Integrated Care for Medicaid/Medicare Dual Eligibles Takes Off —
Complex Care Coordination while Bending the Cost Curve
By: Cheryl Duva, Catherine Sreckovich and David Jacobson

For years, it has been recognized that the largest per capita cost for Medicare and Medicaid has been generated by the nine million individuals who qualify for both programs—referred to as dual eligibles. For instance, this segment represents 15% of Medicaid enrollment and 39% of spending. For Medicare, dual eligibles are 20% of enrollment and 31% of spending. The total cost for dual eligibles across both programs is estimated to be over $300 billion and is one of the fastest growing segments of health insurance spending.

Better coordination of health care delivery and spending on dual eligibles has the potential to improve their quality of life and health outcomes while generating tremendous cost savings. This is one initiative that can help bend the cost curve in a meaningful way. The average annual cost per dual eligible is estimated at more than $55,000.

Costs are further concentrated with a small number of duals. Analysis shows that 20% of dual eligibles accounted for more than 60% of combined Medicare and Medicaid spending across the entire dual-eligible population. The top 10% of Medicaid enrollees account for more than 60% of all dual eligible spending, and 69% of Medicaid spending on dual eligibles is for long-term care services not covered by Medicare or private insurance. The remainder is for Medicare premiums, co-pays and non-Medicare covered acute care services. Just 8% of Medicare enrollees cost more than $40,000 per year each for Medicare benefits.

Dual eligible individuals typically have multiple chronic conditions with behavioral health, cognitive and special functional needs. Those older than age 65 (the aged) include frail elderly and individuals who often have dementia and need institutional care, skilled nursing and functional support for activities of daily living. Individuals under age 65 are typically disabled but more independent, potentially needing functional services that can be provided in the home or community.

This market segment will grow substantially as the population ages. Today, there are 40 million people aged 65 years and older and that number will grow to 72 million in the next 20 years—an 80% increase. The number of individuals in this segment who will be eligible for Medicare and Medicaid is expected to more than double over this time period.

---

1 Medicaid’s Role for Dual Eligible Beneficiaries: Medicare’s Role Dual Eligible Beneficiaries. Kaiser Family Foundation, April 2012.
2 Based on 2008 dual spending as a proportion of total program costs and estimated increase per 2010 total program spending.
5 Medicaid’s Role for Dual Eligible Beneficiaries, Kaiser Family Foundation, April 2012.
6 U.S. Census projections.
TRADITIONALLY FRAGMENTED AND DIFFICULT TO COORDINATE »

Although the dual eligibles segment has the most care coordination needs, it is the least ‘managed’ among government programs. Fewer than 120,000 (2%) of dual eligibles received care through programs that fully integrate Medicare and Medicaid and a majority of them receive fragmented fee-for-service (FFS) care in both programs.iii

One key reason for the lack of coordination is that there have traditionally been significant programmatic challenges to providing managed care for dual enrollees. This is because Medicare and Medicaid are programs with fundamentally different designs that are misaligned in numerous ways including administrative, reimbursement and data hurdles. Medicare is a federally run program for basic medical care and limited long-term services and supports (LTSS). By contrast, Medicaid is state-run and pays for most of the LTSS cost including coverage for community and home-based services that Medicare does not adequately cover.

The programs don’t share data and beneficiaries must enroll and coordinate between the two programs — with two different identification cards, program administrators, provider networks, care management programs and customer service centers. There are limited financial incentives for State Medicaid agencies to coordinate care for Medicaid and Medicare eligibles as cost savings associated with Medicare spending is not shared with the State.

This is now rapidly changing due to initiatives from the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation, both of which are arms of the Centers for Medicare and Medicaid Services (CMS). A large number of states are making changes for duals.

RAPIDLY EMERGING MARKET-INTEGRATED CARE FOR DUAL ELIGIBLES »

In 2011, CMS selected 15 states for demonstrations to integrate care for dual eligible individuals (CMS Dual Demo). Since then, at least 10 additional states are preparing integrated dual proposals. The combined proposals encompass an estimated three million dual eligible individuals in the demonstrations by the end of 2014, which could shift more than $100 billion to a coordinated program model.

The CMS Duals Demo initiative is designed to help streamline innovative ways of integrating the Medicare and Medicaid benefits and services for everyone — consumers, providers, care coordination organizations (health plans), CMS, the states, and various community-based support organizations that are essential service providers. The vision is one-stop shopping for a patient-centered experience with aligned financial incentives for States, CMS, health plans and providers. Imagine, having one ID card and care coordinator, and one place to go for preventive programs, quality initiatives, medical and non-medical claims, customer service, risk management, and monitoring and oversight.

Government leaders recognize the tremendous opportunity to improve quality and reduce costs for the dual eligibles segment, and are implementing changes that are driving this rapid transition. These are:

» Two new CMS financial models to support state efforts to integrate care:iii
  » A three-way capitation model across CMS, the states and health plans.
  » A managed FFS model for states that have invested resources in their delivery systems to provide coordinated care for Medicaid beneficiaries. This model will make retrospective performance payments to states based on Medicare savings.

» Reform initiatives from the Affordable Care Act (ACA) such as: Partnership for Patients, Independence at Home Demonstrations, the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, the Innovation Challenge, and other delivery and payment reform efforts.

» State efforts focused on un-tapped opportunities to improve care while lowering cost — with increased emphasis on “value based purchasing”. These efforts are driven by reduced budgets and successful experience with managed care for non-Dual Medicaid segments, and more than half of the states are proposing a CMS Dual Demo approval.

The combination of these initiatives shows that we have reached the tipping point that makes this the right time to better integrate care for dual eligible individuals.

iv Encouraging Integrated Care for Dual Eligibles, Bella, M. Palmer L; Center for Health Care Strategies, Inc; July 2009.

A DIFFERENT MODEL FOR STATES, HEALTH PLANS, PROVIDERS AND CONSUMERS

Integrated care for dual eligibles is clearly a necessity. However, program administration can be challenging. It requires first having the ability to identify / analyze at risk populations, and then employing unique care coordination capabilities for the individuals with the highest risk and most complex needs; while also efficiently and effectively maneuvering across Medicare and Medicaid programs with CMS and States. Organizations must provide holistic care management and service coordination across a diverse array of providers — including non-traditional providers and community organizations. It’s a model that incorporates high-risk, high-touch and high-tech.

At a cost of thousands of dollars per member per month (PMPM), more care coordination resources are needed. Significant quality and cost improvements are available due to the ongoing opportunities for avoidable utilization related to acute episodes of care and transitioning to lower cost settings. Large savings are achievable in traditional areas such as reduced hospitalization, hospital readmissions and patient care complications, avoided emergency room use and medication compliance. Additionally, enormous improvements can be achieved in quality of life, outcomes and cost by effectively managing the transition of care by setting — skilled nursing facilities, alternative living or home- and community-based locations.

The model of Programs for All-inclusive Care for the Elderly (PACE) provides a good example of the improvement in quality and cost that can be achieved for the dual eligible population. PACE programs are expected to grow as part of the increased care management of duals. Additionally, leading provider systems who are building integrated and accountable models will be well positioned to manage physical, behavioral and custodial care. They will have the electronic health information, multi-disciplinary teams and integrated medical delivery to become the health homes of tomorrow.
The optimum care coordination model to integrate care for dual eligibles has the following capabilities:

### One-stop shopping for complex care coordination and program administration

**Complex Care Management Programs for Medical, Mental & Social Needs**
- Co-morbid conditions with behavioral health
- Integrated bio-psycho-social assessment tools
- Specialized stratification levels
- Holistic person-centered care plans
- Transition care plans
- Frail elderly protocols
- Palliative care
- Hospice medicine reconciliation/contraindication rules

**Multi-disciplinary Care Teams**
- Co-locations and joint clinical rounds
- Shared data and care plans
- Higher staffing ratios
- Inclusion of enrollees, family and/or caregivers

**Sophisticated Data Analytics**
- Leverage integrated claims data, i.e. medical, pharmacy, behavioral health, lab for population health management
- Predictive modeling functionality to identify at-risk individuals and gaps in care
- Payment Integrity — Identify Overpayments, Fraud, Waste and Abuse
- Web based Dashboards, ad hoc reporting and forecasting

**New Technologies for Remote Monitoring and Encounters**
- Bio-metric monitoring
- Telehealth
- Field-based personal aids — personal emergency response system
- Health information technology, including electronic medical records
- Mobile technology

**Specialized Provider Networks with Non-Traditional Providers for Long-Term Services & Support**
- Unique primary care model and health homes, includes specialists or behavioral health primary care physicians
- Skilled nursing facility (SNF), on-site collaboration
- Home- and community-based services (HCBS) and Medicaid waivers
- Medical care performed within the home rather than SNF/Rehab facility
- Personal caregivers
- Home modifications
- Emergency Room alternatives — “Minute Clinics”

**Innovative Financial & Risk Management**
- Reimbursement to align performance and incentives — e.g. Episode Based/Bundled Payments — Professional and Facility, Pay for Performance
- Incentives for SNF and HCBS quality programs and setting transitions
- Funds flow monitoring/performance-based data analytics
- Specialized actuarial expertise

**Collaboration with Community-Based Organizations**
- Services such as Meals on Wheels and adult day care
- Advocate input

**Quality Programs**
- Measures designed for integrated and long-term services and support
- Cultural and linguistic customization
- Consumer protections

**Strong Leadership & Management Process**
- Value-based purchasing and performance — with specific goals and management
- Robust, rigorous and real-time reporting
- Rapid learning for a new and dynamic market segment
- Program compliance
NAVIGANT HAS PROVEN EXPERTISE AND INNOVATIVE SOLUTIONS

Navigant has extensive experience working with providers, state and federal administrators and health plans. We help design, implement and monitor varied and complex service, delivery, management and payment models of integrated care for dual eligible individuals that both differentiates us in the market and exemplifies our thought leadership in the dual eligible sector.

Our strengths and capabilities to support participants include:

» Operational and clinical expertise to develop, implement and execute profitable new healthcare delivery models
» Data analytics to ensure payment integrity
» Sophisticated pricing, rate structure and risk adjustment evaluation software
» Web-based Dashboards, ad hoc reporting, and forecasting

CONCLUSION

Integrated care for dual eligibles is the largest new opportunity to coordinate care for government programs and is rapidly transitioning into a new market segment that will continue to grow as the population ages. New solutions are needed based on information, data, experience and rapid learning. Organizations that establish and further develop their capabilities now will hold a key position in the health care industry of the future.

Contact Cheryl Duva (Cheryl.duva@navigant.com or 203.733.9005), Managing Director or Catherine Sreckovich (csreckovich@navigant.com or 312.583.5747), Managing Director at Navigant today to further discuss how to develop innovative ways to coordinate care for dual eligibles and bend the cost curve.