

A Blueprint for the Integration of Acute and Long Term Care Services: Implementation of Phase I of the Regional Model, Effective September 1, 2007

Governor Timothy Kaine, with support from the 2006 General Assembly, set in motion a major reform of the Virginia Medicaid funded long-term care services program, which will focus on care coordination and integration of acute and long-term care services for our most vulnerable citizens—low-income seniors and individuals with disabilities. The legislation (*Special Session I, 2006 Virginia Acts of Assembly, Chapter 3*) directed the Department of Medical Assistance Services (DMAS), in consultation with the appropriate stakeholders, to develop a long range blueprint for the development and implementation of an integrated acute and long-term care system. In addition to this plan, the Department was directed to move forward with two different models for the integration of acute and long-term care services: a community model and a regional model. Finally, the legislation provided \$1.5 million in start-up funds for six potential PACE sites.

The degree of chronic illness and disability among seniors and individuals with disabilities is a key policy and budget issue for the Commonwealth. Seniors and individuals with disabilities make up 30 percent of the Medicaid population in the state, but 70 percent of the costs of a budget that now exceeds \$5 billion annually. The challenge is how to curb Medicaid growth in the long run without compromising access to services for vulnerable populations. While Virginia has been successful in implementing managed care for low-income children and families, it has not applied the same successful principles to programs specifically designed for the long-term care populations. Currently in Virginia, most Medicaid seniors and individuals with disabilities receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care is provided in a fee-for-service environment with no chronic care management. Long-term care is provided in a nursing facility or by a variety of home and community-based care providers with no overall care coordination or case management. In addition, most Medicaid seniors and individuals with disabilities qualify for both Medicare and Medicaid, which further complicates the access, quality, and funding of an integrated system.

Virginia is one state that moved forward with moving the elderly and disabled into managed care years ago. At the present time, more than 49,000 elderly and disabled have their health care needs successfully managed by one of seven managed care organizations (MCOs) across Virginia. However, once these clients need long-term care services and/or become both Medicaid and Medicare eligible (known as dual eligibles), they are moved out of a managed care environment into a fragmented fee for service environment with little or no coordination of their health care and long-term care needs. This disruption in care is not good for the enrollee and is costly for the Commonwealth. In response to the above mentioned legislation, DMAS will implement a program change that will expand its current managed care population by retaining those enrollees in managed care once they require long term care services.

Effective September 1, 2007, once the enrollee is approved for long term care services (excluding those enrollees receiving Technology Assisted Waiver, nursing facility, and PACE services); they will remain in the MCO for their primary and acute medical care services. Their home and community based care waiver services, including transportation to the waived services, will be coordinated by the MCO but paid through the Medicaid fee for service program. This program change will not address the dual eligibles; all services for these enrollees will still be moved out of managed care when they become Medicare eligible. Phase I will impact approximately 505 enrollees per year.

Phase II of the integration plan begins the full integration of both the primary and acute care needs and the long term care services under one managed care organization. The focus will be on providing the right services at the right time and allowing our elderly and persons with disabilities to make one call to get all their care needs coordinated. This phase will begin implementation in 2008.

Phase I: Process Flow
Implementation: September 1, 2007

Enrollee is entered into a managed care organization (MCO)
 (Excludes all enrollees with a TPL including Medicare beneficiaries)

Enrollee requires LTC services once they have entered the hospital or
 has a need and is still in the community

Pre-Admission Screening Team and hospital screeners determine
 LTC need using the UAI. The CSB and CDCs use the LOF to
 determine LTC for the MR/DD Waivers.

