sure the appointments are kept, and identify social services in the community if needed;
- Provider network having specialized expertise to meet the needs of dual eligibles;

[35] Congressional Budget Office (CBO), "Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies," June 2013.
[36] Kaiser Family Foundation, "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS," September 2013.

- Use of performance and outcomes measures to monitor quality of care and progress toward meeting program objectives;
- Consumer Direction Option for long term care members receiving HCBS;
- 24/7 Nurse Advice Line or Nurse On-Call System;
- Centralized electronic patient record; and
- Member Education and Incentives.

As part of the capitated model, states have the ability to require plans to engage with the provider community in specific ways to ensure appropriate access for members with specialized needs, for example:

- *Massachusetts* – Plans must contract with community-based organizations to provide care coordinators
- *Ohio* – Plans must contract with Area Agencies on Aging to coordinate HCBS for enrollees over age 60
- *California* – Plans must contract with county mental health and social services agencies to provide mental health services and in-home support services.

Shared savings under the capitated model, unlike the MFFS model, are built into the agreements between the state, MCOs, and CMS. Savings that will be realized over the next three years range from one percent in year one to between three and over five percent in year three, depending on the state.

Managed Fee-for-Service (MFFS)

MFFS initiatives seek to adopt managed care principles in order to improve care coordination and integration of Medicare and Medicaid services but do not require contracting with risk-based managed care organizations. The MFFS programs may build on Medicaid programs' existing Health Home and chronic care management programs that have been implemented for Medicaid-only participants.

Like fully capitated models, care coordination under MFSS includes a person-centered care planning process, collaboration among providers, access to enhanced care coordination across all services (physical, mental health and long term care services), and incentives for providers to improve health outcomes. Care coordination services may be provided by community-based organizations, Accountable Care Organizations, contracted entities or state staff.

While care coordination services may be reimbursed on a per member, per month basis, other Medicare and Medicaid services are reimbursed on a fee-for-service basis and providers submit claims as they would absent the managed care model. Because providers continue to bill fee-for-service and do not need to be part of a health plan network, the burden on providers and the need for program participants to change providers is minimized. Although not required, provider reimbursement strategies can include development of case rates based on a set of services, performance-based

payment approaches based on outcomes and quality, savings sharing models and models that permit re-investment of savings to offer flexible services.

Medicare and Medicare payments are not combined into a single stream, but states share program savings with CMS for demonstrated net federal savings, subject to also meeting pre-defined quality benchmarks. For example, a state may receive 50 percent of savings if Medicare expenditures are more than two percent below projections, less any increases in the federal share of Medicaid expenses.

Under this model, the state may assume some risk related to its investment in care coordination, but such services would be matchable under Medicaid and may even be eligible for enhanced Federal Financial Participation as part of the ACA's Health Home initiative. Also, state dollars used to support care coordination functions under MFSS would be significantly lower than state dollars supporting the administrative component of capitation rates paid to managed care organizations under traditional risk-based models. Because states may not have the same experience and tools that MCOs are able to offer, the state may need to make additional upfront investments to develop a comparable care management program.

States are responsible for ensuring that beneficiaries receive integrated access to all acute and long-term care services covered by Medicare and Medicaid. Eight states, including Oklahoma, are pursuing MFSS models. While the models under development generally contemplate serving individuals with chronic health conditions and serious and persistent mental health treatment needs, a MFSS model potentially could be developed for individuals with long term care needs.

Washington is the only state with an approved alignment demonstration to pursue the MFFS model, and will use Health Home care organizations to coordinate all Medicare and Medicaid services, including primary, acute, specialist, mental health, and long-term care services.

MANAGED LONG TERM CARE PROGRAMS

MLTC programs represent risk-based arrangements between state Medicaid agencies and independent entities to provide managed long-term care services and supports. Some of these programs are designed to serve individuals residing in institutions (e.g., nursing facilities and intermediate care facilities for individuals with intellectual disabilities, or ICF-DD) as well as individuals receiving home and community-based services (HCBS), while some programs are limited to only serving individuals residing in the community.

MLTC programs may be designed to serve individuals who are elderly and physically disabled, individuals with intellectual disabilities, or both. While the majority of individuals receiving long-term care are dually eligible, these programs frequently serve both individuals who are dually eligible as well individuals who are eligible for only Medicaid. Otherwise, states would be required to operate existing fee-for-service programs for a relatively small percentage of total long-term care enrollment.

Key elements of MLTC programs include person-centered care, medical homes, extensive care planning, and monitoring of long-term care services (e.g., Electronic Visit Verification) to ensure quality and cost effectiveness of care. However, the specific services covered, level of integration with Medicare, and geographic areas served vary greatly from state to state.

Due to the unique nature of services for the MLTC population, these programs take longer to implement than standard managed care programs. Specialized provider networks must be built, care coordination models have to be staffed, and individual care plans must be developed. In Kansas, the rollout for most dual eligibles is slated for 24 months, with 36 months for the I/DD population. In New Mexico, the program was not fully implemented until after 36 months. In Florida, implementation took 27 months, though it was phased in gradually.

MTLC programs achieve savings mainly in two ways: improved care coordination and care planning, and maximizing the number of long-term care recipients who receive care in the home or community. Examples of savings from other states include:

- *Texas* – The STAR+PLUS program has seen reduction in inpatient utilization of 22 percent, 15 percent for outpatient, and 10 percent for long-term care services.
- *New Mexico* – The Centennial Care program is projected to save over $450 million in the next five years.
- *Kansas* - estimates that already $29 million was saved in fiscal year 2013, with over $850 million in savings through fiscal year 2017.
- *Arizona* – AHCCCS estimates that ALTCS saved the state about $950 million in calendar year 2012.

DIFFERENCES AMONG STATE DUALS INITIATIVES

In the fall of 2012, the AARP performed research based on a survey of 50 states and the District of Columbia. AARP's survey asked about state dual integration initiatives (excluding people with intellectual or developmental disabilities). Thirty-four states responded that they either have a duals integration program in place (DE, ID, MA, MN) or are planning to implement a program (30 states). Fourteen states and the District of Columbia responded that they do not have or plan to have a program.

Key findings from the AARP survey regarding state dual integration initiatives are summarized below:[37]

- Two-thirds of all states are integrating or planning to integrate Medicaid and Medicare services for dual eligibles in state fiscal year (SFY) 2013 and 2014.

[37] AARP Public Policy Institute. Two-Thirds of States Integrating Medicare and Medicaid Services for Dual Eligibles. April 2013.

- Not all states are pursuing the financial alignment model. As noted previously, seven states have withdrawn from the financial alignment demonstration. One of the main reasons that states have given for dropping out is that they already have a robust market for MA plans that serve full duals, and payments to those plans would likely decline under the financial alignment demonstration. Lower payments could cause plans to drop out of the MA program, leaving fewer options for beneficiaries.
- Most integration programs are statewide initiatives, targeting all full-benefit duals, and spanning most long-term care services.
- The majority of states are turning to risk-based managed care models to deliver integrated services to duals, including placing a range of services under capitation.

According to the Congressional Budget Office (CBO), key factors in states' decision making processes about whether to participate in the demonstration, as well as what model to pursue, depended on a variety of factors including:[38]

- State's experience with managed care
- Characteristics of the dual population
- Concerns about costly changes to their health care programs that may prove temporary

Key differences between states that chose to pursue the demonstration and those that have not chosen to do so include:[39]

- States with relatively high rates of enrollment in MA plans and Medicaid managed care plans (more than 20 percent of eligible beneficiaries) were more likely to apply for the capitated portion of the demonstration than other states.
- Differences in managed care enrollment also are apparent between states that applied to test a capitation model and those that applied to test a MFFS model. For instance, applicants that proposed a MFFS model had lower MA penetration rates than did applicants proposing capitation or states that did not apply.
- Applicants that proposed a MFFS model also had lower enrollment in comprehensive Medicaid managed care plans by their full duals—and higher enrollment in primary care case management programs—than other states did.
- Full duals' health status and use of services differ. On average, capitation models were chosen in states with the dual population was healthier and appear less likely to use long-term care services.
- Even when fully integrated plans are established, states lack effective mechanisms to ensure enough enrollment for those plans to operate effectively. Several analysts have pointed out

[38] Congressional Budget Office. Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies. June 2013.
[39] *Ibid*.

that, as long as enrollment in Medicare managed care is voluntary, it will be difficult to enroll dual eligibles in a single plan for all Medicare and Medicaid services.[40]

SELECTED STATE PROFILES

States that were selected to be profiled are states that have been active in seeking to improve care coordination, health outcomes, and program cost effectiveness for dual eligibles through various models and initiatives. This includes states neighboring Oklahoma (Kansas, Nebraska, and New Mexico) and others considered to be national trend setters (Arizona, Florida, and Ohio).

Additional information for programs within each of the profiled states is contained in Appendix C. The table on the following page provides a summary of the key components for the profiled states' managed care models (Exhibit 4-1). Oklahoma's SoonerCare Silver initiative also is included in the table.

[40] Center for Health Care Strategies, "Encouraging Integrated Care for Dual Eligible," July 2009.

Exhibit 4-1: Summary of Selected States Care Coordination Programs for Dual Eligibles

Evaluation Area	Florida SMMC	Kansas	Arizona	Texas	New Mexico	Ohio	Oklahoma
Target Population	3,500,000 (84,000-MLTC + 27,000 on MLTC wait list)	>320,000	1,300,000 All AHCCCS Programs (52,251 ALTCS)	400,790	560,000 (plus additional 175,000 on 1/1/14)	114,972	79,891
Program Name	MMA and MLTC	KanCare	ALTCS	STAR+PLUS/Duals Alignment Demonstration	Centennial Care	My Care Ohio/Duals Alignment Demonstration	SoonerCare Silver
Total Full Duals Population	313,176	42,560	104,149	328,500 (214,328 are LTC duals)	40,000	182,839	78,891
Geographic Service Area	Statewide	Statewide	Statewide	All STAR+PLUS service areas	Statewide	29 Ohio counties over seven geographical regions of three to five counties each.	Statewide
Summary of Covered Benefits	Acute, Medical, Behavioral and Long Term Care	Acute, Medical, Behavioral and Long Term Care	Acute, Medical, Behavioral and Long Term Care	Acute, Medical, and Long Term Care (Mental health carved out)	Acute, Medical, Behavioral and Long Term Care	Acute, Medical, Behavioral and Long Term Care	Acute, Medical, Behavioral and Long Term Care
Financing Model	Capitated	Capitated	Capitated	Capitated	Capitated	Capitated	Managed Fee-for-Service
Care Management Model	MLTC-Face-to-Face; MMA-Telephonic & Face-to-Face based on risk stratification	Face-to-face and telephonic	MLTC-Face-to-Face; MMA-Telephonic	STAR+PLUS-Face-to-Face	MLTC-Face-to-Face; MMA-Telephonic	Face-to-face	Face-to-face and telephonic
Number of MCOs	MLTC – 7 plans MMA – 10 plans	3 plans	MLTC – 3 plans Medicaid – 8 plans	MLTC – 5 plans Medicaid – 17 plans	4 plans	5 plans	None
Implementation Date	MLTC – 8/1/13 MMA – 10/1/14	1/1/13	Medicaid – 1982 ALTCS (LTC)- 1989	1998	1/1/14	10/1/13	4/1/14
Enrollment	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
Special Needs Plans	Optional	Optional	Required	Mandatory for STAR+PLUS under duals alignment grant	Required primarily in urban areas	N/A-Members will be enrolled in one plan that serves both Medicaid and Medicare.	N/A
Program Savings		$1 billion over first 5 years (projected)					

SECTION 5: OPTIONS/CONSIDERATIONSS

INTRODUCTION

Oklahoma has taken gradual steps over the past decade to reform its delivery system for the portion of the dual eligible population comprised of frail elders and adults with physical disabilities in need of long-term care. The expansion of the ADvantage waiver program and its in-home support services has enabled SoonerCare members who in the past would have required nursing facility care to instead remain in the community.

More recently, the OHCA has undertaken new initiatives aimed at the broader dual eligible population. As discussed earlier in the report, three are being implemented under the auspices of federal Medicare-Medicaid Coordination Office (MMCO) Duals Alignment Demonstration, with two utilizing a managed fee-for-service (MFSS) approach and one utilizing capitation under a PACE-like model. Demonstrated Medicare savings achieved under each model will be shared by CMS with the State.

As Oklahoma considers options for expansion of coordinated care to dual eligibles, two key decisions will need to be made: what populations, or "enrollment groups", should be targeted, and under what model(s) should coordinated care be implemented. These decisions will drive the potential fiscal impact of coordinated care, as discussed in the last part of the section.

ENROLLMENT GROUPS

As discussed throughout the report, the dual eligible population is not a single, homogenous group. Rather, it consists of several distinct populations:

1. Frail elders and persons with physical disabilities receiving long-term care, either in a nursing facility or through an HCBS waiver program (e.g., the ADvantage waiver);

2. Persons with intellectual or developmental disabilities (I/DD) receiving long-term care, either in an intermediate care facility for the intellectually disabled (ICF-ID) or through an HCBS waiver (e.g., the Community waiver or Homeward Bound waiver); and

3. Other dual eligibles residing in the community, including healthy seniors and adults with chronic physical and/or mental health needs.

Frail Elders/Persons with Physical Disabilities Receiving Long Term Care

Because of Medicaid's role in funding long-term care services, the first population is responsible for the majority of Medicaid spending on behalf of dual eligibles. Any coordinated care strategy therefore should include this group in order to have a significant impact on program quality and costs.

It also should include adults with physical disabilities who qualify for long-term care but are not yet enrolled in Medicare. This group, which comprises about 10 percent of the nursing facility/ADvantage waiver population, has the same needs as the larger population and higher Medicaid expenditures, since all costs are borne by the program.

Persons with Intellectual or Developmental Disabilities Receiving Long Term Care

Persons with I/DD differ significantly from the other groups. I/DD members often have service needs that are not primarily medical or rehabilitative but instead are habilitative and oriented toward strengthening life skills. These services, such as supported employment for adults, are often delivered by smaller, non-profit providers whose sole mission is serving the I/DD community. By contrast, traditional MCOs often lack expertise in delivering these types of services.

Only a small number of states have chosen to include the I/DD population in coordinated care. Some that have done so, such as Arizona and Kansas, have either contracted with the existing developmental services state agency to act as an MCO (Arizona model) or required private MCOs to contract with existing providers and make minimal changes to existing patterns of care or service plans (Kansas model). Neither approach represents a fundamental departure from the previous system, at least in the short term.

A few states with MCO contracts, such as Hawaii and Tennessee, have taken a middle course by enrolling the I/DD population into MCOs for acute services only (physician, hospital etc.) while retaining existing systems of care for I/DD services. This has the advantage of asking the MCOs to perform the services for which they have the greatest competency, although most of the acute services are covered under Medicare, thereby reducing the potential impact on quality and cost. As with the first group, there are "Medicaid-only" I/DD members whose acute care is covered by Medicaid, but they represent only about 37 percent of the total population.

Any decision to include I/DD members should be approached with caution. The State should expect to encounter resistance from many stakeholders. If the State chooses to enroll I/DD members under a coordinated care model, it should consider leaving this population as the last group to enter the new system, thereby allowing sufficient time for planning and preparation by all parties. This is the approach adopted by Florida and ultimately adopted by Kansas, which delayed enrollment of I/DD members in response to concerns expressed by stakeholders. One MCO RFI respondent similarly recommended excluding I/DD members in the initial enrollment phase, to allow more time for stakeholder input.

Other Dual Eligibles

Healthy seniors and dual eligibles with chronic conditions comprise the majority of Oklahoma's dual eligible population. However, as discussed earlier in the report, this group accounts for only a small portion of total Medicaid dollars (primarily Medicare cost sharing, transportation, and mental health).

Nevertheless, every state that has chosen to enroll the first population (frail elders and persons with physical disabilities requiring long term care) has also enrolled these dual eligibles. This is a prudent strategy, as it affords an opportunity for using coordinated care to improve the health and quality of life of these individuals and potentially forestall the need for long term care. It does not necessarily mean that these dual eligibles must be served under the same model (e.g., the same MCO) as long term care members, so long as the coordination takes place.

Since most services for this group are covered under Medicare, the precise strategy to be adopted also must emphasize integration of Medicare and Medicaid. Options for doing so are addressed within the discussion of care coordination options below.

CARE COORDINATION OPTIONS

As Oklahoma considers additional care coordination models for dual eligibles, the State has two general approaches available:

1. Enroll dual eligibles in a capitated program through contracts with MCOs, or

2. Expand on the State's existing community-based programs and MFFS infrastructure.

Each model has advantages and challenges, as described below. The two models also are not mutually exclusive; that is, the State could elect to enroll some groups into MCOs while coordinating care for others through expansion of existing community-based initiatives.

Option 1: Implement MCO/Capitated Model

The majority of states that have implemented coordinated care have done so through capitated contracts with MCOs. This is true not only for long-term care members and other dual eligibles but also for groups covered solely through Medicaid, such as pregnant women, children, families, and persons with disabilities not eligible for Medicare.

If structured properly, the MCO model offers a number of advantages over a purely unmanaged system of care. These include:

Leveraging Expertise of National Organizations

The Medicaid MCO industry in recent years has seen the emergence of a small number of national plans with contracts throughout the country. Seven of the largest plans (Aetna/Coventry, Anthem Blue Cross/WellPoint, Centene, Health Net, Molina, United Healthcare and WellCare Health Plans) together serve over six million Medicaid members, including dual eligibles and long-term care recipients. These plans are able to bring successful, evidence-based practices to new markets and institute well-defined care management systems. MCOs also have the ability to offer value-added services not otherwise covered by Medicare or Medicaid.

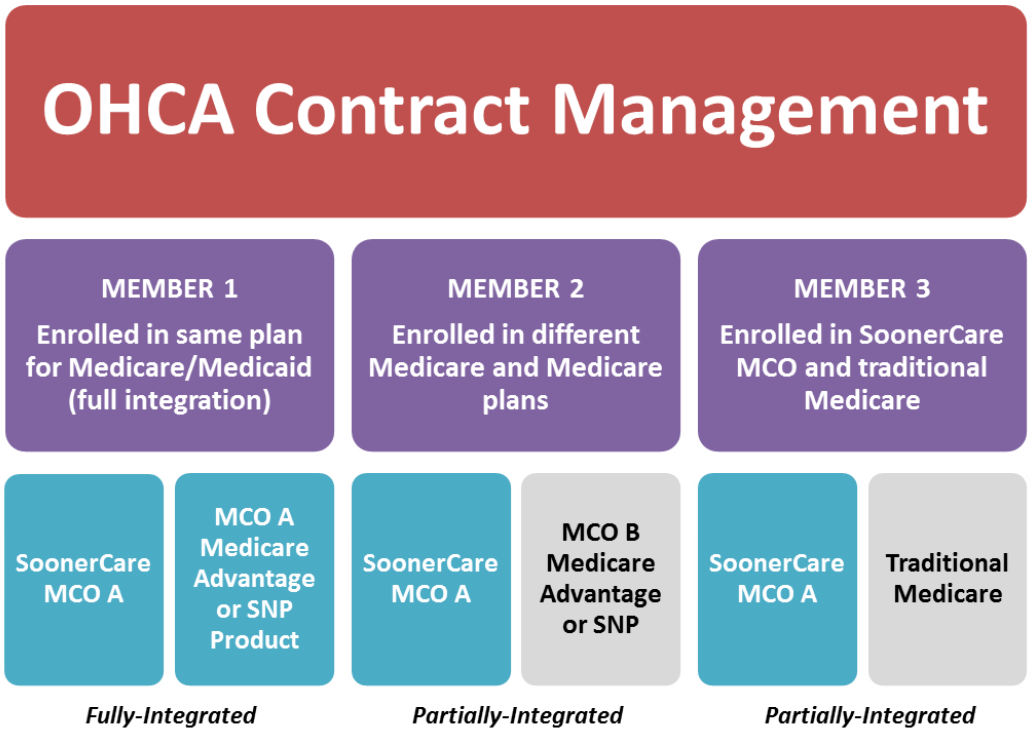
One risk presented by the national plans is their willingness to depart markets if profit expectations are not met. In recent years, Florida, Kentucky, and Ohio all have experienced disruptions to their programs associated with the departure of one or more national plans in the face of capitation rate disputes. Ideally, any MCO program in Oklahoma would find willing partners among some of the national organizations, in addition to attracting local plans that might have less experience with managed long-term care but have deeper roots in the state and already offer Medicare Advantage products.

Platform for Integration of Medicare and Medicaid

Many states that enroll dual eligibles encourage or require participating MCOs also to have Medicare Advantage contracts in the same geographic areas. Although members cannot be compelled to leave traditional Medicare and enroll in a particular Medicare Advantage plan, when both services are available through one entity, members have the opportunity to integrate their own care. States can educate members about the value of selecting a single plan for both Medicare and Medicaid, thereby giving the MCO the necessary funding streams and tools for full coordination.

Exhibit 5-1 on the following page illustrates the three enrollment options available to members, with option 1 offering full integration and options 2 and 3 partial integration to the extent that the Medicaid MCO is able to work with its Medicare counterpart (MCO or providers) to coordinate care.

Exhibit 5-1: MCO-Based System



If the State should elect to utilize Special Needs Plans rather than general Medicare Advantage plans, policymakers should consider potential program changes at the federal level. As noted earlier in the report, the Medicare Payment Advisory Committee (MedPAC) has advised Congress to reconsider reauthorizations for SNPs, including:[41]

- Permanently authorizing I-SNPs, which have shown to have a positive impact on hospital readmission rates;
- Eliminating most C-SNPs (except those for individuals with HIV/AIDS, ESRD, or chronic/disabling mental conditions), as they generally have poor performance;
- Eliminating regular D-SNPs, as most are not integrated and do not perform well;
- Permanently reauthorizing FIDE-SNPs; and
- Allowing MA plans to vary benefit packages based on members' chronic conditions and disabilities.

Regardless of which plan types the State allows, the greatest challenge Oklahoma will face is one of timing. As discussed in more detail below, the MCO option will require new federal Medicaid waiver authority, which could take 12 months or longer to obtain.

[41] Medicare Payment Advisory Committee (MedPAC), "Report to the Congress: Medicare Payment Policy," March 2013.

In addition, MCOs will need sufficient advance knowledge of Oklahoma's intent in order to build Medicare networks and apply for additional Medicare Advantage service areas, if they do not operate in all of the areas of the State (or all parts of a State-defined Medicaid contracting region). Texas has taken over a decade to expand its STAR+PLUS managed long term care program significantly beyond its original boundaries in Harris County (Houston), in part to allow MCOs sufficient time to establish Medicare Advantage products throughout the state.

In their responses to the care coordination RFI, the MCOs stressed the importance of careful planning and implementation, and several recommended phasing-in a capitated model gradually. Two respondents suggested starting with pilot programs in metropolitan areas to allow time for development of plan networks in rural counties. Another recommended enrolling only frail elders initially, to be followed by non-elderly adults with disabilities.

Fiscal/Budget Predictability

Under a capitated model, the State can better predict and limit its expenditures by placing MCOs at risk for service utilization and provider payments. The State retains risk for enrollment growth.

The use of capitation presents an attractive alternative to a fee-for-service system but must be approached with realistic expectations. MCO contractors will require funding to cover their administrative expenses, which in aggregate will be greater than under a model where the State partners with community-based organizations, because program administrative functions (member services, network development, quality improvement etc.) must be replicated by each MCO. MCOs also have a reasonable expectation of earning a profit. In a recent national study of 93 Medicaid MCOs, the average administrative expense (as a percent of capitation) was reported to be 11.6 percent and the average profit margin was 1.6 percent;[42] by comparison, Oklahoma's Medicaid administrative costs in SFY 2012 were 5.5 percent.

In addition, during the first year of an MCO program, the State will begin paying capitation while also paying claims for fee-for-service care provided prior to the transition to coordinated care. This will actually increase costs for a period of months, while the claims "run out" is completed.

Most importantly, Oklahoma should not make the mistake of demanding more in the way of savings from MCOs in the first two years of the program than can be achieved through care coordination and rebalancing of the long term care program from nursing facilities to home- and community-based care. Oklahoma already has lower annual per capita expenditures for dual eligibles than the national average: $13,135 for Medicaid (versus $16,310 nationally) and $16,184 for Medicare (versus $17,254 nationally).[43]

[42] CMS 2012 Medicare & Medicaid Research Review (Vol. 2 No. 2)
[43] 2011 amounts.

Under managed long-term care, sustainable savings occur over time, as new members living in the community receive the necessary supports to forestall placement in a costlier nursing facility. Over the first 24 to 36 months, the placement mix will begin to shift (or rebalance) in the direction of home-based care and savings will result. The State can encourage this shift by building financial incentives into MCO capitation rates that reward plans for meeting or exceeding rebalancing targets but it will still take time.

If the State imposes significant savings in year one or even year two of the program through artificially low capitation rates, the only tools available to MCOs will be to reduce services to members in the community (eventually forcing some into nursing facilities) and reduce provider payment rates. Such savings may prove ephemeral if plans subsequently require rate adjustments or depart the program, but the disruption to provider networks and member quality of life is likely to be long lasting.

The MCOs that responded to the coordinated care RFI echoed these warnings in their submissions. Two of the largest plans indicated that, based on their experience elsewhere, Oklahoma should not expect greater than one percent savings in the program's first year.

Option 2: Expand on Existing Community-Based Programs and Infrastructure

As discussed earlier in the report, community-based/Managed Fee-for-Service (MFFS) initiatives offer an alternative to MCO contracting. Oklahoma could pursue this option through expansion of the initiatives already underway for SoonerCare dual eligibles.

This would involve direct contracts with provider and care management organizations under managed fee-for-service or risk-sharing or full risk arrangements. With SoonerCare Silver acting as the umbrella care management structure, initiatives such as PACE and the ICS Demonstration Model described in Section 2 could be replicated in additional locations and offered to dual eligible members in conjunction with direct care management from the OHCA for persons otherwise not receiving coordinated care.

The community-based model for dual eligibles could be enhanced further if the OHCA is able to link it to a related health information exchange initiative already underway. The "MyHealth Access Network" utilizes an electronic medical record platform to share clinical data across providers and identify members in need of care coordination based on care gaps and quantified risk factors.

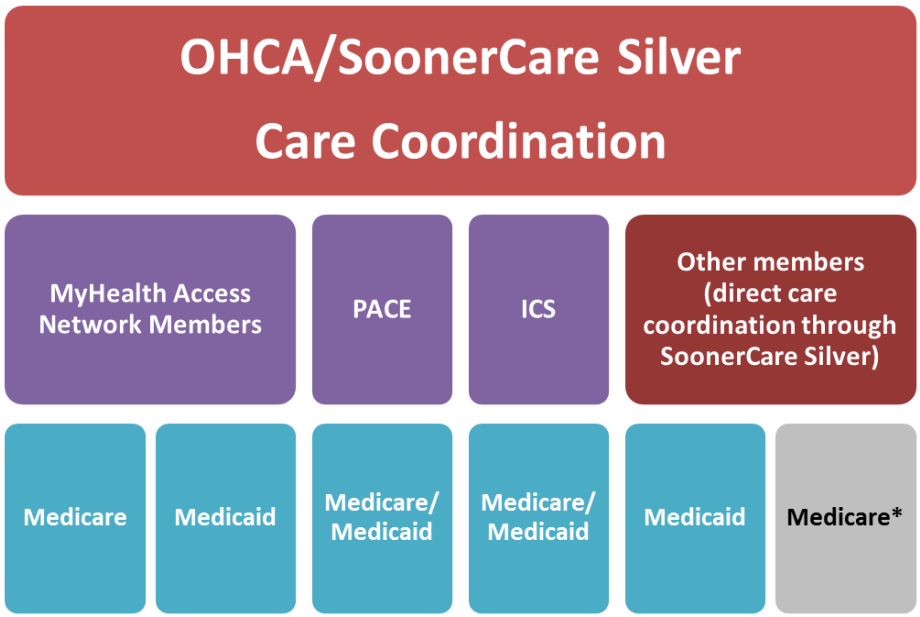
The MyHealth provider community is growing from its original base in northeastern Oklahoma and already includes a significant number of SoonerCare providers. The OHCA is exploring the potential for incorporating Medicaid paid claims data into the MyHealth platform, thereby integrating Medicare- and Medicaid-covered services for dual eligible members treated by participating providers.

Once data is integrated, providers and OHCA care coordinators will be able to collaborate in the identification of care gaps and member care coordination. The potential for delivering holistic care would be as great as for members enrolled in the same MCO for both Medicaid and Medicare services,

and greater than for members enrolled in different Medicare/Medicaid MCOs or in a Medicaid MCO and traditional Medicare.

Exhibit 5-2 illustrates a community-based system that includes the MyHealth Access Network initiative alongside the PACE and ICS programs, as well as direct care coordination for members not enrolled in one of these initiatives.

Exhibit 5-2: Community-Based System



**Medicare services would be indirectly coordinated for other members, through service monitoring and follow-up by SoonerCare Silver care managers*

The community-based approach would offer several other potential advantages, including:

- Lower administrative expenses;
- Retention of savings by the State for program reinvestment or reduction in general revenue fund needs;
- Larger choice of providers as compared to MCOs with closed networks;
- Faster program expansion, particularly in rural areas lacking Medicaid MCO or Medicare Advantage plans;
- Greater potential for targeting high cost members through condition-based initiatives launched in partnership with provider organizations (e.g., targeting members with mental health needs); and
- Greater flexibility for implementing and replicating successful innovations (direct action versus through a third party).

At the same time, any initiative that retains fee-for-service payments will offer less spending certainty in any given fiscal year than the MCO model. This disadvantage could dissipate over time, depending on MCO demands for rate increases in later years should profits fail to meet expectations, but should be factored into the policy making process.

Full integration of Medicare and Medicaid also has the potential to be more difficult under a community-based approach. However, there are Medicaid programs (e.g., Vermont) that are currently pursuing alternative models under which the state would receive capitated payments from CMS to provide Medicare services to dual eligibles outside of a traditional MCO model. Should such a model prove acceptable to CMS, it would mesh well with the OHCA's current approach to serving Medicaid-only populations in SoonerCare Choice.

Exhibit 5-3 summarizes the advantages and disadvantages of each option/approach across select program criteria.

Exhibit 5-3: Summary of Advantages/Disadvantages of Care Coordination Approaches

Evaluation Area	MCO/Capitated Model	Expand Community-Based Infrastructure
Lower Administrative/Implementation Costs		✓
Greater Opportunities to Integrate Medicare-Medicaid Service Delivery	✓	
Better Suited for Rural Service Areas		✓
Enhanced Fiscal/Budget Predictability	✓	
Does Not Require New Federal Authority		✓
Lower Risk of Care being Interrupted/Denied		✓
Value-Added Services Available to Members	✓	
Flexibility to Target Small Number of High Cost, High Need Members		✓
Generally Includes Larger Population of Members	✓	

Mixed Model

Oklahoma is not limited to choosing one approach to the exclusion of the other. The State could, for example, continue to expand its community based/MFFS initiatives for dual eligibles not enrolled in long term care. At the same time, the State could begin the process of evaluating risk-based models for managed long term care, including through MCO contracts.

Other Considerations

Regardless of the model(s) under which Oklahoma pursues coordinated care, the experience of other states yields important considerations for successful implementation.

Establish Realistic Timeframes

Under the MCO model, the State will have to enact authorizing legislation for the OHCA;[44] submit a waiver proposal and negotiate terms and conditions with CMS; conduct a procurement, with sufficient time allotted for protests by unsuccessful MCOs (these have become commonplace among the national plans); and allow MCOs sufficient time to finalize network contracts and perform other readiness activities.

The time required for all of these steps can be two years or longer. In Florida, 27 months elapsed from passage of authorizing legislation to the start of enrollment; the enrollment process itself was staggered by region over several more months. In Kansas, the comparable time period was 24 months. In New Mexico, it was 33 months.

The community-based model would require less time for initial implementation, as the waiver and procurement steps could be avoided or shortened. However, as the single oversight agency, the OHCA would likely roll-out new initiatives on a gradual basis to ensure it had sufficient resources to manage and monitor program activities.

Involve Stakeholders in Planning and Program Design

Consumer, provider and MCO stakeholders can bring valuable experience and perspective to the program development process. Their inclusion will result in a more resilient care coordination structure while reducing anxiety and potential opposition to proposed reforms. Stakeholder outreach also is mandated by CMS as part of the waiver submission process.

The OHCA already has begun this process through release of the care coordination RFI, which garnered recommendations from experienced MCOs regarding care coordination best practices. The OHCA also has established a larger stakeholder workgroup to assist in planning its strategy for integration of Medicare and Medicaid services.

Stakeholder involvement will be important to program design for all dual eligible populations, but it will be particularly critical for persons with intellectual/developmental disabilities and their providers. In many cases, these individuals are served by small, nonprofit entities that deliver services unrelated to

[44] In a review of Oklahoma's managed care statutes, PHPG did not identify any existing law that would present a barrier to implementation of the MCO model.

medical care (e.g., supported employment). Members, their families and providers will expect, and require, early and regular consultation on any redesign that fundamentally changes how services are authorized and reimbursed. As noted earlier, one RFI respondent recommended excluding this population in the initial enrollment phase, to allow more time for stakeholder input.

Emphasize Person-Centered Care and Appropriate Physician Role

As discussed earlier in the report, care coordination for dual eligibles, regardless of model, should be supported by robust clinical processes, including:

- Comprehensive front-end assessments of member needs, regardless of payer (Medicaid, Medicare, other);
- Establishment of interdisciplinary care teams based on the member's specific needs and organized around the member's physician and his/her care manager.
- Rigorous care planning;
- Real-time monitoring of service delivery to ensure no gaps in care; and
- System-wide quality monitoring to measure performance against program goals.

Define Opportunities for Nursing Facilities

Nursing facilities are essential to the health care delivery system. Under coordinated care for long term care members, the nursing facility resident population will continue to decline over time. However, the need for nursing facilities will not disappear and, in fact, their remaining residents will need more care, on average, than those diverted to the community.

It will be important to identify opportunities for nursing facilities to benefit from the rebalancing of the long term care program, whether carried out by MCOs or through a community-based model. For example:

- Assisting nursing facilities to convert unused bed space to community-based services, such as adult day care and institutional respite.

- Creating financial incentives for nursing facilities to identify residents able to transition back to the community, by sharing savings achieved when these former residents are served in less costly settings (e.g., home or assisted living facility).

POTENTIAL MEDICAID SAVINGS

PHPG constructed a baseline model of Medicaid expenditures for the various dual eligible populations to project potential savings achievable through increased care coordination under an MCO/capitated or community-based/managed fee-for-service model.

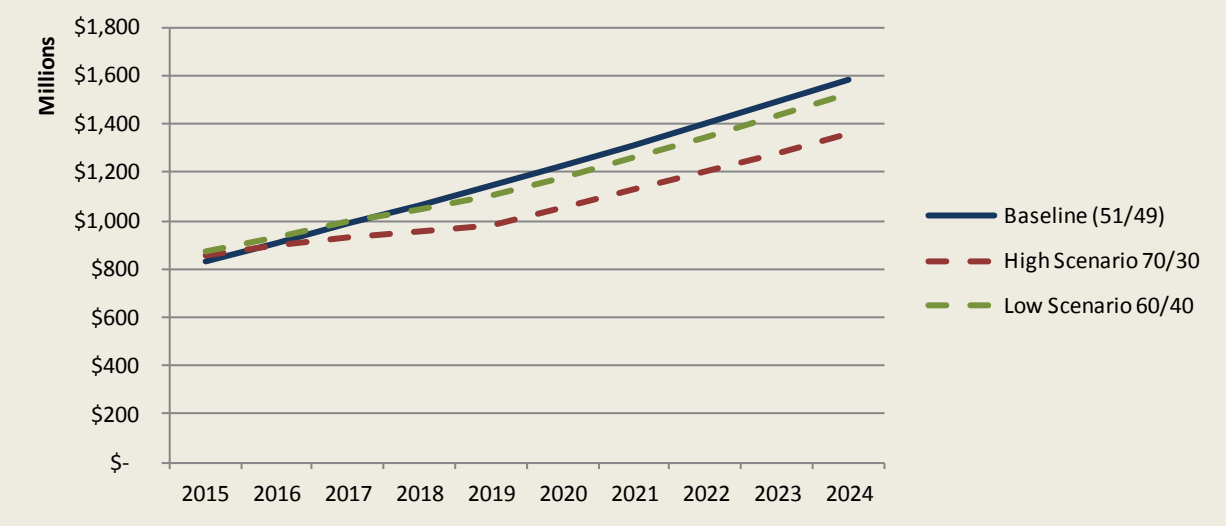
Baseline expenditures were calculated using actual Medicaid paid claims data for calendar year 2012, extrapolated forward for a five-year model evaluation period covering calendar years 2015 through 2019. Trend factors used to adjust enrollment and per enrollee, per month expenditures to 2015 levels were based on historical growth in overall Medicare enrollment (2009-2012) and per enrollee, per month costs (1991-2009).

PHPG projected the impact of coordinate care under “high” and “low” scenarios to illustrate the broad range of potential savings. Each scenario assumed that the current long-term care system in Oklahoma would be “rebalanced,” i.e., more members would receive care in the community than in a nursing facility. Each scenario also assumed a different but modest level of savings due to overall service delivery reforms.

PHPG’s low scenario for the long-term care population includes a rebalancing of the long-term care system such that 60 percent of enrollees receive their care in the community, up from the current level of 51 percent. The high scenario assumes Oklahoma achieves a similar balance to that found in Arizona, where 70 percent of enrollees receive home- or community-based care (among the highest levels in the country).

Exhibit 5-4 on the following page illustrates the effects of rebalancing the Medicaid expenditures over the short- and long-term, based on these two scenarios. Savings under either scenario would be modest in the short-term, as significant front-end investments are made and coordinated care organizations begin to implement care management protocols that affect the placement mix of members (nursing facility versus home or other community setting). The model assumes that nursing facility bed capacity grows in proportion to enrollment.

Exhibit 5-4: Effects of Rebalancing the LTC System on Medicaid Expenditures
Ten-Year Outlook: 2015 – 2024



Low and high scenarios for all populations include an assumed reduction in spending due to service delivery reform of five and 10 percent, respectively. The percentage of costs dedicated to administrative expenses is assumed to be three percent for the community-based/MFFS model and 10 percent for the MCO/capitated model, except for the long-term care population. PHPG assumed the administrative expenses for MCOs for this population would be closer to 7.5 percent, since most medical expenditures are related to nursing facility services and the administrative resources associated with serving nursing facility residents is lower than for residents living at home or another community setting.

Exhibits 5-5 to 5-7 on the following pages present the various savings scenarios for each population under each model. As the exhibits illustrate, and as discussed throughout the report, frail elders and persons with physical disabilities receiving long term care present the greatest opportunity for savings through the gradual rebalancing from nursing facility care to home- and community-based care.

Exhibit 5-5: Projected Potential Savings for Dual Eligibles Requiring Long-Term Care Five-Year Outlook: 2015 – 2019

	Low Scenario	High Scenario
Baseline Costs, Five-Year (2015-2019)	$ 4,933,357,817	$ 4,933,357,817
Potential Savings due to Rebalancing of LTC		
Achieved Mix of HCBS / NF Placement	60% HCBS / 40% NF	70% HCBS / 30% NF
Savings	$ 328,678,760	$ 631,125,757
Savings due to Service Delivery Reform (Applied After Rebalancing of LTC)		
Savings Percentage	5.0%	10.0%
Savings	$ 230,233,953	$ 430,223,206
Projected Savings, Gross	**$ 558,912,713**	**$ 1,061,348,963**
Projected Savings, Net of Administrative Expenses		
MCO/Capitated Model		
Adminstrative Expenses	7.5%	7.5%
Less Administrative Expenses (7.5%)	$ (328,083,383)	$ (271,040,620)
Net Savings	**$ 230,829,330**	**$ 790,308,344**
Percent Savings	**4.7%**	**16.0%**
Community-Based Model		
Adminstrative Expenses	3.0%	3.0%
Less Administrative Expenses (3.0%)	$ (131,233,353)	$ (116,160,266)
Net Savings	**$ 427,679,359**	**$ 945,188,698**
Percent Savings	**8.7%**	**19.2%**

Exhibit 5-6: Projected Potential Savings for Dual Eligibles with Intellectual/Developmental Disabilities Five-Year Outlook: 2015 – 2019

	Low Scenario	High Scenario
Baseline Costs, Five-Year (2015-2019)	$ 741,083,803	$ 741,083,803
Savings due to Service Delivery Reform		
Savings Percentage	5.0%	10.0%
Savings	$ 37,054,190	$ 74,108,380
Projected Savings, Net of Administrative Expenses		
MCO/Capitated Model		
Adminstrative Expenses	10.0%	10.0%
Net Savings	**$ (33,348,771)**	**$ 7,410,838**
Percent Savings	**-4.5%**	**1.0%**
Community-Based Model		
Adminstrative Expenses	3.0%	3.0%
Net Savings	**$ 15,933,302**	**$ 54,099,118**
Percent Savings	**2.2%**	**7.3%**

Exhibit 5-7: Projected Potential Savings for Other Dual Eligibles
Five-Year Outlook: 2015 – 2019

	Low Scenario	High Scenario
Baseline Costs, Five-Year (2015-2019)	$ 1,533,511,525	$ 1,533,511,525
Savings due to Service Delivery Reform		
Savings Percentage	5.0%	10.0%
Savings	$ 76,675,576	$ 153,351,152
Projected Savings, Net of Administrative Expenses		
MCO/Capitated Model		
Adminstrative Expenses	10.0%	10.0%
Net Savings	**$ (69,008,019)**	**$ 15,335,115**
Percent Savings	**-4.5%**	**1.0%**
Community-Based Model		
Adminstrative Expenses	3.0%	3.0%
Net Savings	**$ 32,970,498**	**$ 111,946,341**
Percent Savings	**2.2%**	**7.3%**

Exhibit 5-8 summarizes potential savings across all three groups.

Exhibit 5-8: Summary of Projected Potential Savings Scenarios for Populations of Dual Eligibles
Five-Year Outlook: 2015 – 2019

	Long-Term Care	I/DD	Other Dual Eligibles	All Dual Eligibles
Baseline Expenditures	$ 4,933,357,817	$ 741,083,803	$ 1,533,511,525	**$ 7,207,953,145**
Percent of Total	68%	10%	21%	**100%**
MCO/Capitated Model				
Low Scenario				
Savings	$ 230,829,330	$ (33,348,771)	$ (69,008,019)	**$ 128,472,540**
Percent of Baseline	4.7%	-4.5%	-4.5%	**1.8%**
High Scenario				
Savings	$ 790,308,344	$ 15,335,115	$ 15,335,115	**$ 820,978,574**
Percent of Baseline	16.0%	1.0%	1.0%	**11.4%**
Community-Based/MFFS				
Low Scenario				
Savings	$ 427,679,359	$ 15,933,302	$ 32,970,498	**$ 476,583,159**
Percent of Baseline	8.7%	2.2%	2.2%	**6.6%**
High Scenario				
Savings	$ 945,188,698	$ 54,099,118	$ 111,946,341	**$ 1,111,234,157**
Percent of Baseline	19.2%	7.3%	7.3%	**15.4%**

Conclusion

Oklahoma has multiple feasible pathways to implementing coordinated care for dual eligibles, particularly frail elders and persons with physical disabilities receiving long-term care, as well as other community-based dual eligibles. Coordinated care has the potential to rebalance services in a manner that improves member quality of life and health outcomes and yields significant savings, particularly with respect to the same long-term care recipients.

Whatever strategy is adopted, it should be the result of careful and inclusive planning that involves all major stakeholders. It also should be undertaken with realistic expectations about the amount of time necessary for implementation and achievement of sustainable savings.

APPENDICES

Appendix A: Medicaid Expenditures and Utilization by Dual Eligible Population and Chronic Condition

Appendix B: Integrated Care Activities in Other States by MA Plans in Oklahoma

Appendix C: Select State Profiles

APPENDIX A: MEDICAID EXPENDITURES AND UTILIZATION BY DUAL ELIGIBLE POPULATION AND CHRONIC CONDITION (2012)

Highest three values in each column are highlighted **RED**

Chronic Condition	Nursing Facility				ADvantage HCBS Waiver				DDSD Waiver				Chronic Conditions (No LTC)				All Dual Eligibles			
	Annual Cost	IP Days	ER Visits	NF Days	Annual Cost	IP Days	ER Visits	NF Days*	Annual Cost	IP Days	ER Visits	NF Days*	Annual Cost	IP Days	ER Visits	NF Days	Annual Cost	IP Days	ER Visits	NF Days
Asthma	$37,170	**7,594**	**1,535**	234.7	$14,394	5,988	**2,263**	5.4	**$76,723**	3,297	1,289	-	$4,567	3,367	**2,595**	0.1	$10,295	4,186	**2,413**	19
Congestive Heart Failure	$36,154	6,360	1,148	232.7	$14,732	**6,508**	1,842	10.0	**$75,216**	5,308	1,058	0.4	$4,951	**5,626**	2,098	**1.1**	$16,791	**6,021**	1,737	66
COPD	$36,005	6,654	1,166	230.1	$13,985	5,059	1,593	7.2	$72,731	4,041	1,135	2.5	$3,667	3,205	1,772	0.5	$12,149	4,211	1,609	38
Coronary Artery Disease	$35,027	6,851	1,323	223.0	$14,001	5,373	1,890	8.1	$71,111	**6,334**	1,117	1.9	$3,513	3,305	1,791	0.4	$11,446	4,342	1,730	36
Depression	$36,754	5,783	1,052	235.8	**$15,642**	6,241	2,046	**11.5**	$66,488	1,297	747	0.5	**$9,265**	2,418	2,058	0.3	**$19,421**	3,500	1,764	47
Diabetes	$36,517	5,542	1,015	237.8	$13,921	4,629	1,544	6.7	$69,368	1,713	1,099	1.2	$3,796	2,310	1,431	0.4	$12,435	3,322	1,373	42
High Cholesterol	$35,835	6,883	1,436	226.9	$13,792	4,711	1,848	6.7	$66,849	1,680	847	0.4	$3,596	2,206	1,522	0.1	$9,380	3,102	1,562	22
HIV	$37,093	6,588	1,023	243.2	$12,559	2,988	1,142	5.4	$69,891	1,500	1,500	**39.2**	$2,403	1,683	1,474	0.3	$15,563	3,533	1,267	**76**
Hypertension	$36,169	5,142	962	236.9	$13,757	4,782	1,586	8.2	$70,558	2,376	1,040	1.7	$3,206	2,356	1,498	0.4	$11,416	3,246	1,411	42
Lower Back Pain	$34,578	**7,175**	**1,721**	214.7	$13,725	4,617	2,139	4.9	$65,508	1,221	**1,789**	2.9	$2,769	1,843	2,290	0.1	$7,097	2,622	**2,215**	14
Migraine Headaches	**$42,640**	3,427	**1,619**	**281.1**	$13,773	4,717	**4,224**	3.2	$62,962	821	**1,960**	-	$4,252	2,050	**4,104**	0.0	$7,772	2,395	**3,987**	10
Multiple Sclerosis	$38,867	4,284	757	256.6	$14,404	3,073	1,367	7.5	**$80,643**	**23,571**	857	**18.7**	**$6,176**	1,885	1,744	0.3	**$22,095**	3,250	1,194	**97**
Renal Failure	$35,539	**11,002**	1,359	219.4	**$15,754**	**11,041**	2,241	11.1	$69,638	**14,423**	**2,625**	4.5	$6,036	**11,457**	**2,467**	**1.5**	$16,692	**11,157**	2,109	58
Rheumatoid Arthritis	$34,576	6,448	1,137	216.2	$13,580	3,950	1,417	5.4	$70,129	860	972	-	$3,245	2,227	1,586	0.2	$10,866	3,239	1,457	24
Schizophrenia	$39,445	5,664	881	258.2	**$16,027**	5,878	**2,414**	**14.8**	$74,029	2,453	797	2.6	**$8,204**	2,324	1,695	0.3	**$18,728**	3,308	1,500	65
Stroke	$35,127	6,593	1,141	225.9	$15,010	**7,542**	2,118	**14.3**	$71,699	5,586	1,310	-	$4,867	**9,663**	1,998	**1.8**	$18,417	**7,954**	1,721	**83**
MH/SA Only	**$46,858**	656	272	**322.0**	$12,074	1,075	595	9.6	$62,215	335	400	2.5	$4,924	503	685	0.3	$13,695	529	612	44
Overall Average	**$38,012**	**3,800**	**727**	**253.1**	**$13,098**	**3,865**	**1,270**	**7.3**	**$66,285**	**1,300**	**727**	**1.5**	**$3,847**	**1,816**	**1,305**	**0.4**	**$9,430**	**1,882**	**951**	**33**

Notes:

- Enrollee defined as total eligible months divided by 12
- Utilization includes Medicare crossover claims
- Annual cost defined as annual cost per enrollee, excluding Medicare premiums and crossover claim payments
- Members must have spent over 30 days in a nursing facility to be included in the NF population
- IP Days = Inpatient days per 1,000 enrollees
- ER Visits = ER visits per 1,000 enrollees
- NF Days = Nursing facility days per enrollee. Asterisk (*) means NF days represent post-acute/rehabilitative days and/or months in which the enrollee also received HCBS/DS services.

APPENDIX B: INTEGRATED CARE ACTIVITIES IN OTHER STATES BY MA PLANS IN OKLAHOMA

The health insurance industry has undergone significant evolution in recent years as health insurers have acquired managed care companies in an effort to tap into the $370 billion dual eligible market. A recent study of senior executives at 13 diverse health insurance companies found that nearly all companies believe that dual eligibles will become more important to their business over time. These companies realize the potential to improve care for this population and generate important new business opportunities, including efforts to integrate Medicare and Medicaid financing.[45, 46]

In 2012, large national MCOs invested over $17 billion in acquisitions to improve their capabilities to serve seniors, the poor, and the dual eligible population. Recent notable transactions in this area include:

- Aetna's acquisition of Coventry Health Care;
- CIGNA's acquisition of HealthSpring;
- Multiple acquisitions by Humana, including Metropolitan Health Networks, Arcadian Management Services, M.D. Care, and SeniorBridge Family of Companies;
- United Healthcare's acquisition of XLHealth Corporation; and
- WellPoint's acquisitions of CareMore Medical Group and AMERIGROUP Corporation.

PHPG examined some of the integrated care activities that have been implemented in other states by the national Medicare Advantage plans that exist in Oklahoma today. As part of this analysis, PHPG included the following plans:

- Aetna
- Cigna-HealthSpring (formerly Cigna)
- Humana, Inc.
- UnitedHealth Group, Inc.
- WellPoint

<u>Aetna (Mercy Care Plan) – Arizona</u>

Aetna offers a broad range of traditional, voluntary, and consumer-directed health insurance products and related services, including medical, pharmacy, dental, mental health, group life and disability plans. Aetna also provides medical management capabilities, Medicaid health care management services, workers' compensation administrative services, and health information technology services. Aetna

[45] A Primer on the "Duals" Managed Care Market Opportunity. Triple Tree. March 2013.
[46] Mathematica Policy Research /Kaiser Family Foundation. Medicare Health Plans and Dually Eligible Beneficiaries: Industry Perspectives on the Current and Future Market. March 2013.

provides Medicaid services for over 1.2 million members in 10 states and manages $4.75 billion worth of health care expenses each year.

Arizona has required Medicaid beneficiaries to enroll in a managed care plan since 1982. Mercy Care Plan (Mercy Care), managed by Aetna, was established in 1985 to serve this population. Mercy Care is jointly sponsored by St. Joseph's Hospital and Medical Center (a member of Dignity Health) in Phoenix and by Carondelet Health Network (a member of Ascension Health)in Tucson. Mercy Care serves over 340,000 beneficiaries enrolled in Medicare, Medicaid, or both. These beneficiaries include Medicaid beneficiaries with acute, developmental, and/or long-term care needs, including approximately 16,800 dual eligibles.

Some of Mercy Care's dual eligible members are enrolled in Mercy Care's Medicare Advantage dual eligible special needs plan (D-SNP), which members with both Medicare and Medicaid services, including acute, long-term care, and pharmacy benefits. Approximately 23 percent of the Mercy Care dual eligible population receives long-term care, and five percent are developmentally disabled. Mercy Care's Long Term Care plan offers nursing home and in-home care services.

Mercy Care uses interdisciplinary teams including physicians, pharmacists, nurses, and behavioral health specialists to support intensive case management programs that are operated and managed by Aetna. Though benefits are financed from two different programs—Medicare and Medicaid—Mercy Care has organized an integrated approach to simplify navigating the two systems.

An analysis performed by Avalere Health in 2012 revealed that Mercy Care performs better than Medicare fee-for-service (FFS) for dual eligibles across four key measures: (1) access to preventive/ambulatory health services; (2) inpatient utilization (measured by hospitals days, discharges and length of stay); (3) emergency department utilization; and (4) all-cause readmissions. Specifically, Avalere compared Mercy Care dual eligible beneficiaries (approximately 16,800 individuals) and Medicare FFS dual eligibles across the country on several standardized measures. When adjusted to match the health risk of the FFS dual eligibles, Avalere found that Mercy Care dual eligible members had the following positive health outcomes:

- 43 percent fewer days spent in the hospital (per 1,000 months of beneficiary enrollment);
- 31 percent fewer in-patient discharges (per 1,000 months of beneficiary enrollment);
- 19 percent lower average length of stay;
- 21 percent lower readmission rate;
- 9 percent fewer Emergency Department visits (per 1,000 months of beneficiary enrollment); and
- 3 percent higher proportion of members accessing preventive/ambulatory health services.

Cigna-HealthSpring (formerly Cigna) – Texas, Illinois

In 2012, Cigna completed its acquisition of HealthSpring, adding 340,000 Medicare Advantage customers in 11 states and Washington, D.C., as well as a stand-alone Medicare prescription division with more than 800,000 customers. Cigna-HealthSpring serves over one million customers across the country and is one of the biggest companies in the Medicare Advantage business. Over 30 percent of HealthSpring's national Medicare Advantage membership is dual eligibles.

Texas STAR+PLUS: Cigna has offered Medicare Advantage plans in Texas since 2002 and currently serves more than 100,000 Medicare Advantage customers in the state. Cigna-HealthSpring has participated in Texas' Medicaid STAR+PLUS program since the program expanded in 2011 and currently serves more than 24,000 STAR+PLUS customers in the Dallas/Fort Worth market and Rio Grande Valley.

The STAR+PLUS program combines acute and long-term care services to the elderly and people with disabilities, enabling them to achieve improved health and wellness access, quality outcomes at home or in assisted living facilities. Under the STAR+PLUS program, Cigna-HealthSpring arranges for a continuum of care with a variety of options and flexibility to meet individual needs. Through STAR+PLUS, Cigna-HealthSpring provides eligible enrollees with a wide range of quality health care services including, primary care, specialty care, medical supplies, mental health/substance abuse treatment, and hospital care.

The STAR+PLUS managed care program has yielded proven, positive results for beneficiaries. The Texas Health and Human Services Commission (HHSC) reports that STAR+PLUS beneficiaries enrolled in managed care have lower rates of inpatient stays and ER visits. Additionally, HHSC reports improved clinical outcomes and improved access to care when compared to Medicaid beneficiaries not enrolled in managed care.

Most recently, HHSC selected Cigna-HealthSpring as one of two health plans to serve the approximately 42,000 STAR+PLUS customers in northeast Texas beginning September 1, 2014. STAR+PLUS beneficiaries may choose to select one of the two health plans or be automatically enrolled.

Illinois Medicare-Medicaid Alignment Initiative (MMAI): In November 2012, Cigna-HealthSpring was awarded a three-year contract with the Illinois Department of Healthcare and Family Services to provide managed care services to dual eligibles in the greater Chicago area as part of the Illinois Medicare-Medicaid Alignment Initiative (MMAI). The MMAI program is expected to go live in January 2014. HealthSpring has served the greater Chicago area with Medicare Advantage plans since January 2005. HealthSpring's Special Needs Plan for dual eligibles (D-SNP) is the largest in the greater Chicago area, with a market share of 50 percent.

Enrollment in the demonstration is voluntary and the approximately 118,000 eligible beneficiaries in the greater Chicago area may select which plan to join or opt out to stay with traditional Medicaid. The greater Chicago service area for the MMAI demonstration includes six counties (Cook, Lake, Kane,

DuPage, Will and Kankakee). The state selected this region because of the high density of dual eligibles beneficiaries and the existence of a robust medical infrastructure.

Humana, Inc. – Ohio, Illinois

Humana has more than 25 years of experience with the Medicare program and currently serves 5.3 million Medicare members nationwide. Humana also serves approximately 600,000 Medicaid members, primarily in Puerto Rico and Florida. In 2012, Humana aligned itself with CareSource, a non-profit health plan with a Medicaid enrollment of 900,000 across Ohio and Michigan. As a result, Humana will increase its Medicaid market share, including serving a growing number of dual eligibles.

CareSource and Humana bring experience in both Medicaid and Medicare programs to deliver a fully-integrated, innovative solution to federal and state governments looking to enhance care coordination, provide long-term services and supports, and make the programs simpler and easier to navigate. For example, the alliance will result in one Member ID card, one point of contact, and one care plan with an emphasis on preventative care and wellness.

Ohio Duals Alignment Demonstration: The Ohio Department of Job and Family Services selected CareSource, in partnership with Humana, to be one of (depending on the region) two or three plans to serve dual eligibles (56,000 dual eligibles total) as part of the state's new Integrated Care Delivery System (ICDS).

Illinois Duals Alignment Demonstration: The Illinois Department of Healthcare and Family Services chose Humana to participate in Illinois' demonstration project aimed at integrating health care for dual eligibles. Under the new project, Humana will serve Illinois residents in the greater Chicago area (Cook, Lake, Kane, DuPage, Will, and Kankakee counties) where approximately 118,000 dual eligibles reside. Humana is one of six plans selected to serve residents in the six-county region.

Humana is one of the largest Medicare companies in Illinois, with more than 200,000 residents currently enrolled in Humana Medicare Advantage plans. Humana has formed critical relationships across Illinois, including partnerships with many key health care provider organizations, to develop comprehensive health centers focused both on low-income seniors in medically underserved areas and on complex care management of dual-eligible populations.

UnitedHealth Group, Inc. – Washington

UnitedHealth Group, Inc. (United) provides services to more than nine million Medicare beneficiaries nationally and more than three million Medicaid beneficiaries. United serve more than 350,000 dual eligibles in their Medicare Advantage plans and more than 130,000 individuals in Medicaid long-term care programs. United is one of the pioneer health plans with over 20 years of experience in developing person-centered models of care that have improved quality, driven increased customer satisfaction,

rebalanced long-term care systems, and reduced unnecessary and costly utilization. United offers long-term care programs in nine states and Medicare Dual Special Needs Plans in 25 states.

United offers a comprehensive and integrated care management program that supports the individual's choice to live in the least restrictive environment, maintain independence, and prevent functional decline. A care coordinator is assigned to a dually eligible or long-term care member based on the member's needs (e.g., social worker, registered nurse, aging/disability specialist, behavioral health specialist). The care coordinator performs functional/social, behavioral/medical assessments, risk determinations, and develops and implements member-centric, needs-based care/service plans.

United combines Medicaid, traditional Medicare (Parts A and B), Medicare Part D (prescriptions), mental health, long-term care, and home and community-based services (HCBS) into a single plan in several of the states in which it operates. United employs a dedicated interdisciplinary team works collaboratively with family members, caregivers, health care providers, HCBS providers, and community organizations to help simplify care delivery and improve health outcomes for members.

Washington Medicare-Medicaid Integration Project: In 2005, Washington introduced the Medicare-Medicaid Integration Project (MMIP) to integrate care (medical and long-term care) and financing for dual eligibles in two counties. Through the pilot program, dual eligibles could voluntarily enroll in both United's Medicaid plan (Evercare) and its Medicare Advantage Special Needs Plan (SNP), which would include both Medicaid and Medicare long-term care and supports.

Washington Chronic Care Management Program: The AmeriChoice Washington Chronic Care Management Project provided telephonic and in-person care management interventions throughout Washington State (except for King County) to clients not receiving long-term care services and focused on access to providers and health education. Clients targeted for the project were ABD (aged/blind/disabled), categorically needy, not covered by other health insurance, and were not in receipt of long-term care benefits. The top 20 percent of clients, as identified by the ImpactPro™ risk score for being at risk of having future high medical expenses, were selected for the project. These clients would be provided case management and "medical home" infrastructure services.

Washington Duals Alignment Demonstration: The Washington State Health Care Authority and Department of Social and Health Services will implement HealthPathWashington to improve services and benefits for dual eligibles. A series of Health Homes in 37 of the state's 39 counties will be implemented in 2013. In April 2014, the project will focus on improving chronic care coordination for the 40,000 dual eligibles in the remaining two counties. The two strategies employ different tools in an effort to align financing and to better integrate primary and specialty care, mental health, and long-term services for dual eligibles. United was one of two health plans selected for this program.

Hawaii Quest Expanded Access: United serves approximately 21,000 ABD Medicaid members in Hawaii's QExA (QUEST Expanded Access) program, along with 19,000 Medicare members. Across the

state, United offers a Medicaid long-term care plan and two PPO Special Needs Plans (one local, one regional).

Massachusetts Senior Care Options (SCO): SCO is a comprehensive health plan open to all dual eligibles residing in areas served by the participating health plans. United has less than 2,500 enrollees and contracts with a variety of providers for services. Integration is facilitated through nurse/social worker teams who function to coordinate with physicians. The program covers all of the services reimbursable under Medicare and Medicaid through a senior care organization and its network of providers. The SCO program was created to offer seniors aged 65 or older the opportunity to receive quality health care that combines health services with social support services. By coordinating care and specialized geriatric support services, along with respite care for families and caregivers, SCO offers an important advantage for eligible members over traditional fee-for-service care.

WellPoint – New Mexico, New York, Florida

WellPoint is one of the nation's largest health benefits companies, with nearly 36 million members in its affiliated health plans and nearly 68 million individuals served through its subsidiaries. One in nine Americans receives coverage for their medical care through WellPoint's affiliated plans.

In 2012, WellPoint acquired Amerigroup, which is now WellPoint's affiliated Medicaid health plan. With this acquisition, WellPoint now serves approximately 4.5 million beneficiaries of state-sponsored health care programs in 20 states. WellPoint also now has a presence in several states with significant dual eligible managed care opportunities. Prior to the acquisition, Amerigroup served approximately 2.7 million members in 13 states nationwide, which included 124,000 dual eligibles served through Medicaid and Medicare Advantage.

WellPoint, through its acquisition of Amerigroup, offers an integrated care and service coordination model designed to address the chronic health care needs of dual eligibles. Care is coordinated across Medicare, Medicaid, home and community-based services (HCBS), and social services by:

- Identifying and prioritizing members who will benefit the most from service coordination;
- Calibrating the intensity of service coordination to each individual's specific needs;
- Engaging members in a personalized service plan, thereby improving health status and encouraging adherence to healthful practices;
- Streamlining member health data through the use of field-based screenings;
- Integrating disease management and service coordination programs through joint complex rounds;
- Eliminating gaps in care by promoting provider engagement through primary care and physician outreach; and
- Emphasizing prevention and primary care through member outreach and education.

New Mexico Coordination of Long-Term Services (CoLTS) Program: Implemented in August 2008, Amerigroup Community Care of New Mexico serves more than 20,000 members in its Coordination of Long-Term Services (CoLTS) program statewide. In a state characterized by a rural geography, including some frontier communities, hospital-based care can be a barrier. The cornerstone of CoLTS is care coordination. The goal of the program is to encourage the maximum involvement of the member in the service planning process, resulting in more services being available in home and community-based settings (HCBS) and decreased dependency on institutional levels of care.

Through the CoLTS program, HCBS waivers allow Medicaid recipients to receive funding for in-home care. The average age of the long-term care population in Amerigroup Community Care of New Mexico is 65, with 41 members age 100 or older. The CoLTS coordinated care organizations, including Amerigroup Community Care of New Mexico, Inc., have demonstrated the following results:

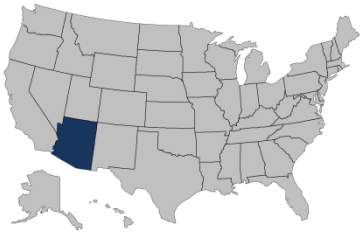
- 207 members have been reintegrated from nursing facilities to the community (since program launch in 2008), and 2,345 healthy dual eligibles at imminent risk of nursing facility placement have been able to remain in their homes.
- 16,282 members have been enrolled into disease management programs.
- Between SFY 2009 and 2012, the total financial contribution of the CoLTS program to the state of New Mexico was anticipated to be $269 million, with $109 million in costs avoided, $31 million in general revenue savings, and $160 million in new premium tax revenue. Cost avoidance included an estimated $52 in PMPM savings in SFY 2009and $64 PMPM in SFY 2011.

New York Managed Long-Term Care (MLTC): Amerigroup began participation in New York's Managed Long-Term Care (MLTC) plan in August 2005. Instead of being auto-assigned to a plan, members of the MLTC program must be identified by participating health plans. Once enrolled, members receive a personalized plan through a range of coordinated long-term care and health-related services in their homes, community, and if needed, a nursing home. Program highlights include:

- For the past five years, statewide program enrollment has grown by approximately 20 percent per year, with Amerigroup's enrollment currently at 1,400 members.
- The majority of enrollees receive services in community-based settings; only seven percent are nursing home residents.
- According to a member satisfaction survey conducted by the New York State Department of Health, 91 percent of respondents said they would recommend their plan to others.
- Amerigroup supports outreach to independent practice associations as a referral source and began a care management incentive payment program to enhance communication between providers and case managers.
- To ensure access, coordination, and timeliness of care, the plan goes beyond traditional referral source relationships, such as providing materials about the program to the Access-A-Ride program, a van service for people with disabilities and limited mobility run by the New York Metropolitan Transportation Authority.

APPENDIX C: SELECT STATE PROFILES

Arizona



Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), provides coverage to nearly 1.3 million people. When Arizona started its Medicaid program in 1983, it was the first in the nation to implement a statewide mandatory managed care model. Under the authority of a Section 1115 federal waiver, all Medicaid beneficiaries enroll in one of the MCOs serving their geographic service area (GSA). Dual eligibles not receiving long term care services are enrolled in AHCCCS health plans alongside Medicaid-only populations, such as children and pregnant women. Long term care was added as a benefit in 1989, through establishment of the Arizona Long Term Care System.

Arizona (2011)	
Dual Eligibles	134,621
Full Duals	104,149
% Full Duals	*77%*
Expenditures per Dual	
Medicaid	$13,498
% Capitated	*89%*
Medicare	$16,162
% Capitated	*57%*
Total	$29,660
% Capitated	*72%*

Arizona Long Term Care System (ALTCS)

Implemented in 1989, the ALTCS program provides services to over 52,000 individuals in need of a nursing facility level of care, including individuals who are age 65 or above as well as individuals with physical disabilities, intellectual disabilities and developmental disabilities (I/DD). In the ALTCS program, plans are financially at-risk for the full spectrum of Medicaid services, including primary, acute, behavioral, pharmacy, and long-term care services.

To qualify, individuals must be in need of greater than 90 days of nursing facility care (the first 90 days are covered by the individual's Acute Care plan). The state relies on a pre-admission screening process to identify eligible individuals. Approximately 72 percent of ALTCS members receive their care at home or in the community, leading to increased member satisfaction, high quality of care, and reduced costs.

ALTCS contracts with national health plans (e.g., Aetna, Centene and United) to serve as ALTCS contractors for frail elders and persons with physical disabilities. It contracts with another state agency to serve as the statewide capitated plan for I/DD members.

Arizona Duals Integration

Full dual eligibles account for 13 percent of the state's Medicare population. Full dual eligibles account for nine percent of total AHCCCS members but account for 18 percent of AHCCCS costs.[47] While this

[47] Arizona Dual Eligibles Integrated Care Demonstration Project Application. May 2012.

seems disproportionately high, Arizona compares favorably to national statistics in which dual eligibles account for about 20 percent of the Medicaid population but 39 percent of program spending.

All of the AHCCCS contracted health plans serve as D-SNPs. This D-SNP model has led to a high degree of dual eligible alignment. Since 2006, one third of all dual eligible AHCCCS members have been aligned in the same D-SNP and Medicaid plan. Currently, all AHCCCS health plans are approved as D-SNPs in at least one, if not all, service areas where they also have Medicaid contracts. Arizona's experience suggests that passive enrollment is the best vehicle through which to align this untapped segment of the dual eligible population. Ongoing passive enrollment addresses the key issue identified through extensive stakeholder engagement in Arizona, i.e., confusion about Medicare and Medicaid.[48]

Duals Initiative for Individuals in Maricopa County with Serious Mental Illness (SMI)

AHCCCS is working with CMS to integrate a system of care for persons with SMI residing in Maricopa County. Approximately 43 percent (7,000) of the AHCCCS members with SMI in Maricopa County are dual eligibles. Care integration will be achieved by requiring the Regional Mental health Authority (RBHA) serving Maricopa County to be responsible for providing integrated physical and mental health care services for members with SMI. In addition, AHCCCS is seeking to require that the Maricopa County RBHA also serve as a health plan.[49]

Program Savings

According to AHCCCS, in calendar year 2012, ALTCS has saved approximately $950 million, up from $550 ten years prior in 2002. These savings have been achieved by reducing the share of long-term care recipients in nursing facilities from over 90 percent in 1989 to less than 30 percent in 2011. In addition, ALTCS plans have reduced hospitalization rates by 31 percent for admissions, 21 percent for readmissions, and nine percent for emergency room (ER) visits. ALTCS has held capitated rates essentially flat since 2006 for all long term care populations.[50]

[48] Arizona Dual Eligibles Integrated Care Demonstration Project Application, May 2012.
[49] *Ibid.*
[50] AHCCCS, "ALTCS Overview."

Florida

Florida (2011)	
Dual Eligibles	529,074
Full Duals	313,176
% Full Duals	*59%*
Expenditures per Dual	
Medicaid	$14,169
% Capitated	*6%*
Medicare	$20,069
% Capitated	*26%*
Total	$34,238
% Capitated	*18%*

Florida has one of the nation's largest concentrations of senior citizens and over 300,000 full dual eligibls. Florida spends nearly 16 percent of its Medicaid expenditures ($3.5 billion) on members enrolled in long-term care, including nursing homes, assisted living facilities, and home- and community-based services.[51,52] In Fiscal Year 2011-12, the state's average monthly savings per consumer was approximately $2,349 for clients receiving home and community-based care versus comparable client groups receiving nursing home care[53].

Statewide Medicaid Managed Care Program (SMMC)

In 2011, the Florida Legislature directed the AHCA to create the Statewide Medicaid Managed Care (SMMC) Program, which makes managed care mandatory for nearly all Medicaid members. The SMMC program has two key program components, the Managed Medical Assistance (MMA), i.e., acute care, and the Managed Long Term Care Managed Care (MLTC) programs. AHCA was required to separately procure each program in the state's 11 regions with a variable number of plans based on population.

MMA was implemented under the authority of a Section 1115 waiver. MLTC was implemented through a combined Section 1915(b)(c) concurrent waiver to facilitate a more rapid review and approval by CMS. (The MLTC program was implemented in advance of MMA.) Florida intends to amend its Section 1115 waiver in the future to include MTLC components and thus operate SMMC under one federal waiver authority. SMMC is expected to control Medicaid program costs by using a capitated rather than fee-for-service payment model.

Florida Duals Integration

Full duals will be required to participate in the SMMC program for their Medicaid services, but Medicare beneficiaries who get only premium and cost-sharing assistance from Medicaid are excluded. Only nine percent of Florida's full duals are in managed-care plans today. The dually eligible and other specialized population groups (e.g., children who are receiving disability payments, children in foster care arrangements) comprise about one-fourth of the statewide Medicaid population[54]. Full duals who require long term care services (nursing facility and HCBS) will be enrolled in the MLTC program. Florida's dual eligibles who do not need long-term care will be mandatorily enrolled into the MMA

[51] Change, D., "State health reform plans include Medicaid managed care," Miami Herald, August 1, 2013.
[52] AHCA
[53] The Florida Legislature Office of Policy Analysis and Government Accountability. June 2013.
[54] Medicaid Managed Care in Florida. Federal Waiver Approval and Implementation. Health Policy Institute at Georgetown University. October 2013.

program. In addition, Florida has contracted with specials plans for persons with certain chronic conditions.

Although Florida decided not to pursue federal demonstration opportunities in order to direct all available state resources to SMMC implementation, the state is tracking national care integration initiatives and is building opportunities for Medicare-Medicaid alignment into SMMC as outlined below:

- The state will assign dual eligibles currently enrolled in an MA plan, including D-SNPs, to the same plan for Medicaid services, if the plan is participating in SMMC;[55]
- Through three-way contracting with D-SNPs, CMS, and the state, Florida is requiring coordination of benefit agreements to share encounter data and outlining standard contract language with covered services and benefits[56]; and
- The SMMC's comprehensive care coordination model will increase opportunities for integration between Medicaid and Medicare.

Managed Long Term Care (MLTC) Program

Florida elected to have the MLTC population be the first to enroll in the SMMC program because of the high cost of members requiring long-term care. The rollout of the MLTC program began in August 2013 and will continue through March of 2014. AHCA awarded contracts to seven companies (six national plans) worth an estimated total of $3 billion. Florida's MLTC program affects as many as 84,000 current Florida Medicaid members, as well as another 27,000 eligible individuals who are on various waiting lists for services (though wait lists for HCBS will be retained). Almost half of these individuals are enrolled in five waiver programs and another half receives nursing facility services. Approximately 94 percent of these individuals also are dual eligibles.[57]

Managed Medical Assistance (MMA) Program

On September 23, 2013, AHCA announced it had awarded 29 contracts to 10 general, "non-specialty" MMA plans and 63 contracts to five "specialty" plans across the same 11 regions. The specialty plans will provide a tailored set of services based on an individual's diagnosis or situation through an MCO

[55] Part IV, Chapter 409, Florida Statutes (2012) Medicaid Managed Care, Section 409.984(1) states: If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan, the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is currently participating in the long-term care managed care program. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

[56] Barth, S., and Ensslin, B. Three State Paths to Improve Medicaid Managed Long-Term Care: Florida, New Jersey, and Virginia Center for Health Care Strategies. July 2013.

[57] Summer, L., and Alker, J. Proposed Medicaid Long-Term Care Changes Raise Host of Questions About Impact. Health Policy Institute Georgetown University. January 2012.

model that targets and enrolls individuals by chronic illness. The MMA program will be available statewide by October 1, 2014.

MMA plans will be responsible for developing and implementing disease management (DM) programs for members living with chronic conditions and for addressing co-morbid conditions. Specialty plans will direct their efforts on targeting individuals diagnosed with HIV/AIDS; children involved in the child welfare and foster care systems; individuals with Serious Mental Illness (SMI); and adults with common chronic health conditions, including cardiovascular disease, COPD, congestive heart failure, or diabetes. Among the specialty plans, Freedom Health (Freedom) was awarded the most contracts (32) comprising eight regions that will offer four different C-SNPs targeting cardiovascular disease, COPD, congestive heart failure, and diabetes.

Spotlight: Freedom Health Specialty Need Plans in Florida for Members with Chronic Conditions

Founded in 2004, Freedom is a Tampa-based health insurance business operated and owned by physicians. The organization administers Medicare and Medicaid benefits throughout many Florida counties, serving over 45,000 members statewide, and offers all three types of SNPs. A number of MA plans offer C-CNPs in Florida, but Freedom has the largest market share, with offerings including combined C-SNPs, which target members suffering from a specific combination of chronic conditions, e.g., diabetes plus certain types of cardiovascular disease. Freedom C-SNPs go by the brand names of V-I-P Savings and V-I-P Care.

Freedom's C-SNPs provide a specialized benefit and network structure to assist individuals in the management of their chronic condition(s). The individual must complete a Pre-Enrollment Questionnaire indicating which disease they have. To qualify for a C-SNP, physician diagnosis of the disease must be verified prior to confirmation of enrollment. Members who are found not to have a qualifying diagnosis are disenrolled and assigned to a general MCO plan under the MMA program.

All individuals who are enrolled into a C-SNP will be enrolled in Freedom's Case Management Program for ongoing management and evaluation. Individuals who qualify are mailed a Health Assessment Tool (HAT) to complete. Freedom then uses the HAT to coordinate any care an individual may need or to enroll them into specialized health and wellness programs and/or member education programs. The use of care plans and physician/member/caregiver involvement is an ongoing management and evaluation activity in order to achieve developed goals.

Kansas

KanCare was implemented in January 2013 and currently provides coverage to more than 320,000 members. KanCare was implemented under the authority of a Section 1115 waiver. KanCare operates concurrently with the state's Section 1915(c) HCBS waivers. AARP ranks Kansas as having the 6th highest nursing facility utilization and 4th highest HCBS utilization rates per capita nationally for adults over 65, respectively.

Kansas (2011)	
Dual Eligibles	57,077
Full Duals	42,560
% Full Duals	*75%*
Expenditures per Dual	
Medicaid	$19,365
% Capitated	*6%*
Medicare	$17,167
% Capitated	*5%*
Total	$36,532
% Capitated	*5%*

Nearly all Medicaid eligibles are required to enroll in one of three MCOs: AmeriGroup of Kansas, Inc. (Amerigroup), Centene-owned Sunflower State Health Plan (Sunflower), and United Healthcare Community Plan of Kansas (United). The inclusion of services provided through the HCBS waiver for consumers with intellectual or developmental disabilities (I/DD) was delayed for one year and will become part of KanCare in January 2014.

Full benefit dual eligibles are covered under the demonstration for Medicaid services. As part of the program, KDHE expects health plans to assist in preparing recommendations to CMS for shared savings relative to serving dually eligible members. KanCare capitated benefits include all physical health, mental health, and long-term care services, including nursing facility care and HCBS.

KanCare program goals include:

- Provide integration and coordination of care across the whole spectrum of health to include physical health, mental health, mental health, substance use disorders, and long-term services and supports (LTSS);
- Improve the quality of care Medicaid members receive through integrated care coordination and financial incentives for plan performance based on quality of care and health outcomes;
- Control Medicaid costs by emphasizing health, wellness, prevention, and early detection, as well as integration and coordination of care; and
- Establish reforms that sustain the improvements in quality of health and wellness for Medicaid members, and provide a model for other states to follow for reforming Medicaid payment and delivery systems.

The state is encouraging high performance by establishing significant monetary incentives and penalties linked to health plan quality and performance, including: three to five percent of total payments will be used as performance incentives to motivate continuous quality improvement; additional penalties are associated with low quality and insufficient reporting; and measures of plan performance will include prevention, health and social outcomes.

Program Savings

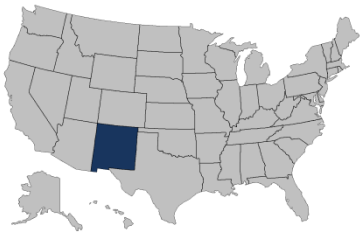
According to a Kansas 1115 Demonstration Concept Paper, the state expects KanCare's person-centered care coordination model will achieve a savings of $853 million over the next five years based on a conservative baseline of 6.6 percent growth in Medicaid without reforms.[58] The state will designate a portion of the managed care savings achieved through the implementation of KanCare to increase the number of available slots in the 1915(c) HCBS waivers, subject to state legislature appropriations.

KanCare Estimated Program Savings (SFY 2013 – SFY 2017)

Savings	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	5-year Total
Total	$29,060,260	$113,513,129	$198,041,997	$235,439,877	$277,004,864	$853,060,127

[58] State of Kansas Section 1115 Demonstration, KanCare, Concept Paper. January 26, 2012.

New Mexico



New Mexico (2011)	
Dual Eligibles	51,529
Full Duals	37,071
% Full Duals	*72%*
Expenditures per Dual	
Medicaid	$15,912
% Capitated	*2%*
Medicare	$10,930
% Capitated	*13%*
Total	$26,842
% Capitated	*7%*

New Mexico is one of the poorest states in the nation and is experiencing a faster-than-average growth in its aging population. The Medical Assistance Division (MAD) of the Human Services Department (HSD) administers the Medicaid program for the state of New Mexico to over 600,000 residents who fall into approximately 40 categories of eligibility under 12 separate waivers. New Mexico began its Medicaid Managed Care program, "Salud!" in 1997; its managed care for mental health in 2005; and its Coordination of Long-Term Services (CoLTS) program in 2008.

Coordination of Long-Term Services (CoLTS)

CoLTS is a mandatory managed care program covering primary, acute, and long-term care services for 36,607 individuals. The state phased-in all geographic areas over the first year of implementation, with all counties phased in by April 1, 2009. CoLTS was an important step in placing the Medicaid benefit for dual eligibles under managed care; however, the separate financing for the two programs have reduced the economic benefit for the state. Health plans are required to offer SNP products to dual eligible members but they are primarily offered in urban areas.

New Mexico Duals Integration

On January 1, 2014, New Mexico will implement a Section 1115 global demonstration waiver. Under this waiver, New Mexico will consolidate its existing Section 1915(b)/(c) waivers to create a comprehensive mandatory managed care delivery system called Centennial Care. Four contracted health plans will offer the full array of current Medicaid services, including acute, mental health, institutional, and community-based long-term services. Enrollment into managed care for dual eligibles will be mandatory for all Medicaid-covered benefits, except Native Americans who will have the opportunity to opt-in on a voluntary basis only.[59]

Centennial Care's delivery model includes the following guiding principles:

- Principle 1: A Comprehensive Service Delivery System
- Principle 2: Personal Responsibility
- Principle 3: Payment Reform (Pay for Performance)
- Principle 4: Administrative Simplification

[59] Medical Assistance Division (MAD) of the Human Services Department (HSD).

During the Medicare open enrollment period, dual eligibles will be notified of their upcoming enrollment into Centennial Care and will be requested to select one of the four health plans that will be available in their county. The notification letter will inform individuals that they will be enrolled in their plan of choice for both Medicaid and Medicare benefits, unless the recipient notifies the state of his or her decision to opt out of Centennial Care for Medicare benefits. While New Mexico submitted a proposal for the dual eligible financial alignment initiative, HSD withdrew their proposal after learning that they could not carve out the 2,200 Developmentally Disabled (DD) dual eligibles who receive their LTSS services through the state's DD waiver.

New Mexico Dual Eligibles

New Mexico has been considered a leader in overall Medicaid budget expenditures that create rebalancing of the long-term care delivery system from institutional care toward HCBS. In a 2011 AARP and SCAN Foundation study, New Mexico spent 63.9 percent of Medicaid and State funded LTSS spending on older people and adults with physical disabilities, ranking first in the nation.[60] The same study ranks New Mexico's LTSS performance improvement along the dimensions of affordability, access, choice of care setting, and providers.

Approximately 47 percent of dual eligibles receive LTSS of which 5,300 full duals (28 percent) will receive LTSS in an institutional setting and 13,800 (72 percent) in HCBS settings. Around 4,800 (12 percent) dual eligibles in New Mexico are expected to require services to treat a serious mental illness. Approximately 53 percent of dual eligibles are estimated not to receive LTSS. Six percent are developmentally disabled dual eligibles who will continue to receive their LTSS services through the state's development disabilities waiver.[61]

[60] Houser, Ari, Kassner, Enid, Mollica, Robert, Reinhard, Susan "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Oder Adults, People with Physical Disabilities, and Family Caregivers." September 2011.
[61] New Mexico Dual Eligibles Integrated Care Demonstration Project Application. May 2012.

Program Savings

Total projected savings for Centennial Care over five years is estimated to be $453 million comprising $138.1 million in state funds.[62] The aim is to manage per capita costs but the state would not be "at risk" for higher enrollment or reductions in federal participation.

Centennial Care Estimated Program Savings (SFY 2013-SFY 2017)

Savings (in Millions)	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5-year Total
Without Waiver	$4,042	$4,381	$4,772	$5,164	$5,570	$23,932
With Waiver	$4,020	$4,273	$4,680	$5,057	$5,442	$23,479
Savings	$22	$108	$87	$107	$128	$453

[62] Presentation to the NM Rio Grande Chapter of the Case Management Society of America Brent Earnest, Deputy Secretary, HSD. October 18, 2012.

Ohio

The Ohio Department of Medicaid (ODM) delivers health care coverage to nearly 2.4 million residents. Ohio created its Medicaid managed care program in 1978, which remained limited as a voluntary program for children and parents in a limited number of counties until being expanded in 2006 to include mandatory enrollment statewide to include families, children, and aged/blind/disabled members.

Ohio (2011)	
Dual Eligibles	271,136
Full Duals	182,839
% Full Duals	*67%*
Expenditures per Dual	
Medicaid	$21,291
% Capitated	*2%*
Medicare	$18,570
% Capitated	*12%*
Total	$39,861
% Capitated	*7%*

Excluded from managed care are individuals who reside in a facility, receive services from a Section 1915(c) home and community-based services (HCBS) waiver, or are dual eligibles. Ohio does not currently use a managed care delivery model for LTSS.

Managed care for the Medicare-only population also is not a new concept in Ohio. Ohio has the sixth highest Medicare enrollment in the United States and ranks fifth in Medicare Advantage (MA) enrollment.[63] The percentage of Medicare members in an MA plan in 2011 was 34 percent, significantly higher than the national average of 26 percent.[64] While the percentage of Medicare-only members in Ohio in MA plans is higher than the national average, MA enrollment among dual eligibles is low – less than three percent are in SNPs.

Ohio full duals make up 14 percent of Ohio's Medicaid enrollment, but they account for 34 percent of all expenditures.[65]

Passport

Ohio's HCBS waiver for individuals with a nursing facility level of care over the age of 60, called PASSPORT, provides services to over 30,000 individuals across the state, and is the third largest HCBS waiver program in the nation.[66] Interested individuals are screened to determine preliminary Medicaid eligibility and care needs. They also are provided information about the variety of long-term care options available.

Once a consumer is determined eligible, a case manager works with him or her to develop a package of in-home services to be provided by local service providers. The case manager then monitors the care for quality and changes the care plan as necessary. Passport has had a clear impact on reducing nursing

[63] Kaiser Commission on Medicaid and the Uninsured.
[64] Ohio Dual Eligibles Integrated Care Demonstration Project Application. April 2012.
[65] John B. McCarthy, Director, Ohio Medicaid. Office of Medical Assistance. Care Delivery Coordination through Medicaid-Medicare Integration. U.S. Senate Finance Committee. December 13, 2012.
[66] *Ibid.*

home use in the state. Despite significant growth in the aged population over the last decade, the average daily census of persons receiving Medicaid-financed nursing home care has declined by about five percent.

Ohio Duals Integration

Ohio is developing a fully integrated, capitated managed care system, known as MyCare Ohio to manage the full continuum of Medicare and Medicaid benefits for dual eligibles, including physical, behavioral, and LTSS. Beginning in March 2014, MyCare Ohio will launch in 29 Ohio counties over seven geographical regions of three to five counties each. Each of the seven regions includes a metropolitan area, with most also serving a rural area, and at least three MA plans currently serving Medicare members in the region. The presence of established MA plans was influential in the choice of regions.

The program is expected to serve more than 114,000 full dual eligibles, which amounts to 62 percent of Ohio's total dual eligible population and nine percent of total Ohio Medicaid enrollment. As the program is rolled out across the state, it is expected that the MyCare Ohio will be the primary program model for providing all LTSS in Ohio, both institutional and HCBS. Individuals with Serious and Persistent Mental Illness (SPMI) also will be included in the ICDS program.

Texas

Texas (2011)	
Dual Eligibles	591,548
Full Duals	366,205
% Full Duals	*62%*
Expenditures per Dual	
Medicaid	$10,059
% Capitated	*9%*
Medicare	$17,734
% Capitated	*15%*
Total	$27,793
% Capitated	*13%*

STAR+PLUS

Texas started implementing managed care for its Medicaid members in 1993, including an expansion as recent as 2012 when the state added additional service areas for its STAR+PLUS program.

Started in 1998, the STAR+PLUS program is a mandatory managed care delivery system for approximately 400,000 Medicaid members who have a disability and/or chronic illness and are living in over 90 of Texas's 254 counties. Five plans serve the STAR+PLUS program, and are financially at-risk for primary, acute, and long-term care services. Plans in most populous areas must offer D-SNPs.

Full dual eligibles make up a more than half of the total STAR+PLUS members. Texas has an estimated 328,500 full dual eligibles statewide as of 2012, about 67 percent of whom reside in the more urban areas of the state and are enrolled in STAR+PLUS. The remaining full dual eligibles (i.e. those living in the rural parts of the state), receive their Medicaid benefits through the traditional fee-for-service system.

Only about 20 percent (about 43,000) of the total STAR+PLUS dual eligible population are also enrolled in an MA/SNP plan. Of those individuals, a little over 33 percent are enrolled with the same health plan for both STAR+PLUS and the affiliated MA plan/SNP. Texas hopes to dramatically increase those numbers under their Dual Eligibles Integrated Care Project.

Texas Duals Integration

Texas submitted a proposal to participate in the federal financial alignment for dual eligibles to implement a fully integrated, capitated approach that involves a three-party agreement among the state, CMS, and the STAR+PLUS health plans. A plan with both an existing STAR+PLUS contract and a MA/SNP contract with CMS will offer a full array of Medicaid and Medicare services. The integrated agreement will provide a single point of accountability for the delivery, coordination, and management of primary, preventive, acute, specialty, mental health, LTSS, and prescription medication services. Texas is targeting implementation of its integrated care initiative for January 2014.

The target population for the demonstration project is full dual eligible adults (age 21 and above) residing in a STAR+PLUS service area (mostly urban areas) who are required to receive their Medicaid benefits through the STAR+PLUS managed care program. The initiative also includes STAR+PLUS members up to the first four months in a nursing facility. If the individual is in a nursing facility for more

than four months, the individual is disenrolled from STAR+PLUS and receives their Medicaid services through the traditional fee-for-service program.[67]

The state's proposal includes the following program elements:[68]

- All Medicare and Medicaid services will be provided through a single managed care organization;
- Medicaid health plans must have a corresponding MA/SNP in the STAR+PLUS counties where they operate;
- Dual eligibles who are mandatorily enrolled in STAR+PLUS will be passively enrolled into the MA/SNP plan that corresponds to their STAR+PLUS plan. These individuals will be allowed to opt out of their MA/SNP on a monthly basis;
- There will be data sharing and coordination across providers and the continuum of care to enhance care coordination;
- Person-centered medical homes will be used to address the needs of members with multiple chronic conditions or a single serious and persistent mental health condition;
- Members will have a single care coordinator to assist in the development of person-centered plans of care based on member choice and to facilitate access to community-based care whenever possible;
- Quality management strategies and measurements will be implemented that are not available in the current Medicare FFS models; and
- Consumer protections, including grievance and appeal processes, will meet the standards required by both Medicare and Medicaid.

Program Savings

Reduced costs in STAR+PLUS compared to non-capitated systems savings as percentage reductions include:

- 22 percent for in-patient
- 15 percent for acute out-patient
- 10 percent for LTSS[69]

[67] Texas Dual Eligibles Integrated Care Demonstration Project Application. May 2012.
[68] *Ibid.*
[69] Medicaid Managed LTSS: What have We Gotten Into? Texas STAR+PLUS Program. Texas Department of Aging and Disability Services. ALFA Conference & Expo. May 7, 2013.