OPTIONS FOR DELIVERING INTEGRATED CARE SERVICES TO AGED, BLIND, AND DISABLED CLIENTS IN THE DALLAS/TARRANT COUNTY SERVICE DELIVERY AREA

for

Senate Bill 1
General Appropriations Act
81st Texas Legislature, Regular Session, 2009

Article II
Health and Human Services
Special Provisions Relating to All Health and Human Services Agencies

Section 46
Integrated Model of Care – Aged/Blind/Disabled Population

Strategic Decision Support
FINANCIAL SERVICES DIVISION

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

— June 2009 —

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I – Executive Summary

In May 2009, the Texas Health and Human Services Commission (HHSC) and Evercare of Texas agreed to terminate Evercare's contract for the Integrated Care Management (ICM) program, which had provided services to approximately 74,000 aged, blind, and disabled (ABD) Medicaid clients in the Dallas/Tarrant county service delivery area (SDA). Subsequently, the 81st Texas Legislature, Regular Session, 2009, passed Senate Bill 1, Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 46, requiring HHSC to implement a new health care delivery system for this population. The Legislature directed HHSC to evaluate prospective delivery models' cost-effectiveness, impact on disproportionate share hospital (DSH) and upper payment limit (UPL) programs, and degree of service integration. This overview also considers the models' records of delivering high quality of care. The service models reviewed include: Primary Care Case Management (PCCM); STAR+PLUS; and an updated ICM. The main findings are as follows:

Cost-Effectiveness
While only limited evidence is available regarding the cost-effectiveness of ICM and PCCM with the target population, the state's experience with the partially capitated STAR+PLUS program indicates that the model delivers care at significantly reduced costs in urban areas compared to non-capitated systems. A recent analysis estimates STAR+PLUS may save up to 22 percent for in-patient care, 15 percent for acute out-patient care, and 10 percent for long-term services and supports (LTSS) compared with fee-for-service (FFS). These projected savings are built into STAR+PLUS capitation rates, thus transferring the risk for the cost of services from the state to the HMOs. In addition, the state's 1.75 percent tax on HMO premiums indirectly improves the cost-effectiveness of STAR+PLUS relative to the non-capitated PCCM and ICM models.

Quality/Satisfaction
A review of nationally recognized outcome measures reveals that STAR+PLUS has delivered cost efficiencies, while maintaining quality of care at similar levels to other service models. These reports consistently reveal few differences between STAR+PLUS clients and clients in other programs across a range of indicators. Moreover, compared to FFS beneficiaries, STAR+PLUS beneficiaries had fewer visits to an emergency room and fewer hospitalizations for preventable conditions.

Impact on DSH and UPL
The Centers for Medicare and Medicaid Services (CMS) prohibits DSH and UPL payments to public hospitals that receive capitated reimbursements from Medicaid HMOs. The three models under consideration preserve full DSH and UPL payments to public hospitals. STAR+PLUS in-patient claims are carved out and paid through FFS so that there is no DSH or UPL impact. Additionally, physician UPL revenues would be preserved by using current intergovernmental transfer (IGT) amounts to support higher rate payments in the capitated model.

Integrated Delivery
While enhanced PCCM allows for a degree of care coordination, the model does not offer beneficiaries a full range of integrated services. In comparison, STAR+PLUS and ICM were designed specifically for the ABD population. Both models coordinate acute and long-term services, provide all beneficiaries with a service coordinator, include unlimited prescriptions, and offer other value-added services.

II – Introduction

In May 2009, citing Evercare of Texas' performance problems in delivering the necessary level of care to Texas Medicaid clients, HHSC and Evercare of Texas agreed to terminate Evercare's contract for the Integrated Care Management (ICM) program. Evercare had been responsible for providing care coordination services to approximately 74,000 aged, blind, and disabled (ABD) Medicaid clients in the Dallas/Tarrant County service delivery area (SDA) since February 2008.

The 81st Legislature, Regular Session, 2009, passed Senate Bill 1, Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 46, requiring HHSC to implement a new health care delivery system for the Dallas/Tarrant county ABD population. The Legislature directed HHSC to consider the following criteria when selecting a new delivery model: cost-effectiveness; impact on disproportionate share hospital (DSH) and upper payment limit (UPL) programs; and degree of integration in the care delivery model. The text of Section 46 is included below.

This report reviews existing data and literature to evaluate the advantages and disadvantages of care delivery models available to serve the ABD population in the Dallas/Tarrant county SDA. In addition to the three criteria designated in the legislation, this overview examines prospective models' records of delivering a high quality of care as reflected by positive results on measures of health outcomes and client satisfaction. The delivery models covered by this analysis include: an enhanced Primary Care Case Management (PCCM) program; STAR+PLUS; and an updated, or new, ICM.

Section 46
Integrated Model of Care – Aged/Blind/Disabled Population

It is the intent of the Legislature that the Health and Human Services Commission implements the most cost-effective integrated managed care model for the aged/blind/disabled population in the Dallas and Tarrant service area.

It is specifically provided that funds appropriated for the provision of services to the Medicaid aged/blind/disabled population may not be expended to implement an integrated managed care model which would eliminate the revenues received for hospital and physician payments under the current federal Upper Payment Limit (UPL) program.

Medicaid funds appropriated to the Department of Aging and Disability Services and the Health and Human Services Commission may be transferred between the agencies during the 2010-11 biennium to support the implementation of an integrated model of care under this provision, with prior approval. The Commission shall request approval from the Governor and the Legislative Budget Board at least 30 days prior to any proposed funding transfer. The request shall indicate the impact to performance measures at both agencies.

The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.

The Aged, Blind, and Disabled (ABD) Population

The ABD population comprises about 20 percent of Medicaid clients in the State of Texas. These clients often have complex medical needs and frequently utilize community-based long term-services and supports (LTSS), thus requiring greater care management and coordination than other Medicaid clients. Over half of the ABD beneficiaries are dual-eligibles, receiving much of their care through Medicare, further complicating the coordination of services. Even with Medicare paying for a substantial portion of their needs, ABD clients still account for 60 percent of Texas Medicaid spending, and costs for this group continue to grow at a faster pace than the overall program.

Models of Care

Care coordination is key to providing high quality services to the ABD population while keeping growth in program expenditures at a sustainable level. Assisting clients to effectively navigate the array of health and other services available to them, particularly regarding access to timely preventive care and community supports, can avert costly and unwanted emergency rooms, in-patient, and nursing facility stays benefiting both state taxpayers and program beneficiaries. Each of the three models described below provides opportunities to closely manage and integrate service delivery to achieve these goals.

Primary Care Case Management (PCCM)

The main feature of the PCCM model is the requirement that program participants select a primary care provider (PCP) to act as a gatekeeper to more specialized health care services. Providers in this model are reimbursed based on fee-for-service (FFS) principles, and PCPs receive a small additional payment for each assigned patient each month. The PCCM model was first introduced in Texas Medicaid in 1993 and has been available in most counties to blind and disabled clients since 2005. The enhanced program envisioned for the Dallas/Tarrant county ABD population would provide additional care management programs for beneficiaries with the most complex care needs. However, the PCCM model does not coordinate the delivery of long-term services and supports, does not cover dual-eligibles who comprise half of the ABD population, and does not provide ongoing case management. The PCCM model has not offered an entitlement to nursing facility waiver services offered under STAR+PLUS and ICM. The community care services offered under the nursing facility waiver are perceived to be critical to the success of any model serving this population.

STAR+PLUS

STAR+PLUS is a partially capitated managed care program created specifically for the Medicaid ABD program. First implemented in Harris County in 1998, the model has a long history of providing integrated acute and LTSS to ABD beneficiaries living in urban areas of the state. The population it serves includes dual-eligibles. This model features a service coordinator who creates a service plan, oversees client transition from acute to long-term services, and makes home visits to assess members' needs. As part of their current contracts with the state, each STAR+PLUS HMO is required to reduce in-patient utilization, even though those services are carved out of the capitated rate. Quality measures are generally positive for the model. However, some providers have expressed reluctance to support a capitated reimbursement model.

Integrated Care Management (ICM)

The year-long ICM pilot in the Dallas/Tarrant county SDA was an attempt to integrate long-term care, acute care, and care management services into a model serving the entire ABD population, including dual-eligibles, while retaining the non-capitated payment methods used in PCCM. In other words, ICM represented a novel approach to blend features of the PCCM and the STAR+PLUS models into an integrated service delivery program. However, the private contractor selected to manage the system was not able to implement the program to the satisfaction of beneficiaries, HHSC, and many regional stakeholders. A new ICM pilot would provide an opportunity for Texas to test an integrated but non-capitated service delivery model with a different vendor and apply lessons learned in the initial attempt.

Cost -Effectiveness

The state's experience with the partially capitated STAR+PLUS program indicates that the model delivers care at significantly reduced costs in urban areas compared to non-capitated systems. Independent examination by both the Lewin Group (2004) and Deloitte Consulting (2009), along with HHSC internal analyses, support this conclusion. An HHSC care coordination study, for example, found that after controlling for health status and other factors, STAR+PLUS beneficiaries have lower rates of in-patient stays, lower emergency room utilization, and lower health care costs than members of a non-capitated control group (The Institute for Child Health Policy (ICHP), 2003). In its latest actuarial report, Deloitte estimates the following savings for STAR+PLUS versus non-capitated FFS:

- 22% for in-patient care;
- 15% for acute out-patient care, including emergency room care;
- 15% for non-physician services, ambulatory care, home health, and behavioral health; and
- 10% for long-term services and supports (LTSS).

These projected savings are built into STAR+PLUS capitation rates on which HMOs freely contract, thus transferring the risk for the cost of health care services from the state to the HMOs. A portion of the savings can be used to fund value-added services such as an unlimited prescription benefit.

In contrast, only limited evidence is available regarding the cost effectiveness of ICM and PCCM. In theory, the initial ICM contract required significant efficiencies compared to FFS (12 percent for acute care services and 5 percent for LTSS). Even so, these cost reductions fell short of savings expected from STAR+PLUS and, with the termination of the ICM contract after only one year, the ability of the model to sustain these assumed contracted savings and continue to provide services is unproven. On the other hand, according to the Bailit Health Purchasing Firm, which conducted an analysis for HHSC in 2008, STAR+PLUS HMOs have been able to manage their expenses and show positive net income, even with the savings assumptions built into the capitated rates.

PCCM has a longer experience serving the ABD population than ICM, but, as Bailit (2008) points out, sufficient data are still lacking to support the cost-effectiveness of the program. The information that is available suggests that in an urban area, PCCM offers significantly less cost control than STAR+PLUS. A preliminary review by the Texas Medicaid and Healthcare Partnership (TMHP, 2009) found savings of about 3.1 percent for PCCM acute care services relative to FFS (about one-fifth the level assumed for STAR+PLUS). Moreover, no cost efficiencies can be expected for LTSS since those services are not integrated into the enhanced PCCM model.

In addition to the record on efficiency discussed above, the state's tax code includes a 1.75 percent tax on HMO premiums that indirectly improves the cost-effectiveness of STAR+PLUS relative to the non-capitated PCCM and ICM models. This premium tax results in significant net dollars to the state. HHSC estimates that expanding STAR+PLUS to the Dallas/Tarrant ABD population could further increase revenue by $10 million over the next biennium depending on how quickly the model could be implemented. Neither enhanced PCCM nor ICM are subject to the premium tax.

For the next biennium, including both cost efficiencies and proceeds from the existing premium tax, HHSC estimates that implementing STAR+PLUS would produce up to a $20 million benefit in general revenue relative to ICM and up to $25 million compared to PCCM.

Quality/Satisfaction

A review of nationally recognized outcome measures indicates that STAR+PLUS has delivered cost efficiencies while maintaining quality of care at similar levels to other service models. As Bailit notes, quality reports regarding care provided for STAR+PLUS have been "generally positive" (p. 48, 2008). Controlling costs, while providing quality health care, can be achieved through timely and effective out-patient treatment that prevents expensive and unwanted acute hospital stays and emergency room visits. ICHP (2006 and 2007), on behalf of HHSC, has prepared several reports measuring the rate at which Medicaid clients visit the hospital for these ambulatory care sensitive conditions (ACSCs).[1] These reports consistently reveal few differences between FFS clients on Supplemental Security Income (SSI), PCCM clients on SSI,[2] and STAR+PLUS across a range of ACSCs such as complications from diabetes, COPD, dehydration, angina, and urinary tract infection. In a 2005 study, ICHP found that compared to FFS beneficiaries, STAR+PLUS beneficiaries had fewer hospital stays related to their condition, had fewer hospitalizations with a primary diagnosis of an ACSC, and were less likely to visit an emergency room due to an ACSC.

Consumers also appear relatively pleased with STAR+PLUS. Eighty-eight percent of disabled/under age 65 beneficiaries reported that they were satisfied or very satisfied with the assistance they received from their STAR+PLUS service coordinator (ICHIP, 2008), and 93 percent of aged/over age 65 beneficiaries reported that it was easy to get help from their care coordinator (Texas Health Quality Alliance, 2001).

Data regarding quality of care for the short-lived ICM pilot are not available.

Impact on DSH and UPL

The Centers for Medicare and Medicaid Services (CMS) prohibits DSH and UPL payments to public hospitals that receive capitated reimbursements from Medicaid HMOs. The three models under consideration preserve full DSH and UPL payments to public hospitals. PCCM and ICM are not capitated. Claims under these systems are paid the same as under FFS. STAR+PLUS in-patient claims are carved out and paid through FFS so that there is no DSH or UPL impact. Despite the inpatient carve-out, STAR+PLUS HMOs are still contractually required to reduce in-patient hospital utilization by their clients. Additionally, physician UPL revenues would be preserved by using current intergovernmental transfer (IGT) amounts to support higher rate payments in the capitated model.

Integrated Delivery

While enhanced PCCM allows for a degree of care coordination through PCPs, the model does not offer beneficiaries a full range of integrated services. PCCM includes care management only to the two percent of clients with the highest level of need. Moreover, PCCM neither coordinates the delivery of long-term services, nor serves dual-eligibles.

In comparison, STAR+PLUS and ICM were designed specifically for the ABD population and offer a high degree of integration. Both models coordinate acute and long-term services, provide all beneficiaries with a service coordinator, include unlimited prescriptions, and offer other value-added services. Each allows flexibility in benefits, so, for example, non-Medicaid covered services could be substituted for Medicaid services.

[1] ACSCs refer to those conditions that are not expected to result in in-patient or ER use if there is good access to care in the outpatient setting.
[2] SSI pays monthly cash benefits to people who are age 65 or older, those who are blind, or those who have a disability and who are low income.

Table 1

Comparison of Service Coordination Models for the Aged, Blind, and Disabled Population

Model	Advantages	Disadvantages
Enhanced PCCM	• Vendor is in place. • Targets highest cost and risk cases for intervention. • PCP coordinates some acute care services. • Established administrative structure.	• Requires a waiver to include dual-eligibles, offers community-based alternative (CBA) type services and extra benefits (e.g., unlimited Rx). • Provides care management only to top two percent high cost/risk SSI members on a monthly basis. • Does not integrate or coordinate delivery of long-term services and supports (LTSS). • Does not address the dual-eligible population. • Does not provide ongoing case management.
STAR+PLUS	• Integrates acute and LTSS. • Provides all SSI with service coordinator. • Provides SSI clients that qualify for the 1915(c) waiver access to waiver services without being placed on an interest list. • Provides extra benefits (unlimited Rx, service coordination, well visits, value added services). • Allows flexibility in benefits (can provide non-Medicaid covered services as service substitutions). • Transfers risk for the cost of health care services from the state to the HMO. • Facilitates utilization of preventive health care and community support services. • Established administrative structure.	• Requires a waiver to include dual-eligibles, offers CBA-type services and extra benefits (e.g., unlimited Rx). • Requires a procurement and implementation (one to two years). • Some providers may be reluctant to enroll in a capitated reimbursement model.
New ICM	• Opportunity to test acute/LTSS non-capitated model with another vendor. • Challenges known, so improvements in the design and implementation can be made. • Integrates acute and LTSS. • Provides all SSI with service coordination. • Enrolls and coordinates care for dual-eligibles. • If cost-effective, can provide extra benefits with savings (unlimited Rx, service coordination, well visits, value added services).	• Requires a waiver to include dual-eligibles, offers CBA type services and extra benefits (e.g., unlimited Rx). • Model is complex and requires coordination between multiple parties to authorize services. • Issues with accountability between parties. • Cannot offer alternative or substitute services like STAR+PLUS. • Financial risk remains with the state. • HHSC cancelled pilot after one year.

IV – Recommendations/Conclusion

History and data support expansion of STAR+PLUS as the best option to provide integrated health services to the ABD population in the urbanized Dallas/Tarrant county SDA. Table 1 summarizes the relative strengths and weaknesses of each of the three models.

Of the three models, STAR+PLUS is the only proven approach that meets all criteria specified by the Legislature, including cost-effectiveness, integration of services, and preservation of UPL and DSH payments. STAR+PLUS was created to serve the ABD population and has a long tenure of operation in Harris County, providing fully integrated acute and long-term care services.

By aligning financial incentives in favor of preventive health care, disease management, and community support services, HHSC projects that implementation of STAR+PLUS would help produce $20-$25 million in savings to the state over the next biennium, result in more budget certainty than other potential delivery systems, and maintain or even improve the quality of care that beneficiaries currently receive.

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