



# Integrated Care for Medicare-Medicaid Enrollees

Virginia Department of Medical Assistance Services

March 21, 2012

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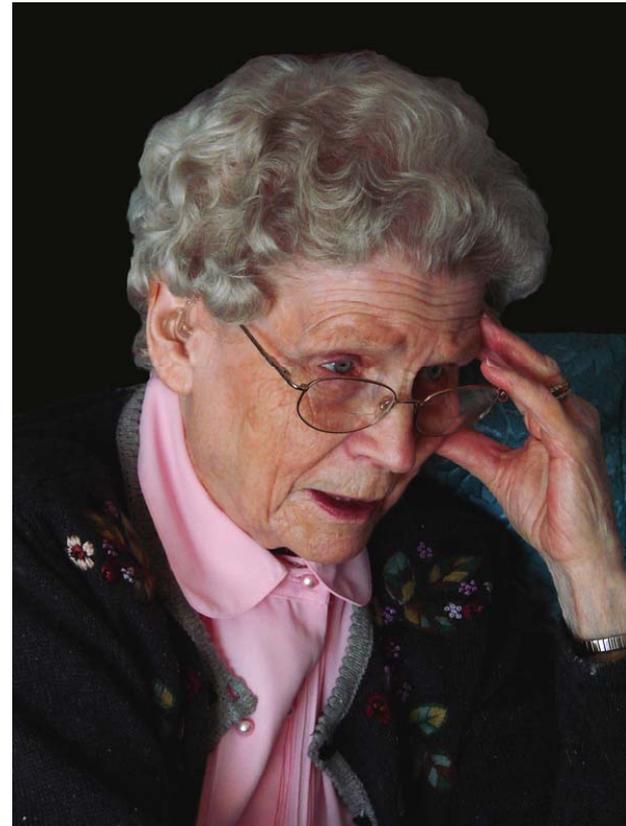
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## Meet Mrs. Smith

- 79 year old widow
- Retired teacher
- lives alone
- Resources: Social Security, Medicaid and Medicare
- Daughter, lives 10 miles away with three teenagers
- She has five chronic conditions
- Three physicians
- Takes eight medications





## In 2011, Mrs. Smith has had...

- 19 outpatient visits
- 3 hospital admissions
- 6 weeks sub-acute care
- 2 nursing home stays
- 5 months homecare
- 6 community referrals
- 22 scripts
- 8 medications
- 8 physicians
- 6 social workers
- 5 physical therapists
- 4 occupational therapists
- 37 nurses
- 2 home care agencies



## Why Focus on Integrating Care?

- Mrs. Smith:
  - Confused by care and multiple medications;
  - Discouraged;
  - Takes medications inconsistently.
- Mrs. Smith's Daughter:
  - Stressed out;
  - Reduced work to half-time;
  - Considered a nursing home.



# Characteristics of Fragmented System

Medicare Paid Services	Medicaid Paid Services
<ul style="list-style-type: none"> <li>➤ Hospital care</li> <li>➤ Physician &amp; ancillary services</li> <li>➤ Skilled nursing facility (SNF) care</li> <li>➤ Home health care</li> <li>➤ Hospice</li> <li>➤ Prescription drugs</li> <li>➤ Durable medical equipment (DME)</li> </ul>	<ul style="list-style-type: none"> <li>➤ Medicare cost sharing</li> <li>➤ Nursing home</li> <li>➤ Hospital and SNF once Medicare benefits exhausted</li> <li>➤ Optional services (vary by state): dental, vision, home- and community-based services, personal care, and select home health care</li> <li>➤ Some prescription drugs not covered by Medicare</li> </ul>
	<ul style="list-style-type: none"> <li>➤ DME not covered by Medicare</li> </ul>



## Consequences of Fragmented System

	Dual Eligibles	Providers	Payors
Administrative burden	<ul style="list-style-type: none"> <li>• Multiple cards to access services (Medicare, Medicaid, prescription drugs)</li> <li>• 3 different sets of benefits and program rules</li> </ul>	<ul style="list-style-type: none"> <li>• Conflicting program rules and requirements</li> <li>• non-unified service authorization</li> <li>• Conflicting claims/billing processes</li> <li>• Coordination of benefits – need to bill multiple payors</li> <li>• Multiple ID cards</li> </ul>	
Fragmented care	<ul style="list-style-type: none"> <li>• Multiple providers who rarely communicate</li> <li>• Health care decisions uncoordinated and not made from patient-centered perspective</li> <li>• Gaps in care</li> <li>• Poorly planned transitions can result in readmissions</li> <li>• Serious consideration for nursing home placement</li> </ul>	<ul style="list-style-type: none"> <li>• Poor communication between providers</li> <li>• No incentives to coordinate care</li> <li>• Incomplete history on recipients</li> <li>• transitions and discharges may be poorly facilitated</li> </ul>	<ul style="list-style-type: none"> <li>• Unnecessary and duplicative services which increase costs</li> </ul>



## Consequences of Fragmented System

	Dual Eligibles	Providers	Payors
Quality	<ul style="list-style-type: none"> <li>• Lack of quality measurement &amp; monitoring</li> <li>• Unnecessary, duplicative, or missed services</li> <li>• Poorer health outcomes</li> <li>• Incomplete information</li> <li>• Follow up after discharge</li> </ul>	<ul style="list-style-type: none"> <li>• Poor communication between providers</li> <li>• No incentives to coordinate care</li> <li>• Incomplete history on recipients</li> <li>• limited transition and discharge communications</li> </ul>	<ul style="list-style-type: none"> <li>• Undesirable recipient outcomes</li> <li>• Care provided in less than optimal settings</li> <li>• Lack of quality oversight</li> </ul>
Costs	<p>May get balance billing invoices in error</p>	<p>Decisions may be influenced by highest payor</p>	<ul style="list-style-type: none"> <li>• Financial misalignment</li> <li>• Cost shifting</li> <li>• Reduced budget predictability &amp; ability to control costs</li> </ul>



## Core Elements of Capitated Model

- Strong primary care base;
- Comprehensive provider network;
- Care coordination;
- Interdisciplinary care teams;
- Person-centered plan of care;
- Data-sharing and communications system;
- Quality monitoring; and,
- Adequate consumer protections (e.g., choice of providers; access to a unified set of grievances and appeals rights; and, customer service assistance).



## Stakeholder Involvement

- During design phase, contribute to discussion of critical elements in models.
  - Draft Proposal will be posted for two, 30 day public comment periods; by DMAS mid-April and by CMS June/July.
- During implementation, contribute to outreach and real-time feedback.
- Post implementation, contribute to monitoring and evaluation.
- Dedicated e-mail box ([DualIntegration@dmas.virginia.gov](mailto:DualIntegration@dmas.virginia.gov)).



## Capitated Model – CMS Requirements

- CMS/MMCO requiring States and health plans follow Medicare Advantage (MA) and Part D processes, criteria and timelines.
  - Plans upload information via CMS' Health Plan Management System (HPMS) website, including: formulary, Medication Therapy Management Program, networks, benefits, Model of Care.
  - Implementation coincides with Medicare Advantage open enrollment period.



## Capitated Model – CMS Requirements

- States and CMS develop: quality performance plan and measures, Model of Care criteria, grievance and appeals process, marketing rules, etc., but with heavy reliance on Medicare rules.
- State rules apply to: long-term care networks; credentialing; and, health plan solvency.
- States awaiting further guidance from CMS/MMCO on specific design elements.



# Proposed Capitated Model Design

- Geographic service areas
- Populations
- Enrollment process
- Services
- Person-centered care coordination
- Reimbursement
- Quality Monitoring
- Expected outcomes



# Geographic Service Areas

- Demonstration areas to include:
  - Central Virginia (42 localities);
  - Northern Virginia (11 localities);
  - Tidewater (13 localities); and,
  - Western/Charlottesville (14 localities).
- Demonstration regions selected because of their strong health systems, market characteristics, and the size of the regions' populations.
- Two or more health plans will operate in each region.



# Population

- Will include:
  - Approximately 57,600 adult (aged 21 and over) full-benefit dual eligibles who are:
    - Eligible for Medicare A, B and D;
    - Eligible for full Medicaid benefits;
    - Approximately 7,880 are EDCD waiver participants;
      - 5,916 agency directed and 1,964 consumer directed.
      - Technology Assisted waiver in Year 2;
    - Approximately 6,300 Residing in nursing facilities;
    - Some individuals in Assisted Living Facilities.



# Population

- **Will exclude:**
  - Individuals < 21 years old;
  - Individuals in the following Home and Community Based Services Waivers:
    - Individual and Family Developmental Disabilities;
    - Intellectual Disabilities;
    - Day Support;
    - Alzheimer's;



# Population

- **Will exclude:**

- Individuals in State mental hospitals, ICF/MR facilities, Residential Treatment Facilities, long stay hospitals;
- PACE participants (although they may choose to opt in);
- Individuals enrolled in Money Follows the Person;
- Individuals enrolled in Hospice at the time of implementation; and,
- Individuals with other comprehensive group or individual health insurance.



## Enrollment Process

- CMS is allowing passive enrollment with opt out during open enrollment and any time thereafter.
- DMAS can assign an individual to a health plan if he/she does not select one.
- Individuals can change from one health plan to another in his/her geographic region or opt out and return to FFS.



# Services Under Capitation

- **Medicare** services:
  - Medicare A services;
  - Medicare B services; and
  - Medicare Part D pharmacy.
    - Including Medication Therapy Management Programs.
      - Targets recipients who have multiple chronic diseases, are taking multiple medications, and are likely to incur annual drug costs that exceed a predetermined level;
      - Partnership between pharmacist, the recipient or caregiver, and other health professionals (as needed); and,
      - Promotes the safe and effective use of medications and optimizes health outcomes.



# Services Under Capitation

- **Medicaid** acute and long term care services:
  - Current Medicaid state plan primary and acute care services, including mental health and transportation services.
  - All EDCD waiver services:
    - Including adult day health care, personal care (agency and CD), personal emergency response systems and medication monitoring, respite care (agency and CD), transition coordination, transition services.



## Services Under Capitation

- Medicaid acute and long term care services:
  - Nursing facility care.
  - New and additional services:
    - Person-centered care coordination;
    - 24-hour/7 days a week access line;
    - Disease and chronic care management (if applicable); and,
    - Health plans may add supplemental/enhanced services, such as dental care, vision, and hearing.



# Person-Centered Care Coordination

- Health Risk Assessments
- Interdisciplinary care teams
- Individualized care plans
- Use of evidence-based practices
- Levels of coordination based on needs (basic/enhanced)
- Coordinate referrals to non-covered supportive services
- Technology to assist communication between team members/providers/enrollees
- Hospitalist and care transition programs
- Health Education
- 24/7 nurse advice line



## Reimbursement

- Plans will receive a capitation rate that will reflect the integrated delivery of the full continuum of Medicare and Medicaid benefits.
  - In past, cost of care coordination could not be offset by Medicaid savings (savings on acute care services would go to Medicare); this model provides shared savings to resolve issue.



# Reimbursement

- Rates will be developed by CMS in partnership with States based on baseline fee-for-service spending in both programs and anticipated savings that will result from integration and improved care management.
  - Part D portion of the rate will be based on the standardized national average bid amount and will be risk adjusted in accordance with the rules that apply for all other Part D plans.
- CMS requires that rates provide upfront savings to both CMS and States.



# Reimbursement

- CMS and its actuary will work with States and its actuary to determine the portion of the capitated payment paid by CMS (for Medicare) and the State (for Medicaid).
- Rates will be risk-adjusted.
- Plans will be subject to quality & performance withholds (1, 2 and 3 percent in Years 1, 2 and 3, respectively).
  - Can earn back if meet objectives; 1<sup>st</sup> year objectives may be process measures (e.g., submitting encounter data).



# Quality Monitoring

The demonstration will include monitoring to ensure that individuals receive, and MCOs are accountable for providing, high quality care.

- DMAS and CMS will monitor:
  - Provider network adequacy
  - Grievances and appeals
  - MCO quality improvement plans
  - MCO Model of Care and Medication Therapy Management Programs
- Types of quality measures may include:
  - HEDIS or HEDIS type measures appropriate for the enrolled population
  - Hospital admissions and readmissions
  - Emergency Room use
  - Up to date individualized care plans
- External Quality Review Organization and Independent Evaluation



# Expected Outcomes

	Dual Eligibles	Providers	Payors
Administrative simplification	<ul style="list-style-type: none"> <li>• One ID card to access services</li> <li>• One set of comprehensive benefits: primary, acute, behavioral, prescription drugs, and long-term care services and supports</li> </ul>	<ul style="list-style-type: none"> <li>• One set of program rules and requirements</li> <li>• One claims/billing process</li> <li>• One ID card</li> <li>• One place to call for service authorizations</li> </ul>	<ul style="list-style-type: none"> <li>• No coordination of benefits</li> </ul>
Coordinated care	<ul style="list-style-type: none"> <li>• Single, coordinated care team</li> <li>• Health care decisions based on the individual's needs and preferences</li> <li>• Availability of flexible, non-medical benefits that help recipient stay in their homes</li> <li>• Help with transitions</li> <li>• Health education and monitoring</li> </ul>	<ul style="list-style-type: none"> <li>• Interdisciplinary care teams</li> <li>• Incentives to coordinate care</li> <li>• Facilitated transitions and discharges</li> </ul>	<ul style="list-style-type: none"> <li>• Appropriate service utilization - reduced unnecessary utilization</li> </ul>



# Expected Outcomes

	Dual Eligibles	Providers	Payors
Quality	<ul style="list-style-type: none"> <li>• Improved quality of life</li> <li>• Improved health</li> <li>• Easier navigation of system</li> <li>• Improved access</li> <li>• Fewer hospital/ER visits</li> <li>• Care in settings of choice</li> </ul>	<ul style="list-style-type: none"> <li>• Better communication between providers</li> <li>• Hospitalists/SNFists/extenders to help ensure all appropriate services are received</li> </ul>	<ul style="list-style-type: none"> <li>• Better health outcomes</li> <li>• Care provided in optimal settings</li> <li>• Reduce avoidable IP/ER</li> </ul>
Costs	<ul style="list-style-type: none"> <li>• Less time spent navigating multiple systems</li> <li>• Enhanced benefits possible (dental, vision, meals-on-wheels etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Interdisciplinary care team, Hospitalists/transition coordinators/physician extenders to help manage care</li> </ul>	<ul style="list-style-type: none"> <li>• Savings from better care</li> <li>• Increased budget predictability &amp; ability to control costs</li> </ul>



## Tasks overview

- Stakeholder input throughout entire demonstration;
- DMAS drafts a proposal and posts for 30 day public comment period Mid-April to Mid May;
- Submit proposal to CMS by May 31; second 30 day public comment period June - July;
- CMS and state develops a Memorandum of Understanding for state participation in the demonstration (signals acceptance into demonstration);
- Develop Health Plan Request for Proposals;
- Release final Request for Proposals;



## Tasks overview, cont'd.

- Interested plans respond to RFP and submit information to HPMS website;
- DMAS submits 1915(b)(c) waiver application to CMS;
- CMS and state make plan selections;
- CMS and state conduct health plan readiness review;
- Three-way contracts signed (CMS, DMAS and health plans);
- Beneficiary notification/open enrollment period;
- Demonstration start – runs three years;
- National evaluation of demonstration;
- If successful, program can be made permanent.



# Summary

- **How will integrated care impact...**
  - **Nursing Facilities?**
    - Streamline billing and support nursing facilities in providing person-centered care;
    - Coordinators help improve access to acute and primary services
    - Address three-day hospital stay Medicare requirement.
  - **Hospitals?**
    - Streamline billing and increase the resources hospital discharge planners have to expedite transitions and discharges;
    - Reduce unnecessary re-admissions.
  - **Long-Term Care Providers?**
    - Provide increased access to supports that enable participants to reside in the setting of their choice.



## Summary

- **How will integrated care impact...**

- **State Agencies?**

- Preadmission screenings conducted in the community will continue to be done by a nurse from the local health department and a social worker from the local department of social services.
- Screenings will determine eligibility for NF level of care, offer choice of institution, PACE, or waiver services.



## Summary

- **How will integrated care impact...**
  - **Health plans?**
    - Offer streamlined access to quality health and long-term care services, person-centered care coordination, and referrals to appropriate community resources.
    - Ensure consumer protections.
    - Provide access to comprehensive provider networks.
    - Responsible for quality oversight and reporting.
    - Comply with many Medicare Part C and D requirements; submit data via HPMS.



## How will integrated care impact enrollees and their families?

**Improved: health care, health and quality of life; ease of access; better communication between providers; and support care in setting of choice.**





*Department of Medical Assistance Services*



## Letters of Support

DMAS is gathering letters of support to include with the proposal package. Letters of support must be included in the proposal sent to CMS by May 31. Please send your letter of support to DMAS care of Cindi B. Jones by May 20, 2012 but address to the letter to:

Melanie Bella  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Proposal comments and letters of support may be sent to DMAS electronically at [dualintegration@dmass.virginia.gov](mailto:dualintegration@dmass.virginia.gov). Your support is greatly appreciated.



# Comments



Not able to comment today? Submit comments in writing today or at [Dualintegration@dmas.virginia.gov](mailto:Dualintegration@dmas.virginia.gov)



## Additional Meetings

Date/Time	Interest Group	Location
March 21, 2012 2:00 – 4:00	Nursing Facilities & Hospitals	DMAS Meeting Room 7
March 23, 2102 10:00 – Noon	Community long-term care & behavioral health	DMAS Meeting Room 7
March 26, 2012 2:00 – 4:00	Health Plans	DMAS Meeting Room 7
March 28, 2012 10:00 – Noon	Potential enrollees, family members & advocates	DMAS Meeting Room 7
March 28, 2012 2:00 – 4:00	State agencies & other contractors	DMAS Meeting Room 7

RSVP to [dualintegration@dmas.virginia.gov](mailto:dualintegration@dmas.virginia.gov)