The Hilltop Institute

analysis to advance the health of vulnerable populations

Innovations in Integrated Care: New Opportunities to Better Serve Dual Eligibles

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UMBC

AN HONORS UNIVERSITY IN MARYLAND

Preview of Presentation

I. Background: The Importance of Integration

II. Case Study on Dual Eligibles

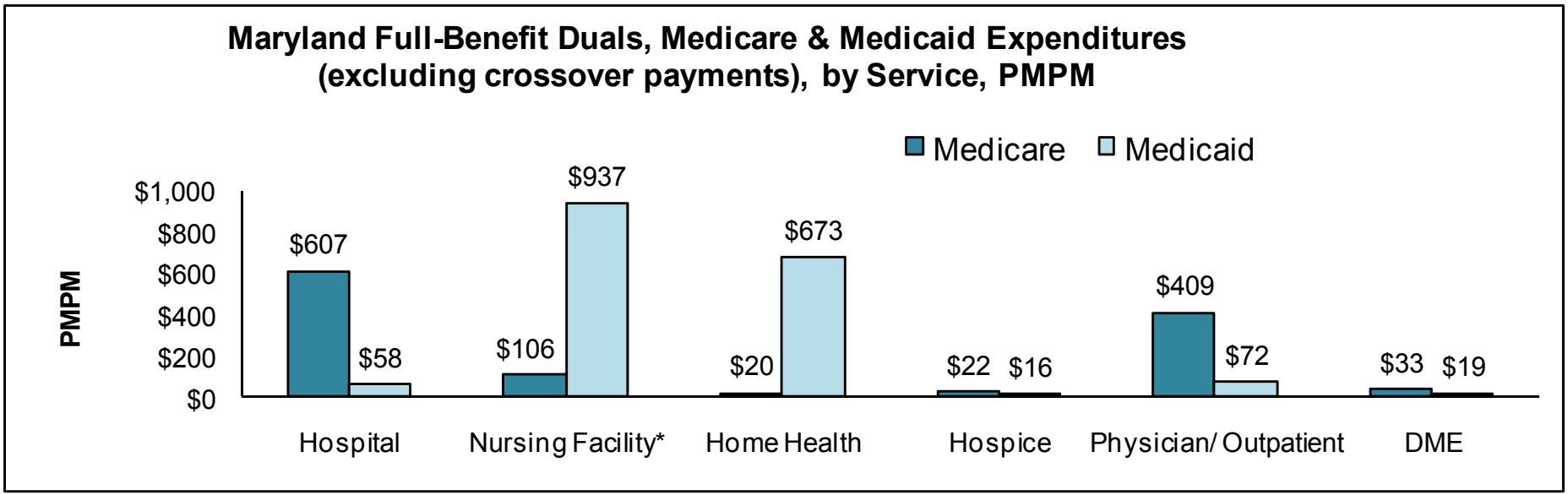
III. New Opportunities under the Affordable Care Act (ACA)

I. Background:
The Importance of Integration

Medicaid programs seek to promote community-based LTC

- States use home and community-based services (HCBS) Medicaid waivers to provide cost-neutral alternatives to nursing facilities (NFs)
- One challenge is that Medicare, which often is the payer on entry to a skilled nursing facility (SNF) or NF, may not provide a financial incentive to promote HCBS, and active discharge planning is neglected
- Another challenge is the fiscal fear in states about the so-called woodwork effect—that HCBS slots will not displace NF expenditures

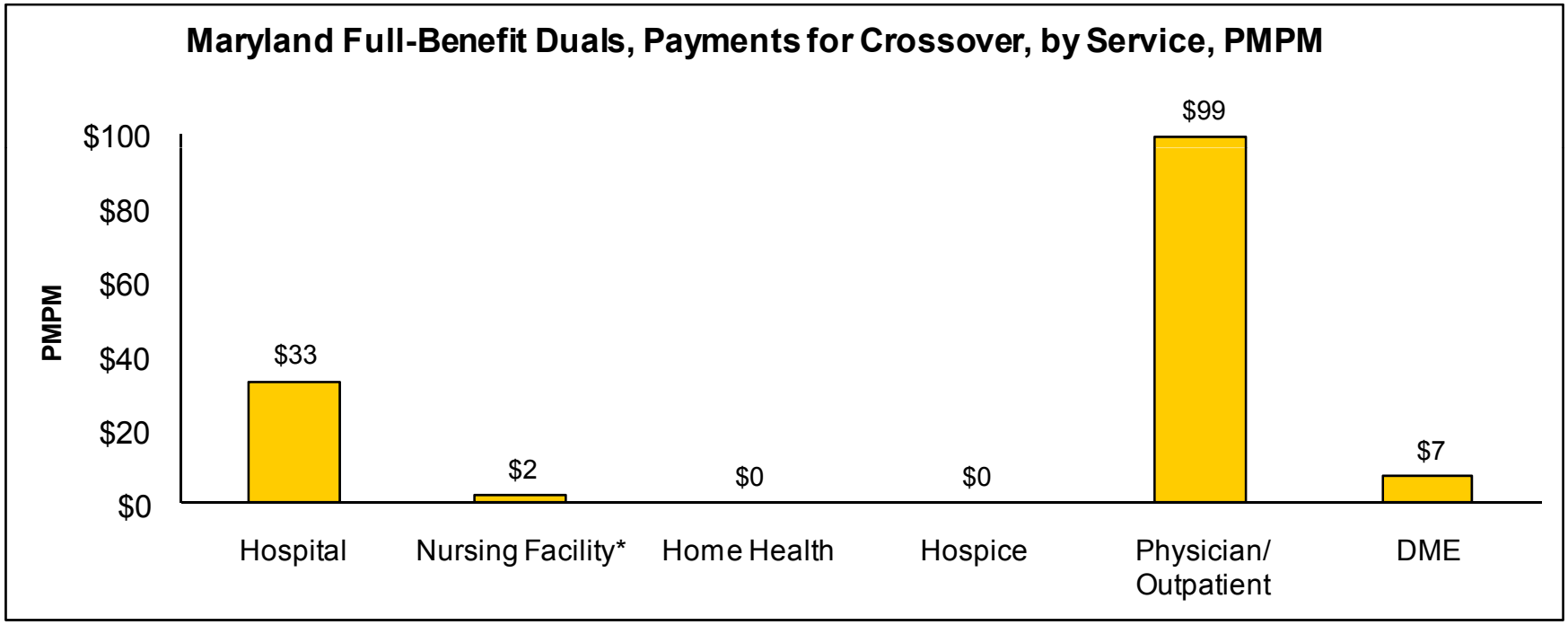
Dual eligibles consume a lot of Medicaid and Medicare services, and the distribution varies by service . . .



Source: The Hilltop Institute, 2008

Notes: Includes only continuously enrolled full-benefit duals with no group health coverage. "Nursing Facility" figures also include ICF-MR expenditures, and "Home Health" includes all Medicaid HCBS waivers.

. . . Medicaid also pays for Medicare cost sharing . . .



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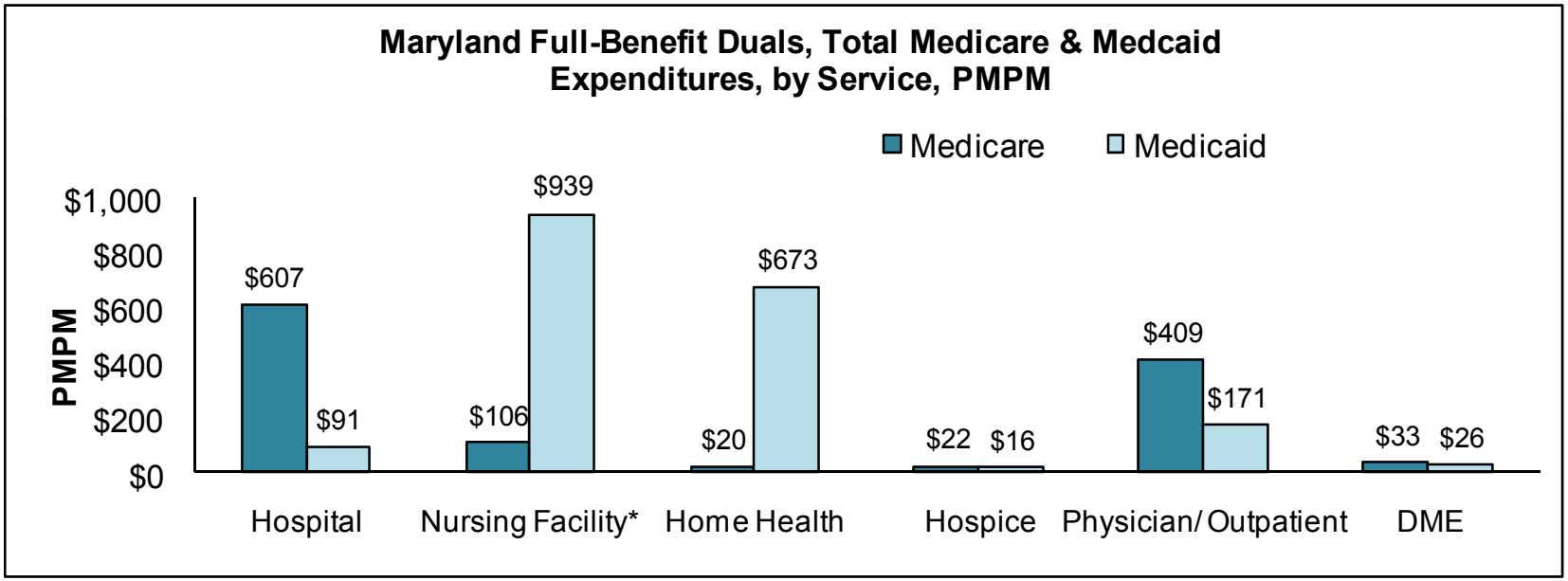
. . . which completes the picture for Medicaid and Medicare expenditures for dual eligibles by service.



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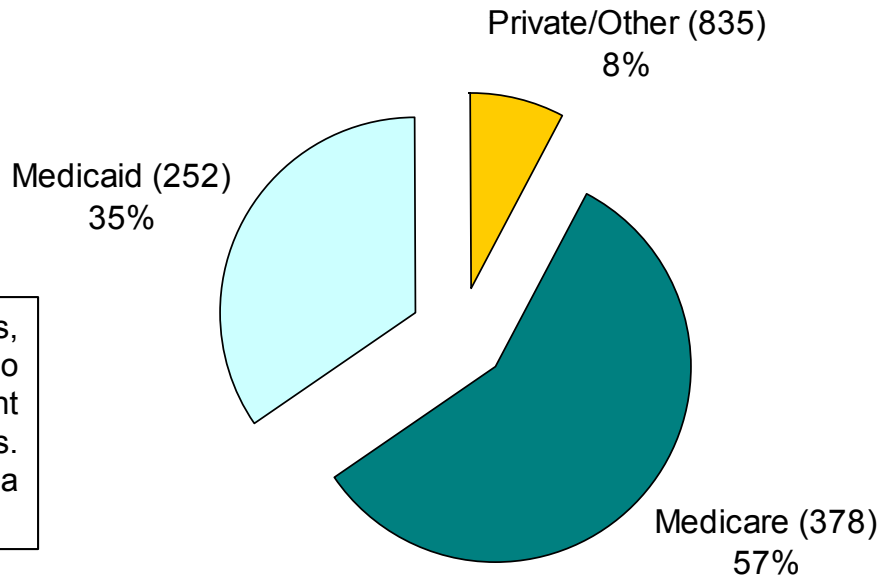
In Maryland, nearly 60 percent of extended SNF/NF stays that involve Medicaid payment during the stay began as a post-acute Medicare SNF stay . . .

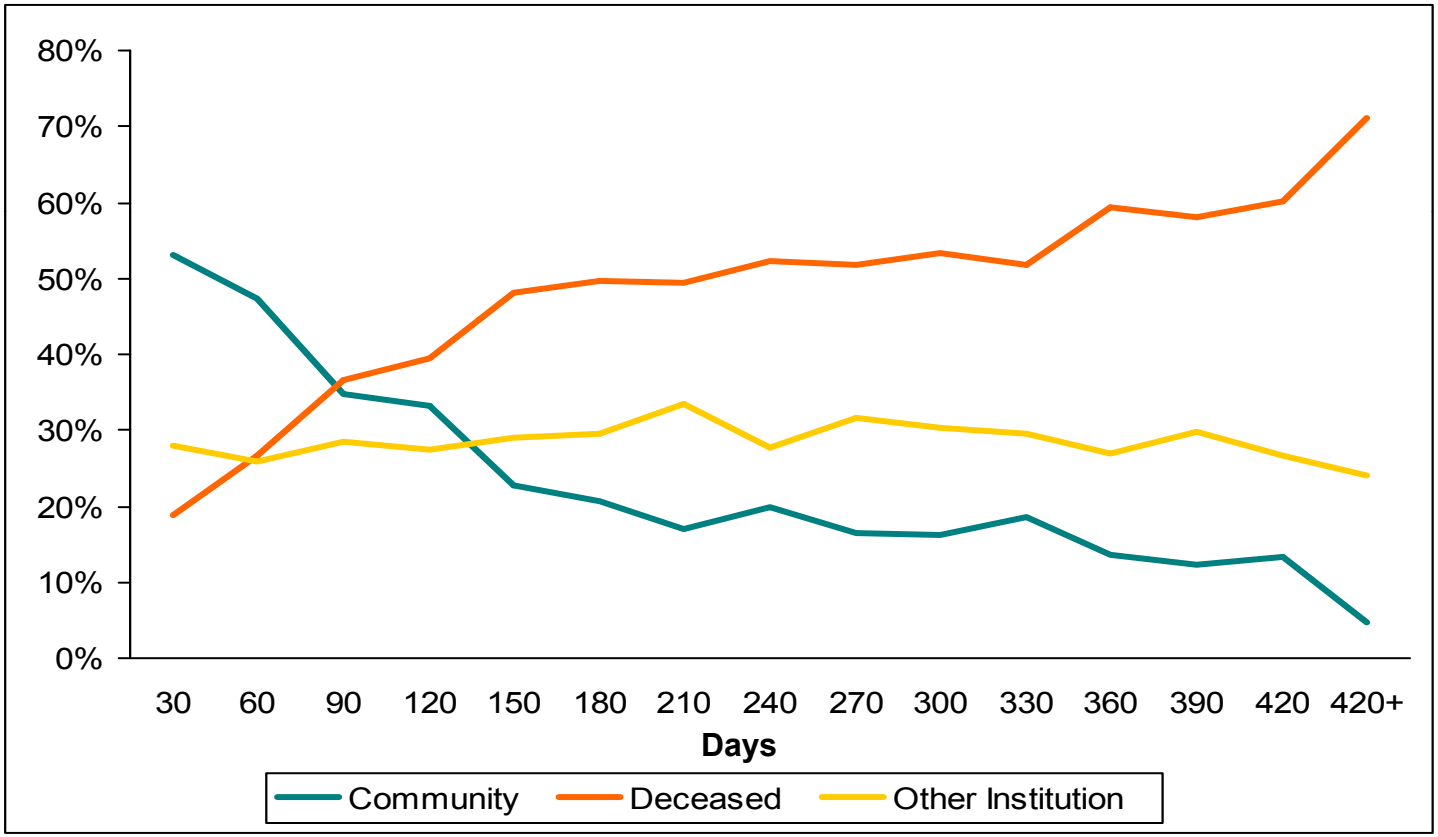
Source of Payment at Initial Admission
(with average LOS), Extended Stays



An "extended" stay links multiple stays, across institutions and time, with no home or community-based placement longer than 30 days between stays. An "extended" stay could involve a single stay or multiple linked stays.

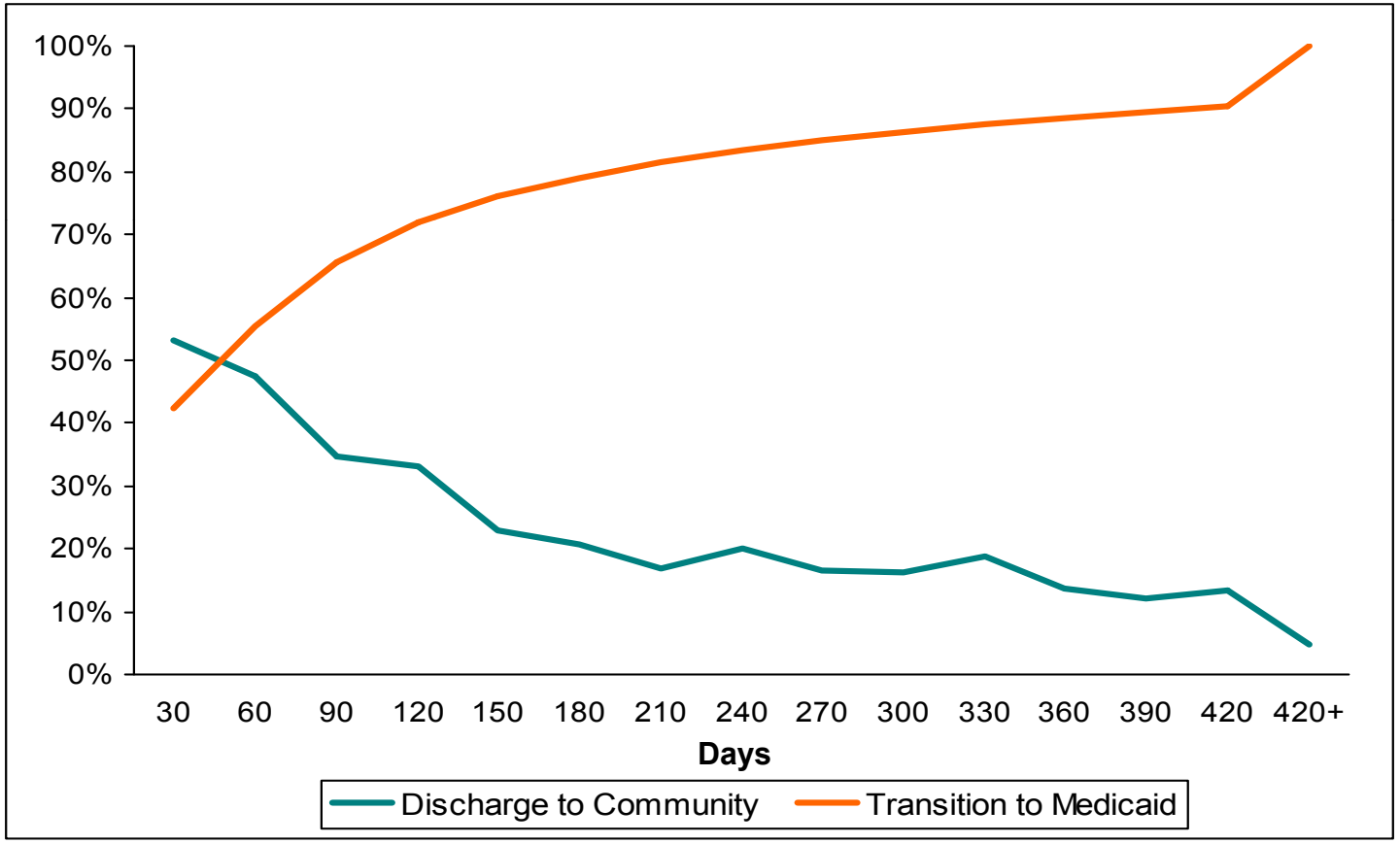
Hilltop-refined MDS data for Maryland, 2000-2009 (95,911 stays).
Limited to stays for those with Medicaid eligibility at some time during the stay (regardless of payer).

. . . and the likelihood of returning to the community from a NF diminishes as the LOS increases . . .



Hilltop-refined MDS data for Maryland, Extended Stays w/Discharge 1999-2008, limited to the stays that convert to Medicaid

. . . so a key predictor of a conversion to the community is a nursing facility resident's LOS, which must involve Medicare.



Hilltop-refined MDS data for Maryland, Extended Stays w/Discharge 1999-2008, limited to the stays that involve Medicaid eligibility at some point during the stay

II. Case Study on Dual Eligibles

Hilltop conducted research, funded by the state of Maryland and RWJF, on Medicare-Medicaid cross-payer effects.

- Constructed and utilized a database that linked, at the individual level, Medicaid claims, Medicare claims, and MDS records
- One area of analysis: the cross-payer effects for dual eligibles who meet nursing facility level of care (NF LOC), regardless of setting (community or institution)
- One subgroup analysis: Maryland's 1915(c) Older Adults Waiver (OAW), the largest NF LOC waiver in Maryland
- OAW beneficiaries were compared to two "control" groups using propensity score methods: (a) individuals in the community and not in the OAW and (b) individuals in institutions (CY 2006 used)

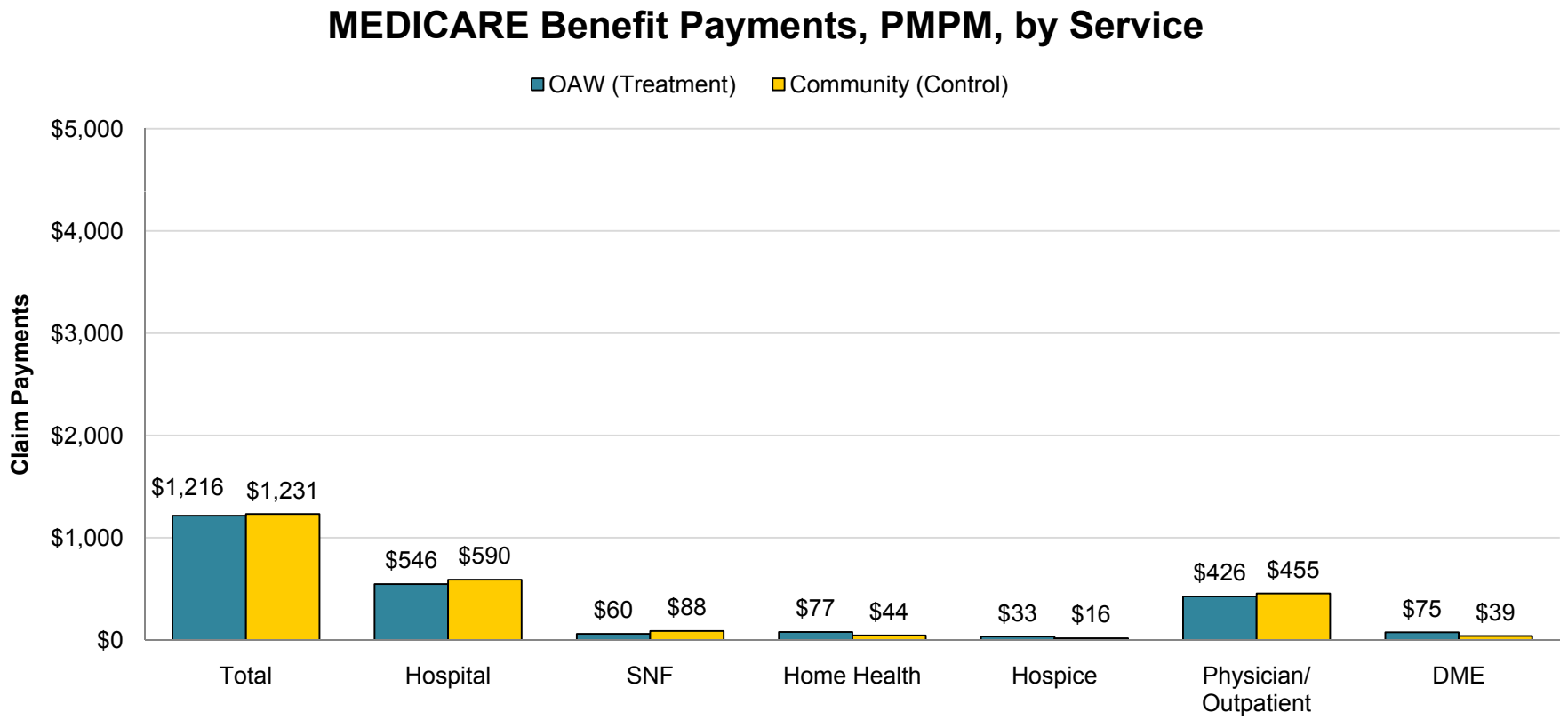
In the following slides, the "HCBS Waiver Group" means the OAW in Maryland in 2006.

Covariates used in the propensity score methodology

- Demographics (age, gender, race)
- CMS-HCC relative value
- 20 Chronic Condition Data Warehouse indicators (AMI, AD/dementia, COPD, diabetes, depression, hip fracture, stroke, etc.)
- Disability as reason for original Medicare enrollment
- Frailty indicator (diagnosis-based, Hopkins ACG system)
- ESRD indicator
- Months of full Medicaid coverage

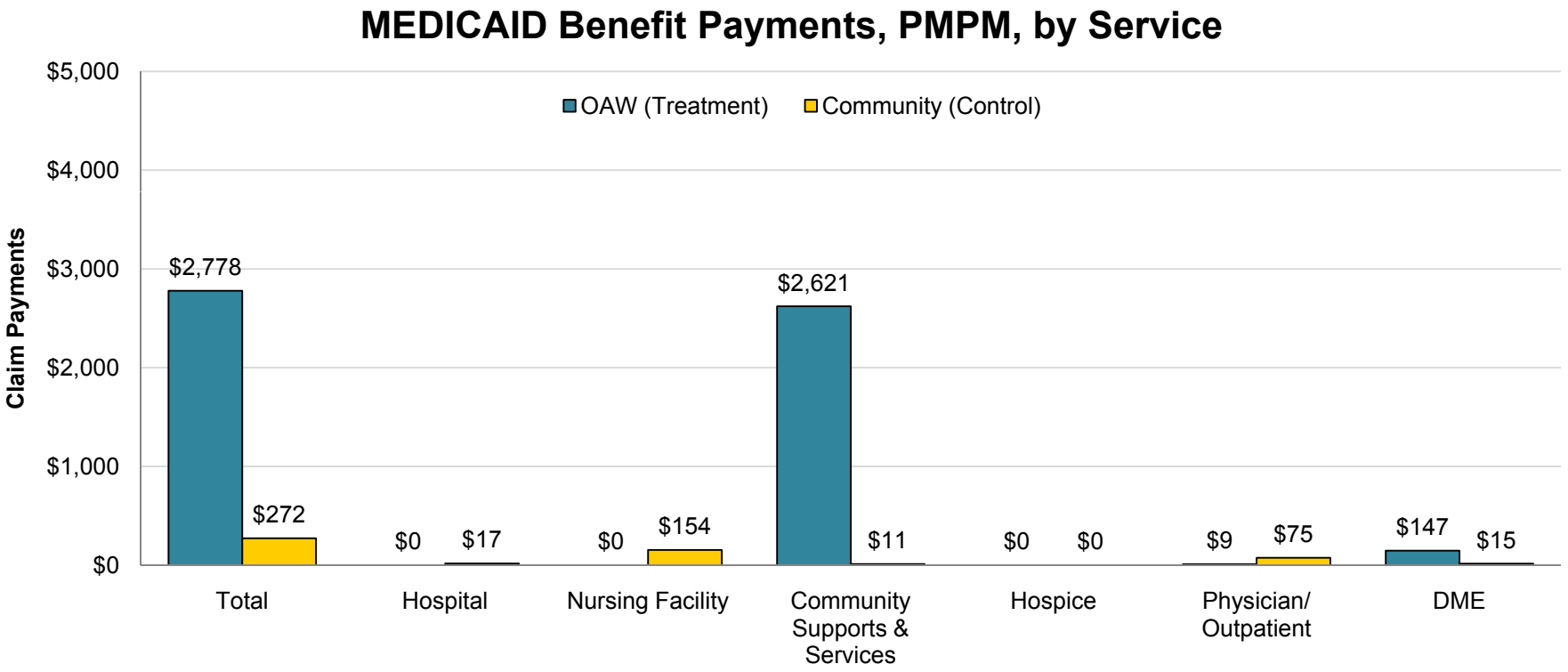
HCBS Waiver Group Compared to Community Non-Waiver Group

Total Medicare payments were nearly identical for HCBS beneficiaries and the matched group in the community . . .



Source: Tucker, A., & Johnson, K. (2010). *Cross-payer effects on Medicare resource use: Lessons for Medicaid administrators*. Baltimore, MD: The Hilltop Institute.
Notes: Maryland OAW (treatment) and community (control) samples of 1,410 full-benefit duals aged 50 and older, enrolled for 12 months (with no group health coverage) in 2006.

. . . while Medicaid payments were far higher for the HCBS group than the community group . . .



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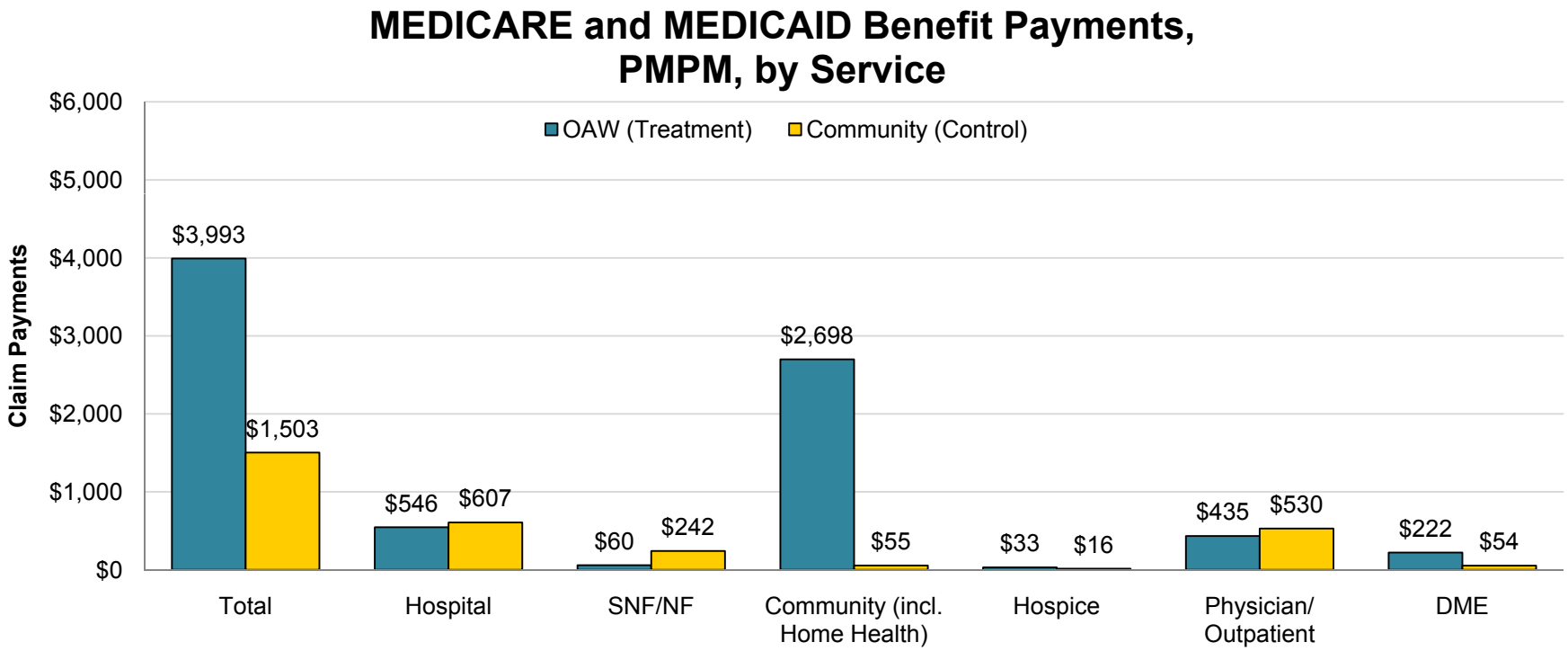
. . . and as a result, the HCBS group was far more expensive than the community group, in total dollars.



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Notes: Maryland OAW (treatment) and community (control) samples of 1,410 full-benefit duals aged 50 and older, enrolled for 12 months (with no group health coverage) in 2006. Medicare crossover payments paid by Medicaid not included.

Now let's focus just on Medicare: HCBS waiver group compared to community non-waiver group

While the total *Medicare $$* was similar, more HCBS individuals utilized a Medicare service.

Resource Use Measure	With HCBS (treatment)	Without HCBS (control)
Beneficiaries	1,410	1,410
PMPM	$1,216	$1,231
User of any Medicare service	1,405	1,360

- The community control group had a slightly higher PMPM
- Yet there were more users of a Medicare service among the HCBS group

HCBS versus Community: Medicare Hospital

Resource Use Measure	With HCBS (treatment)	Without HCBS (control)
Hospital PMPM	$546	$590
Users	539	507
Hospital Stays	1,081	1,158
Stays Per User	*2.0*	*2.3*

- Lower PMPM in the HCBS group
- More users in the HCBS group
- Fewer total stays in the HCBS group
- More multiple stays for the community control group users

HCBS versus Community: Medicare SNF

Resource Use Measure	With HCBS (treatment)	Without HCBS (control)
SNF PMPM	$60	$88
Users	108	134
SNF Stays	142	194
Stays Per User	*1.3*	*1.4*
Medicare-Paid Days	2,827	4,734
Days Per User	*26.2*	*35.3*
Days Per Stay	*19.9*	*24.4*

- Lower PMPM in the HCBS group
- Fewer users in the HCBS group
- Fewer SNF stays and far fewer days in the HCBS group
- Shorter LOS in the HCBS group

HCBS versus Community: Medicare Home Health

Resource Use Measure	With HCBS (treatment)	Without HCBS (control)
Home Health PMPM	$77	$44
Users	299	211
HH Episodes	367	268
Episodes Per User	*1.2*	*1.3*
HH Visits	6,531	4,467
Visits Per User	*21.8*	*21.2*
Visits Per Episode	*17.8*	*16.7*

- Higher PMPM in the HCBS group
- More users in the HCBS group
- More episodes in the HCBS group
- More visits per episode in the HCBS group

HCBS versus Community: Medicare Hospice

Resource Use Measure	With HCBS (treatment)	Without HCBS (control)
Hospice PMPM	$33	$16
Users	22	9
Hospice Episodes	25	11
Episodes Per User	*1.1*	*1.2*
Medicare-Paid Days	4,065	1,930
Days Per User	*184.8*	*214.4*
Days Per Episode	*162.6*	*175.5*

- Higher PMPM in the HCBS group
- More users and total episodes in the HCBS group
- More days per user and per episode for the community group

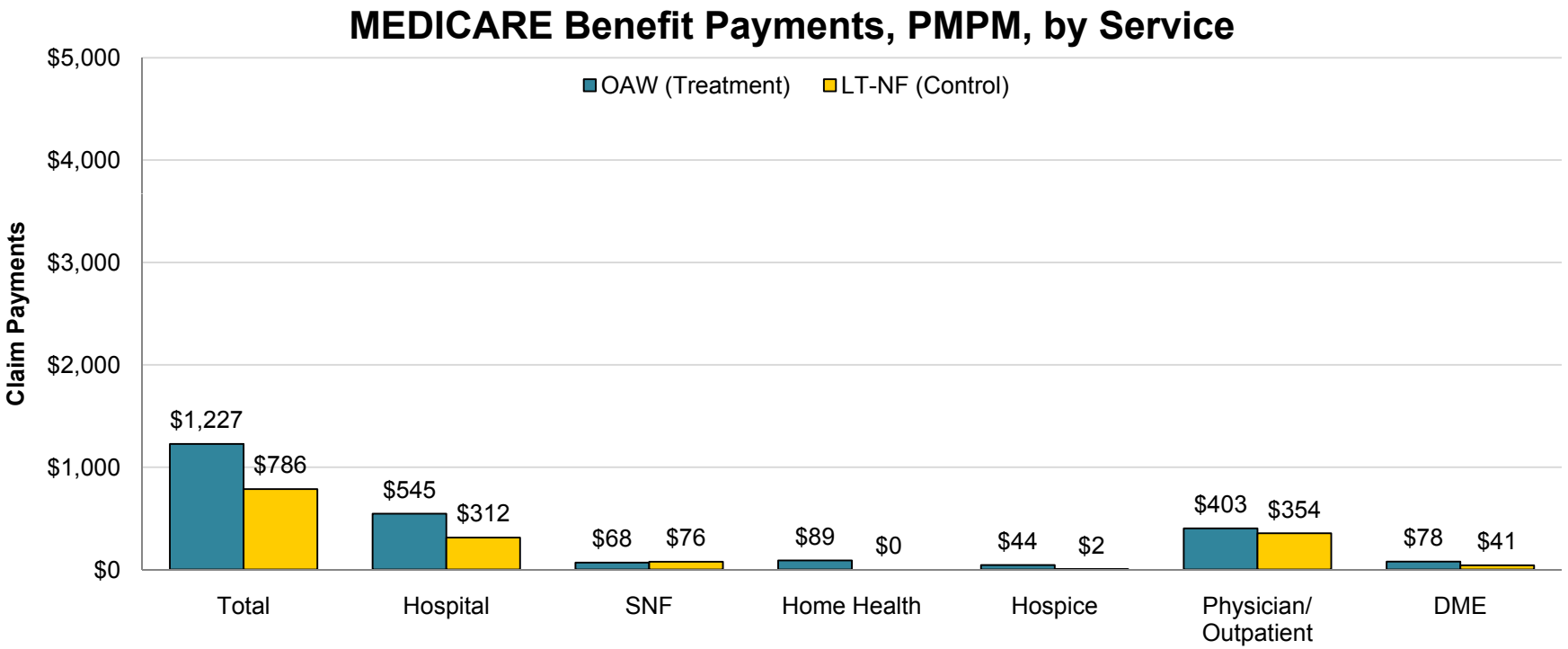
HCBS versus Community: Medicare Part B (Physician, O/P, DME)

Resource Use Measure	With HCBS (treatment)	Without HCBS (control)
Part B PMPM	$501	$494
Users	1,403	1,360
Physician Users	*1,399*	*1,352*
DME Users	*965*	*615*
Other outpatient Users	*952*	*1,007*

- Higher PMPM and more users in the HCBS group
- Those differences driven by physician services and DME
- Higher use of "other outpatient" by community control group, which was driven by ER visits

HCBS Waiver Group Compared to LT-NF Group

Medicare payments were $441 higher PMPM for the HCBS group than for the matched LT-NF group . . .



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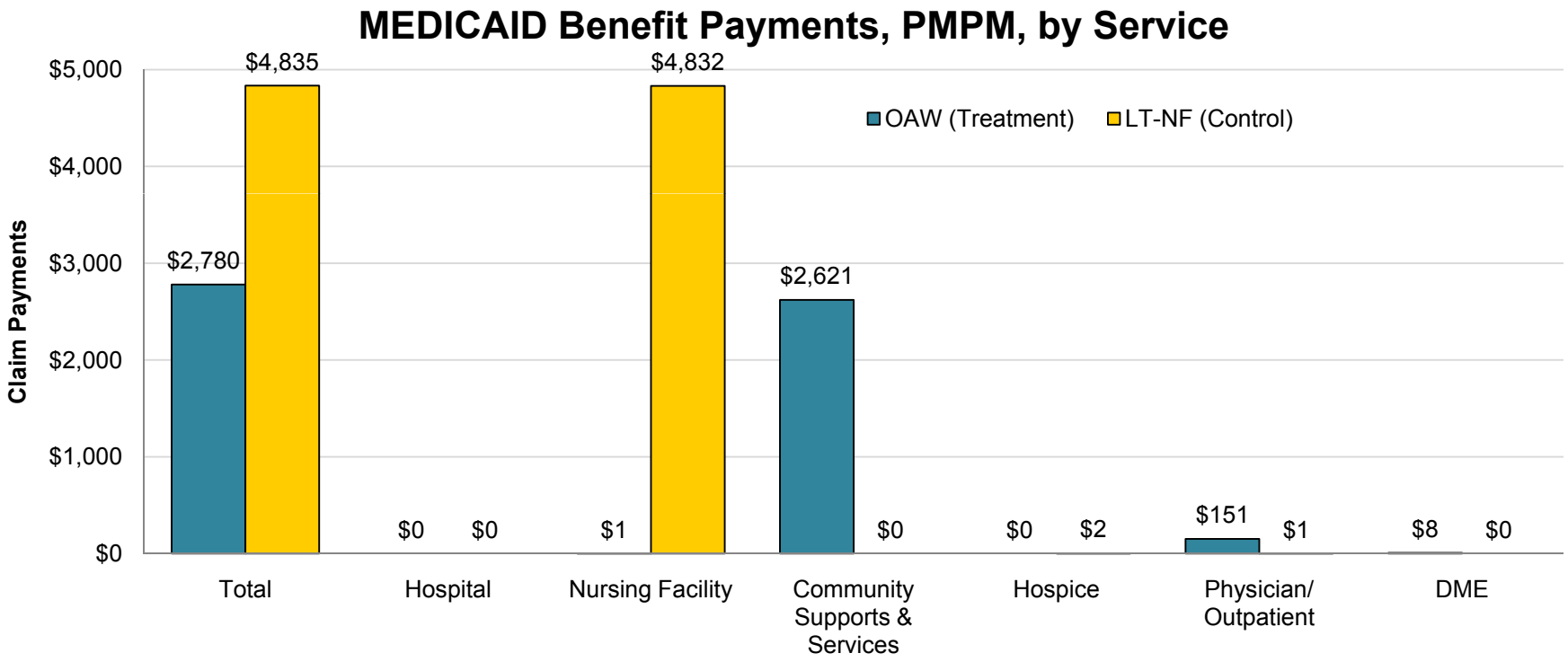
Notes: Maryland OAW (treatment) and community (control) samples of 1,731 full-benefit duals aged 50 and older, enrolled for 12 months (with no group health coverage) in 2006.

. . . while Medicaid payments were $2,055 PMPM higher for the LT-NF group, compared to the HCBS group . . .



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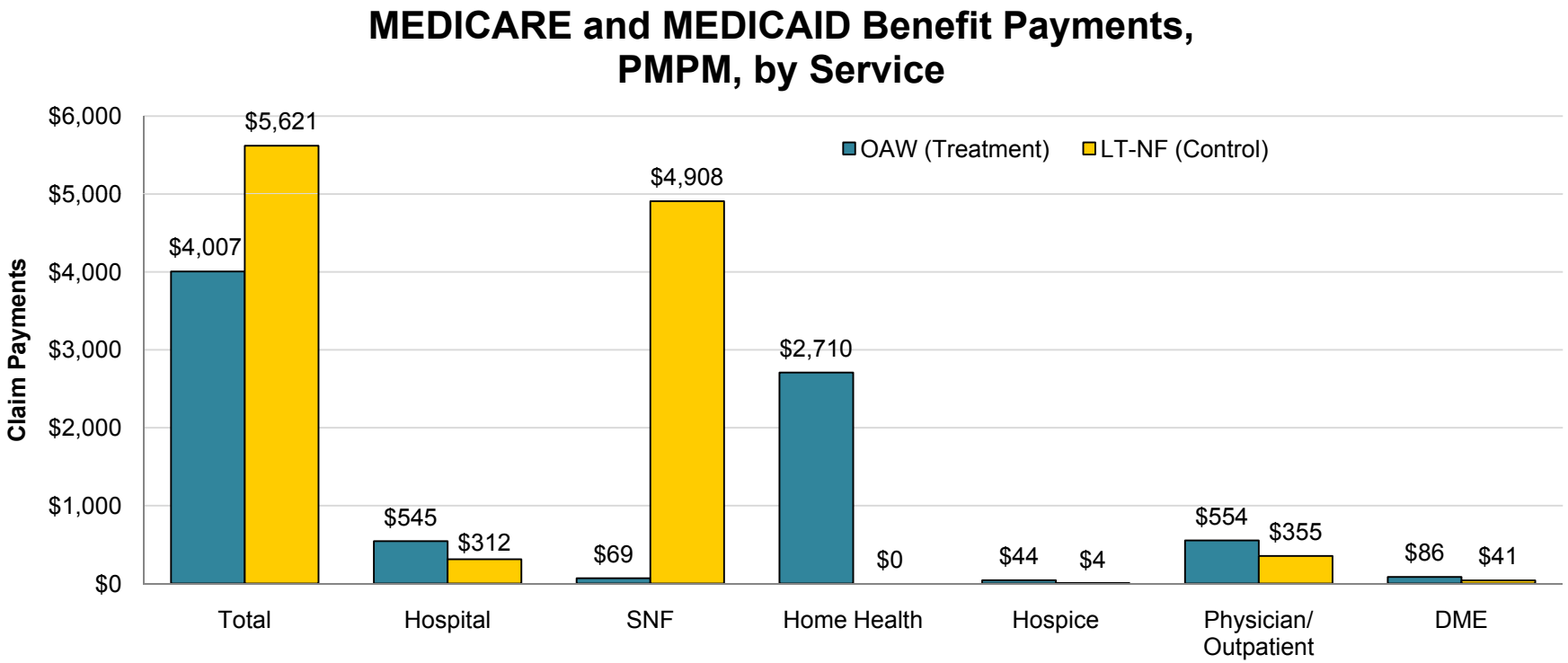
. . . and in total dollars, the HCBS group was *far less expensive* than an LT-NF group.



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Now let's focus just on Medicare: HCBS waiver group compared to long-term nursing facility (LT-NF) group

HCBS versus LT-NF: Total Medicare

Resource Use Measure	HCBS Group (treatment)	LT-NF group (control)
Beneficiaries	1,731	1,731
PMPM	$1,227	$786
Users	1,726	1,729

- The HCBS group had ***higher overall Medicare costs*** than the LT-NF group

HCBS versus LT-NF: Medicare Hospital

Resource Use Measure	HCBS Group (treatment)	LT-NF Group (control)
PMPM	$545	$312
Users	698	428
Hospital Stays	1,357	741
Stays Per User	*1.9*	*1.7*
Medicare-Paid Days	6,723	4,020
Days Per User	*9.6*	*9.4*
Days Per Stay	*5.0*	*5.4*

- Higher PMPM in the HCBS group
- More hospital users, stays, and days in the HCBS group
- More readmissions in the HCBS group

HCBS versus LT-NF: Medicare SNF

Resource Use Measure	HCBS Group (treatment)	LT-NF Group (control)
PMPM	$68	$76
Users	153	217
SNF Stays	200	288
Stays Per User	*1.3*	*1.3*
Medicare-Paid Days	3,896	5,462
Days Per User	*25.5*	*25.2*
Days Per Stay	*19.5*	*19.0*

- Higher PMPM in the LT-NF group
- More users and stays in the LT-NF group
- Stays per user, days per user, and days per stay were similar

HCBS versus LT-NF: Home Health

Resource Use Measure	HCBS Group (treatment)	LT-NF Group (control)
PMPM	$89	less than $1
Users	400	- ds -
HH Episodes	502	- ds -
Episodes Per User	*1.3*	*- ds -*
HH Visits	9,847	- ds -
Visits Per User	*24.6*	*- ds -*
Visits Per Episode	*19.6*	*- ds -*

- Only limited home health use among the LT-NF group (less than $3,000 for the entire group for the entire year)

HCBS versus LT-NF: Hospice

Resource Use Measure	HCBS Group (treatment)	LT-NF Group (control)
PMPM	$44	$2
Users	37	- ds -
Hospice Episodes	41	- ds -
Episodes Per User	*1.1*	*- ds -*
Medicare-Paid Days	6,882	- ds -
Days Per User	*186.0*	*- ds -*
Days Per Episode	*167.9*	*- ds -*

- Very little hospice use among the LT-NF group
- Significantly more hospice days for the HCBS waiver group

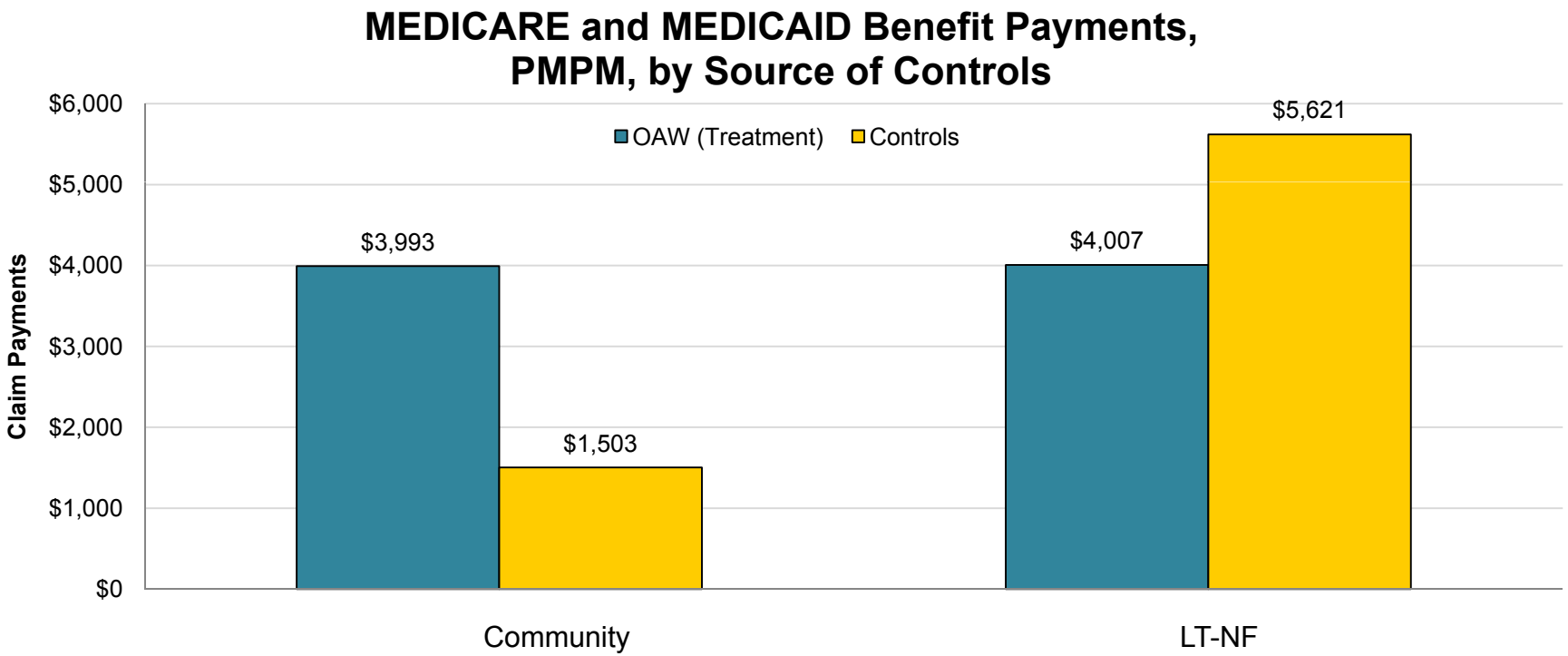
HCBS versus LT-NF: Medicare Part B

Resource Use Measure	HCBS Group (treatment)	LT-NF Group (control)
PMPM	$481	$395
Users	1,724	1,729
Physician Users	1,718	1,725
Outpatient Users	1,179	1,555
DME Users	1,197	411

- Similar number of users and physician users
- More physician visits per user (not on the slide) for the HCBS group
- Higher cost for the HCBS group was driven by physician visits and DME
- Outpatient use was significantly higher in the LT-NF group due to physical/occupational therapy visits

Key Takeaways from Case Study

In *total dollars*, the HCBS group is far more expensive than the community group, and far less expensive than the LT-NF group.



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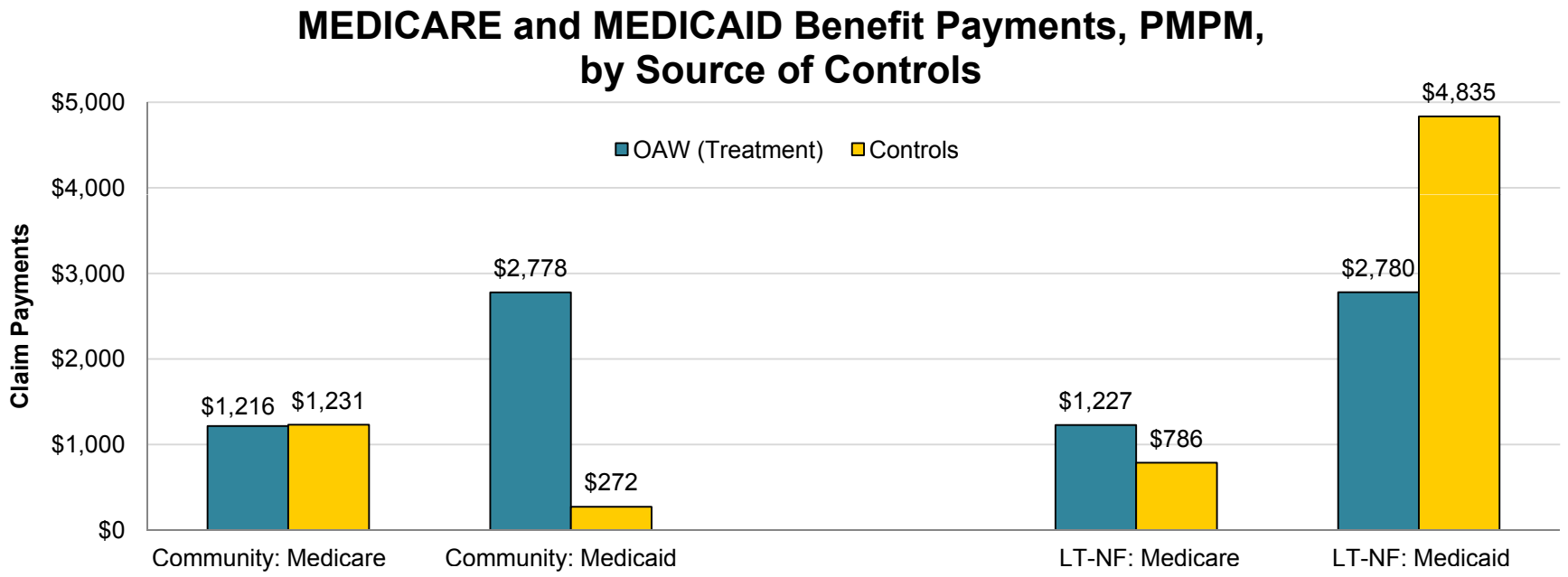
Medicare $$ was similar between HCBS and the community, but the Medicare program *saved $$ when people were in NFs*.



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Takeaways

- Medicare and Medicaid financing do not align to promote HCBS. ***Medicare saves $441 PMPM*** when a dual eligible is in a stable custodial LT-NF stay, whereas Medicaid ***spends $2,055 PMPM more*** in a LT-NF compared to HCBS.
- Medicaid's HCBS program helped promote better care and service utilization *in the Medicare program*, but receives no incentives ($$) from Medicare.
- Because most extended NF admissions begin with a Medicare admission, community integration for dual eligibles must engage Medicare; engaging Medicare providers is a barrier.
- The HCBS waiver is only cost-effective (at the individual level) for Medicaid when it truly avoids a NF placement.

III. New Opportunities under the ACA

Key Elements in the ACA

- Creation of Dual Eligibles Office, officially called the "Federal Coordinated Health Care Office" (Section 2602)
- The authority of the Dual Eligibles Office includes granting a five-year demonstration waiver of virtually any provision of the Medicaid Act (Section 2601)
- CMS chose to ***locate*** the Dual Eligibles office ***inside*** the new "Center for Medicare and Medicaid Innovation" (CMMI) (created under Section 3021), which has the authority to waive virtually any component of Medicare law

Key Elements and Implications

- CMMI-approved demonstrations are not subject to budget neutrality (Section 3021)
- The new Dual Eligibles Office has the authority to waive virtually all aspects of Medicare and Medicaid law
- These waivers are approved for an initial five-year demonstration period

Recent Request for Proposal

- The Dual Eligibles Office recently released an RFP calling for state innovations in the area of dual eligibles
- Proposals were due February 1. Up to 15 states will win contracts worth up to $1 million each.
- The contracts will fund planning activities to create a demonstration waiver proposal, due in approx. 18 months.
- CMS has sought innovative ideas that would go to scale that integrate care along four axes: acute + LTC; somatic + behavioral; Medicaid + Medicare; community-based + institutional

Conclusion

- The ACA created important new authorities
- The decision to locate the new Dual Eligibles Office inside CMMI leverages all those authorities across Medicaid and Medicare
- Many states intend to capitalize on these provisions to improve access, quality, affordability, the alignment of incentives, and rebalancing

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