ACAP Plans and the Duals Demonstrations: Early Progress, Innovations and Challenges

In 2013, the Centers for Medicare & Medicaid Services (CMS) began implementation of a series of demonstration projects to test new models of care coordination and financing for people who were dually eligible for Medicare and Medicaid benefits. Dual-eligible beneficiaries are frequently among the costliest beneficiaries in either Medicare or Medicaid, and are often lost in the gaps between both programs.

To bridge these gaps, new Financial Alignment Demonstrations (or "duals demonstrations") were created by the Affordable Care Act to improve care coordination and outcomes, implement new care delivery systems for beneficiaries, and generate savings to the Medicare and Medicaid programs. The duals demonstrations are a step further towards integration compared with dual-eligible special needs plans (D-SNPs). While D-SNPs are required to cover some, but not all, Medicaid benefits, demonstration plans are required to integrate all Medicare and Medicaid benefits. The demonstrations also test passive enrollment of dual eligibles into health plans for their Medicare benefits, and attempt to align certain Medicare and Medicaid requirements and administrative processes.

As of July 2014, CMS had approved demonstrations in 13 states. The Association for Community Affiliated Plan (ACAP), which represents 59 not-for-profit and community-based Safety Net Health Plans, has 14 member plans participating in the duals demonstration as Medicare-Medicaid Plans (MMPs). A fifteenth intends to participate in 2016. Collectively, ACAP's MMPs comprise 15 percent of all duals demonstration contracts but enroll more than 30 percent of all demonstration beneficiaries.

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Given their place on the front line of implementation, ACAP-member plan experiences can inform early successes and challenges with the duals demonstration. This brief highlights how ACAP MMPs:

- **Help dual eligibles find sustainable housing in the community**
- **Create new service delivery options**
- **Link physical and behavioral health providers**
- **Develop inclusive and comprehensive care teams**
- **Offer targeted, high-touch case management**

This brief also discusses ACAP plans' challenges in operating MMPs in the demonstration environment. The experience of ACAP plans in the duals demonstration provides helpful guidance for policymakers and health plans alike, as they continue working to better integrate care for dual-eligible individuals.

Helping dual eligibles find sustainable housing in the community

In California, Health Plan of San Mateo (HPSM) launched a program that combines intense case management and housing assistance services with medical care in an effort to minimize long-term stays in nursing facilities and help people to live safely and independently in their communities.

For many dual-eligible beneficiaries who reside in a skilled nursing facility (SNF), a return to community living can be challenging—especially if they lose their former residence or skills that are necessary to live independently. HPSM is implementing a program where it partners with local case management and housing assistance organizations to ease dual-eligible beneficiaries' transition from nursing facilities to the community. The program began diverting long-term nursing home stays by enabling individuals to return to their communities – a goal of both integrated care programs for dual eligibles and of state programs to deliver long-term care services in community-based rather than institutional settings.

Member Profile

Health Plan of San Mateo is already making a positive difference for the county's dual-eligible individuals.

A 71-year-old man was admitted to a skilled nursing facility for rehabilitation following surgery. He had been living for 20 years in a Section 8 apartment and after a year at the nursing facility, his primary barrier to discharge was securing a new Section 8 unit. His case manager worked in collaboration with a local housing assistance organization to find a unit that would accept his Section 8 voucher. They eventually succeeded in finding an apartment, helped him move in, and secured a waiver to help him obtain furniture and houseware free of charge.

With his independence reclaimed, and a dedicated case manager assigned to him until he is fully adjusted, the member says he cries when he looks around his housing unit and realizes he is finally home.

Member Profile

Santa Clara Family Health Plan (SCFHP) understands the link between a safe home and good health. SCFHP staff discovered that a 63-year-old member suffering from diabetes, severe chronic obstructive pulmonary disease and depression was living in a mobile home unfit for human habitation. To improve the member's housing situation, SCFHP and community partners coordinated home clean-up, scheduled medical appointments, and helped secure prescriptions and counseling, ultimately transitioning the member into a much safer housing situation.

The member reports a dramatic improvement in her mental and physical health, crediting the collaborative intervention of SCFHP and its partners.

Just south of San Mateo, Santa Clara Family Health Plan (SCFHP) works with providers and community partners to help demonstration enrollees with care transitions. SCFHP created a new SNF Provider Services Liaison position, which supports SNF and SCFHP coordination around the challenges encountered in transitioning members back into the community.

SCFHP case managers have identified members with long-term stays in the nursing facility who may be able to return to the community and work alongside the SNF social service staff and other community partners, to facilitate transitions into safe, affordable housing whenever possible. SCFHP has also worked to strengthen its relationships with long-term services and supports providers in the area, leading to partnerships that have prevented homelessness and facilitated successful care transitions.

Characteristics of People Enrolled in ACAP-member MMPs

52% are under 65 and live with disabilities

48% are over age 65

Creating new service delivery options

In Massachusetts, Commonwealth Care Alliance (CCA) is developing creative solutions to meet dual-eligible beneficiaries' behavioral health needs. CCA enrolls more than 10,000 dual-eligible beneficiaries in its demonstration plan. Among its membership, behavioral health is a serious concern: about 70 percent of the plan's members have a behavioral health diagnosis.

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Serious mental health conditions led to more than 900 inpatient psychiatric admissions over the first 15 months of the demonstration. For many of these individuals, however, outpatient therapy proved insufficient while inpatient acute psychiatric hospital care was an excessive level of care; they were admitted to a facility because there were so few options between those two extremes.

CCA responded to this challenge by creating its first outpatient behavioral health treatment option for its members in October of 2014. CCA opened a 12-bed crisis stabilization unit in Boston and a 14-bed unit will soon be opening in another neighborhood of Boston. In 2016, CCA will explore locations in Central and Western Massachusetts for similar clinical capacity. The crisis stabilization units offer short term intensive behavioral health and medical intervention services for members in need who are clinically appropriate to be diverted from an acute inpatient psychiatric hospital admission.

For CCA, the responsibility for both the Medicare and Medicaid expenses created the incentive to create this sub-acute capacity. If these beneficiaries were still enrolled in traditional fee-for-service Medicare, they likely would have been admitted to acute care facilities for treatment – a more costly and intensive level of service than needed – at Medicare's expense.

In addition to developing outpatient crisis stabilization capacity, CCA opened regional care centers staffed with primary care physicians and nurse practitioners for members that lacked a regular or meaningful relationship with a primary care provider before they were enrolled in the demonstration. This capacity was necessary to accommodate subsets of the dual eligible population who were poorly served in the traditional Medicare system. An increased commitment to coordinated care has made a significant difference for many high-cost individuals, who are newly engaged in the health care system after years of experiencing fragmented health care in an uncoordinated system.

Linking physical and behavioral health providers

Inland Empire Health Plan (IEHP) in California developed new approaches to helping its duals demonstration enrollees in need of behavioral health services. IEHP's behavioral health program endeavors to break down the longstanding structural silo that has traditionally isolated mental health care from the rest of the health care system.

More Characteristics of People Enrolled in ACAP-member MMPs

44% have been diagnosed with a mental health condition	**28%** use community-based LTSS
16% have a substance use disorder or addiction issues	**13%** use institutional LTSS

IEHP created a web-based coordination of care system to facilitate communication and collaboration among behavioral health providers, the member's primary care physician, and the plan's behavioral health care managers. The system enables behavioral health providers to view their member's health history – such as current medications, lab reports, and other relevant medical history – and to submit their assessment and treatment plans to IEHP's behavioral health care managers. The treatment plan is shared with the member's primary care physician instantly. The system also allows the primary care physician to communicate with the behavioral health provider and IEHP's behavioral health care manager. The web-based coordination of care system has been highly successful – over 70 percent of IEHP's primary care physicians have downloaded their patients' behavioral health treatment plan. In addition, IEHP has improved access to behavioral health care for members by building a large behavioral health provider network based on a "no gatekeeper" model which allows members to access mental health or substance abuse treatment services without a primary care physician referral.

Offering targeted, high-touch case management

IEHP has also created a Special Mobile Assessment Response Team (SMART) for their duals demonstration that brings team members to an enrollee's home or place of residence to coordinate care, assess a member's living situation and resolve any issues that may adversely affect their health status. The SMART team conducts member home visits that assist with coordination of care, such as in-home assessments for custodial placement and community-based resources. The SMART team also works alongside SNFs to smooth out transitions of care. After discharge, the SMART team educates members about how to stay healthy and live safely in their homes.

Member Profile

Upon returning to his home after a stay at a long-term care facility, a **CareSource** member received a check-in phone call from his care manager. The CareSource manager learned that the member's wife and primary caregiver had fallen, sustained a hip fracture, and was recovering in a local rehabilitation facility. The member's daughter had moved back into the house to care for him; nevertheless, the care manager reached out to the member's wife and visited her in the rehabilitation facility—even though she wasn't a member of the plan.

The member's wife, feeling overwhelmed by her injury and caretaking responsibilities for her husband, admitted that she was struggling to understand the mountains of documents and bills piling up in her mailbox. She produced a freezer bag stuffed with mail: some was relevant to her injury, some to her husband's recovery. The CareSource care manager went through every item in the bag, writing explanatory notes on each and highlighting those requiring immediate attention. The member's wife was relieved to have the burden of interpreting and following up on the paperwork lifted. She asked the care manager to help take her picture to email to her husband, to assure him that her recovery was progressing well.

Developing inclusive and comprehensive care teams

CareSource, which enrolls nearly 16,000 dual-eligible beneficiaries in Ohio's duals demonstration, has developed a Trans-Disciplinary Care Team (TDCT) to provide members with an integrated, comprehensive approach to care. The TDCT includes the member, care manager, the member's primary physician and other health care providers, as well as the member's family and caregivers.

An assigned care manager visits in person to monitor the care needs of the member and the TDCT, and ensures ongoing communication between the member and all health care providers to chart a course of action when necessary. Led by the care manager, the TDCT can be instrumental in aiding members returning to their homes after long stays in nursing facilities. A Community Waiver Care Manager, who aids with transition, meets with the TDCT to ensure effective care management in the home and that community-based services are available to the member.

Challenges in the Duals Demonstrations

Although ACAP MMPs are developing innovative solutions to make the financial alignment demonstrations work, the early months of implementation have also revealed a number of challenges. They include:

Opt-out and Enrollment Rates

Perhaps the most well-publicized challenge with the duals demonstration is the beneficiary opt-out rates, leading to lower-than-expected enrollment totals in some states. Opt-out rates vary widely across states. While pinpointing the cause of opt-out is difficult, ACAP MMPs have cited enrollee confusion around a new program, and opt-outs as the result of prompting by some health care providers as potential explanations.

Though some ACAP MMPs have expressed concern over opt-out rates, others have warned about the consequences of rapid enrollment increases. In one state, an influx of 100,000 dual-eligible beneficiaries, many suffering from chronic and complex conditions, into the demonstration in the first 90 days placed tremendous stress on MMPs' ability to provide necessary and effective member and provider support. Large numbers of enrollment at one time can make it difficult for smaller plans to conduct timely face-to-face assessments and home visits that offer a needed personal touch.

Accuracy of Medicare and Medicaid payments to MMPs

Many ACAP MMPs stressed the need for accurate payments to plans and note that the duals demonstrations are revealing that Medicare and Medicaid rates based on historical spending do not cover the cost of enrollees' care. As a result, MMPs are being asked to do more with less. In the Massachusetts demonstration, where only beneficiaries under age 65 are eligible, this issue is particularly evident in the Medicare Part D payment methodology. Part D payments to all MMPs are based on the experiences of a typical Medicare member, rather than the under-65 dual-eligible beneficiaries with high pharmacy costs that the demonstrations were created to help. MMPs in Massachusetts are finding that Part D payments do not cover the dual-eligible enrollees' pharmacy costs. Moreover, an 18-to-20 month lag in Part D reinsurance payments is unsustainable for smaller plans.

Finding difficult-to-reach dual-eligible beneficiaries

ACAP MMPs report that many dual-eligible beneficiaries enrolling in the duals demonstrations are difficult to reach – plans in some cases do not receive accurate contact information, and some beneficiaries move frequently or are homeless. It is important for plans to find their enrollees, assess them, develop care plans, and build relationships with their plan members, but incorrect contact information and transient members make it difficult for them to do so.

Difficult-to-reach beneficiaries also lead to inaccurate payments. One MMP has been unable to reach about 30 percent of the enrollees who were initially placed in the least complex (and lowest paid) Medicaid rating category. The plan estimates that when they do find these individuals, a significant portion of them are likely to have behavioral health conditions and will be placed in a higher rating category.

Aligning Medicare and Medicaid administrative processes

Under the duals demonstrations, Medicare and Medicaid payment systems, appeals and grievances systems, and encounter data submissions are still separate. It is challenging for plans to navigate the separate systems. In addition, aligning some Medicare and Medicaid administrative processes is one goal of the demonstration that has not yet been realized.

Working with providers

ACAP MMPs agree that effective collaboration with providers is key to the success of the duals demonstrations, but getting providers to buy into the program has been an obstacle in many states. One ACAP MMP reports success in engaging primary care providers through persistent education efforts, but still struggles to convince nursing facilities to embrace the demonstration.

To confront these challenges, ACAP MMPs have gone to great lengths to solicit provider buy-in for the duals demonstration. One MMP, for instance, holds weekly provider calls and hosts training events to communicate directly with the provider community. Another has developed performance improvement programs for participating providers to work jointly to improve quality and involve providers in the member care management process. The provider relations team at another MMP visits individual offices and serves as a point of contract for doctors and office staff.

Looking Forward – "We would do it again!"

The duals demonstrations represent a promising step forward toward a more integrated, robust and responsive health care system for the nation's dual eligible beneficiaries. ACAP MMPs overwhelmingly agreed that they would participate again in the demonstration because it is the right thing to do for beneficiaries. Implementation of the demonstration has already produced impressive successes and innovations—from new initiatives and partnerships to ensure safe housing for members to the development of crisis-stabilization facilities. Though ACAP MMPs have also reported challenges related to funding and provider buy-in, they are eager to be involved in crafting solutions to improve and strengthen the effectiveness of managed integrated care programs for dual-eligible beneficiaries.

About the Association for Community Affiliated Plans

ACAP represents 59 nonprofit Safety Net Health Plans in 24 states, which collectively serve more than thirteen million people enrolled in Medicaid, Medicare, the Children's Health Insurance Program (CHIP), and other health programs.

ACAP plans serve approximately one-third of all Medicaid managed care enrollees. Eighteen ACAP-member plans operate D-SNPs. Sixteen operate managed long-term care (MLTC) plans.

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