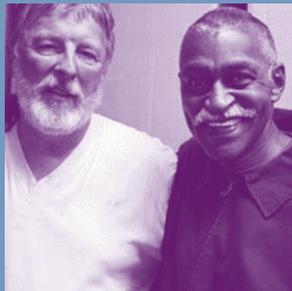


CHCS

Center for
Health Care Strategies, Inc.



Medicare-Medicaid Integration: National Update



Virginia Stakeholder Meeting
March 21, 2012



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Center for Health Care Strategies

- I decide where and with whom I live.
- I make decisions regarding my supports and services.
- I work or do other activities that are important to me.
- I have relationships with family and friends I care about.
- I decide how I spend my day.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect.



Outcomes for the Wisconsin Family Care Partnership

Focus on improved quality of life
and better health outcomes

<http://www.dhs.wisconsin.gov/LTCare/Reports/>

Overview

- What is Integrated Care?
- National Leaders in Improving Care
- Now is the Time
- Ideas for Stakeholder Input

What is wrong with how things are now?

Two distinct programs, not designed to work together:

- Not person-centered and very confusing for beneficiaries
- No quality oversight across the entire spectrum of benefits
- Benefits and program rules are not aligned
- Program financing promotes “cost shifting” between states and federal government and limit innovation

Programs not designed to support individual choice of setting:

- Facility-based care is an “entitlement”
- HCBS often has waiting lists
- Limited coordination for HCBS participants across all service areas

What is Integrated Care?

- Creates one accountable entity to coordinate delivery of primary/preventive, acute, behavioral, and long-term services and supports (LTSS)
- Promotes and measures improvements in quality of life and health outcomes
- Promotes the use of home- and community-based long-term services and supports
- Blends/aligns Medicare's and Medicaid's services and financing to streamline care and eliminate cost shifting
- Slows the rate of both Medicare and Medicaid cost growth

AND, most importantly...

- Provides high-quality, person-centered care for Medicare-Medicaid enrollees that is sensitive to their needs and preferences

National Leaders in Integrated Care (1995-2012)

State	Name of Program	Type of Program
Arizona	ALTCS	Managed Long-Term Services (MLTS) with Special Needs Plan (SNP) enrollment option
Hawaii	QExA	MLTS with SNP enrollment option
Massachusetts	Senior Care Options	Fully integrated MLTS and Medicare
Minnesota	MN Senior Health Options	Fully integrated MLTS and Medicare
New Mexico	CoLTS	MLTS with SNP enrollment option
Tennessee	CHOICES	MLTS only
Texas	STAR+PLUS	MLTS with SNP enrollment option
Wisconsin	Family Care Partnership	Fully integrated MLTS and Medicare

Leading States' Reasons to Pursue Integrated Care

- Use integrated care to **decrease and/or end waiting lists** for home- and community-based waiver services (Hawaii, Texas and Wisconsin)
- Provide a **more flexible set of benefits** and more choice than typically found in Medicaid FFS, particularly for community based care (Minnesota and Massachusetts)
- Strengthen the **quality of care** and/or build upon existing managed care experience and/or infrastructure (Arizona and Tennessee)

Source: A. Lind, S. Gore, L. Barnette, and S. Somers. *Profiles of State Innovation: Roadmap for Managing Long-term Supports and Services*. Center for Health Care Strategies, November 2010. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261187.

Include attendant care and/or paid family caregivers in benefit package

Arizona's ALTCS program:



- Includes paid family members as caregivers through traditional attendant or self-directed attendant care program
- Training includes CPR, first aid, infection/disease control
- Spouse as paid caregiver (up to 40 hours per week) recently added to program
- Supplemental benefits include oral health care and vision services

Structure benefits to appropriately incentivize the right care

Tennessee CHOICES:



- TennCare CHOICES plans are responsible and at-risk for providing the full continuum of LTSS services, including nursing facility and HCBS, in addition to all primary, acute, and behavioral health services for eligible members.
- Care management/coordination is included.
- Fewest exclusions are the ideal!

Expansion has been Slow



- Previous vehicles for integration have not achieved broad scale, full integration
- Administrative hurdles
- States' reluctance to invest in upfront costs
- Lots of anecdotal evidence of improved care, but limited funding for empirical research



WHY NOW?

New Opportunities & Support: Integrated Care



- Affordable Care Act established the Medicare-Medicaid Coordination Office, which is helping states to design integrated care programs.
- Opportunity to combine Medicare and Medicaid funding streams.
- Substantial interest from states.
- Beneficiaries and advocates understand that they have a lot to gain from integrated care.

Who pays for what services?

MEDICARE

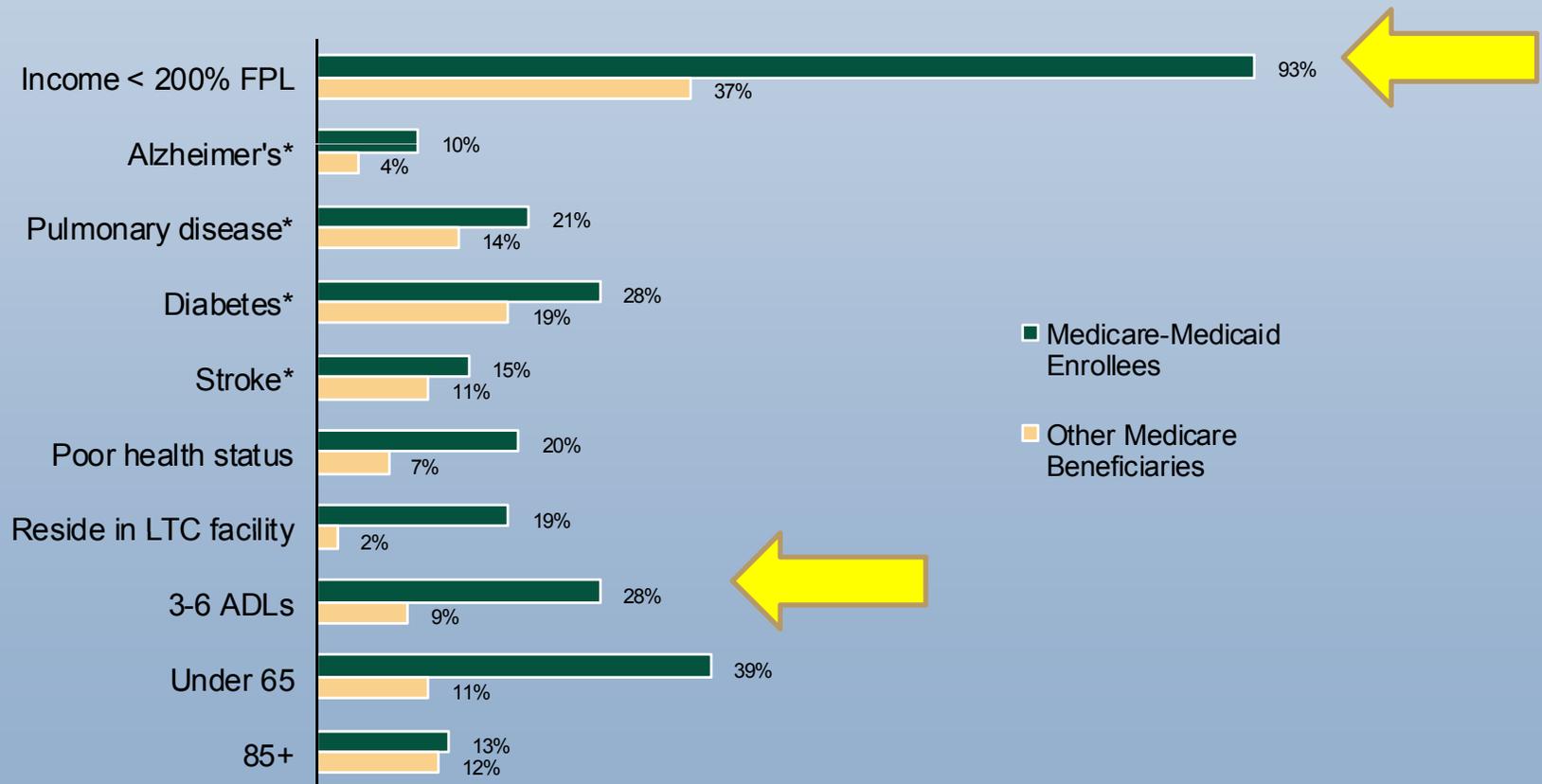
- ▶ Hospital care
- ▶ Physician & ancillary services
- ▶ Skilled nursing facility (SNF) care (up to 100 days)
- ▶ Home health care
- ▶ Hospice
- ▶ Prescription drugs
- ▶ Durable medical equipment

MEDICAID

- ▶ Medicare cost sharing
- ▶ Nursing home (once Medicare benefits exhausted)
- ▶ Home- and community-based services (HCBS)
- ▶ Hospital once Medicare benefits exhausted
- ▶ Optional services (vary by state): dental, vision, and select home health care
- ▶ Some prescription drugs not covered by Medicare
- ▶ Durable medical equipment not covered by Medicare

Medicare-Medicaid enrollees are sicker and more functionally impaired than other Medicare beneficiaries

Characteristics of Medicare-Medicaid Enrollees Compared to Other Medicare Beneficiaries, 2005

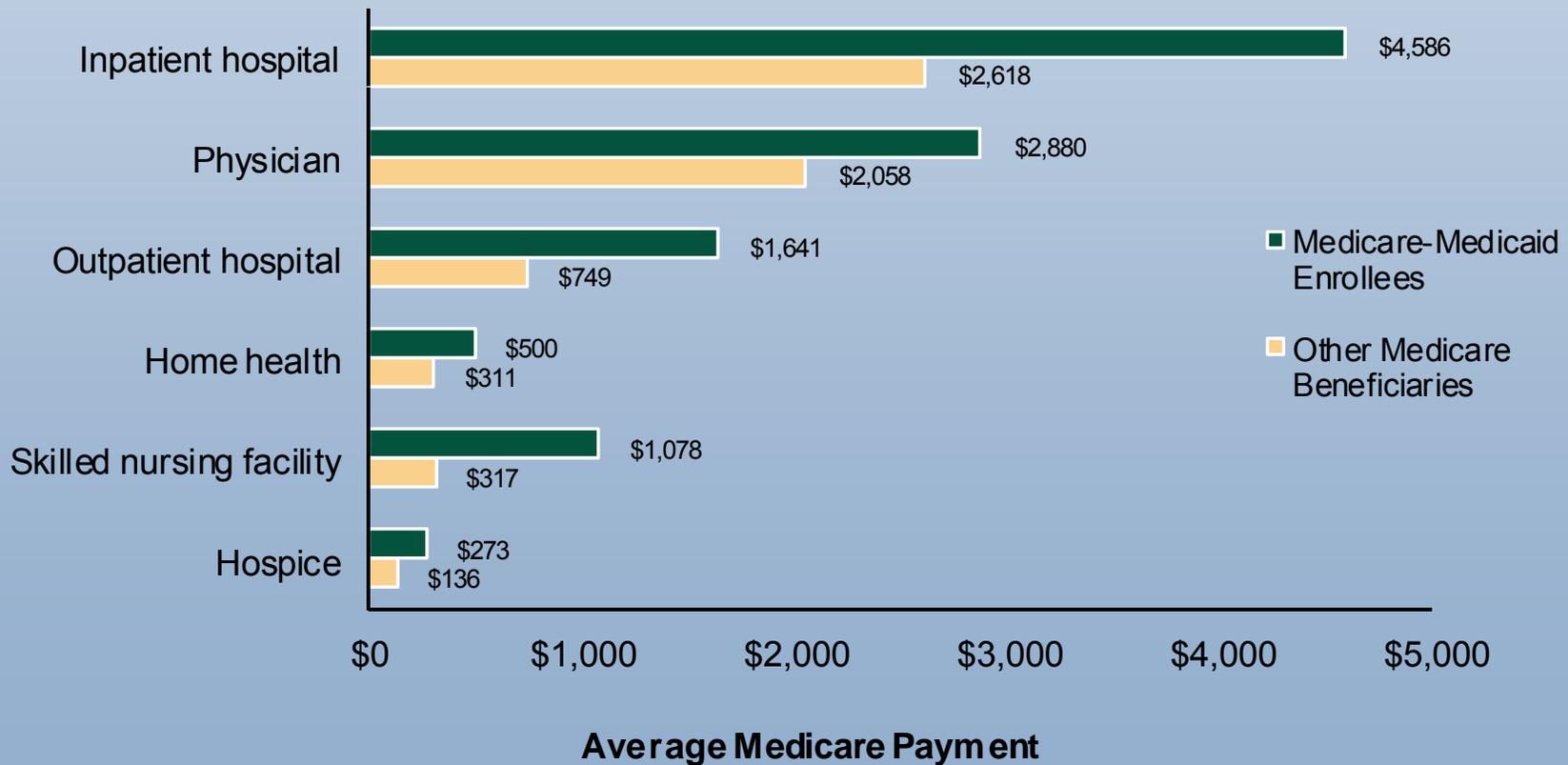


Source: Hilltop Institute -- MedPac, June 2008; based on data from the 2005 MCBS Cost and Use file

*Data from 2003 MCBS http://www.cms.hhs.gov/MCBS/Downloads/CNP_2003_dhsec8.pdf

Costs are higher for Medicare-Medicaid enrollees than for other Medicare beneficiaries across all major services . . .

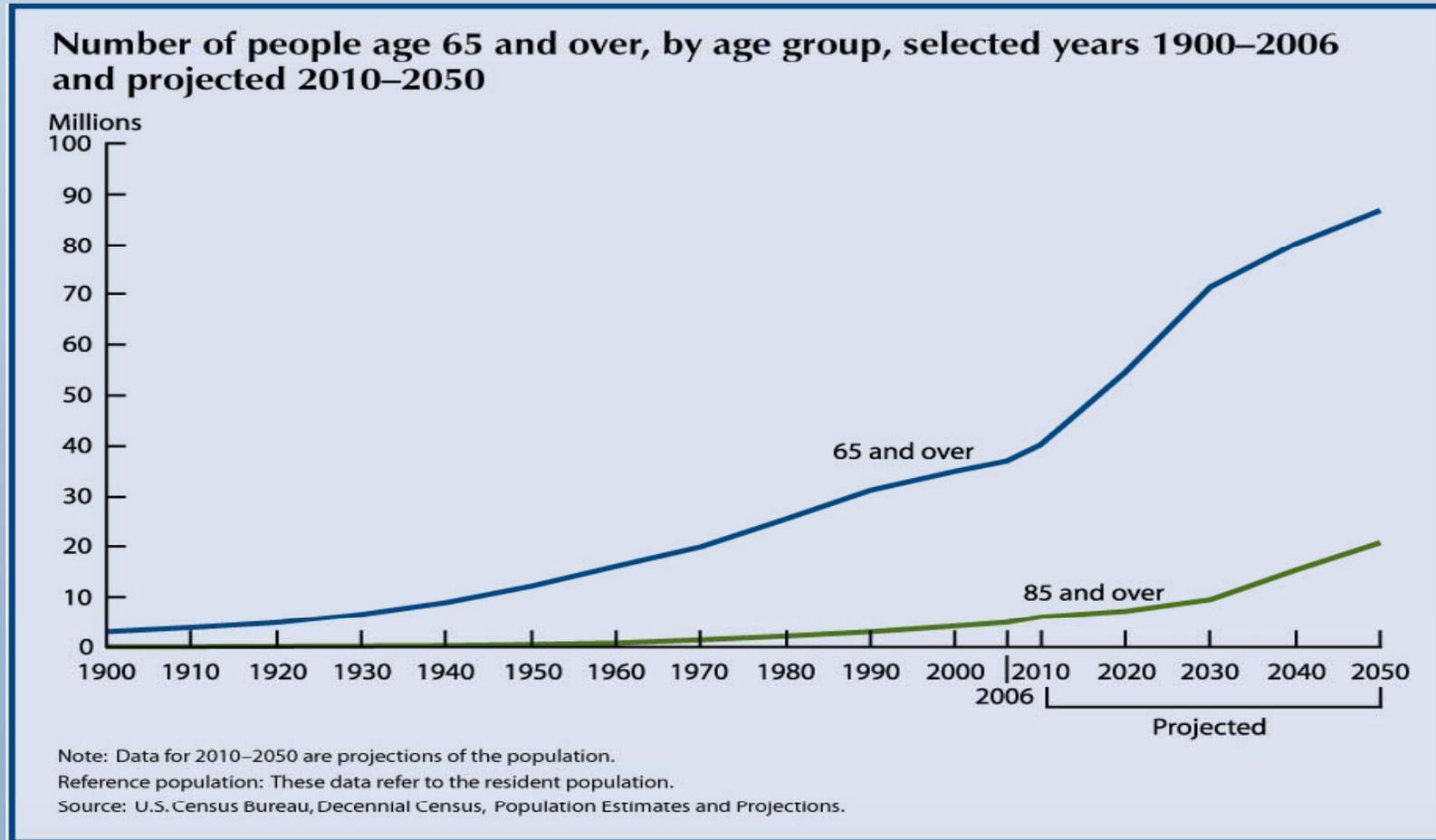
**Average Medicare Payment,
by Service Type and Eligibility Status, 2005**



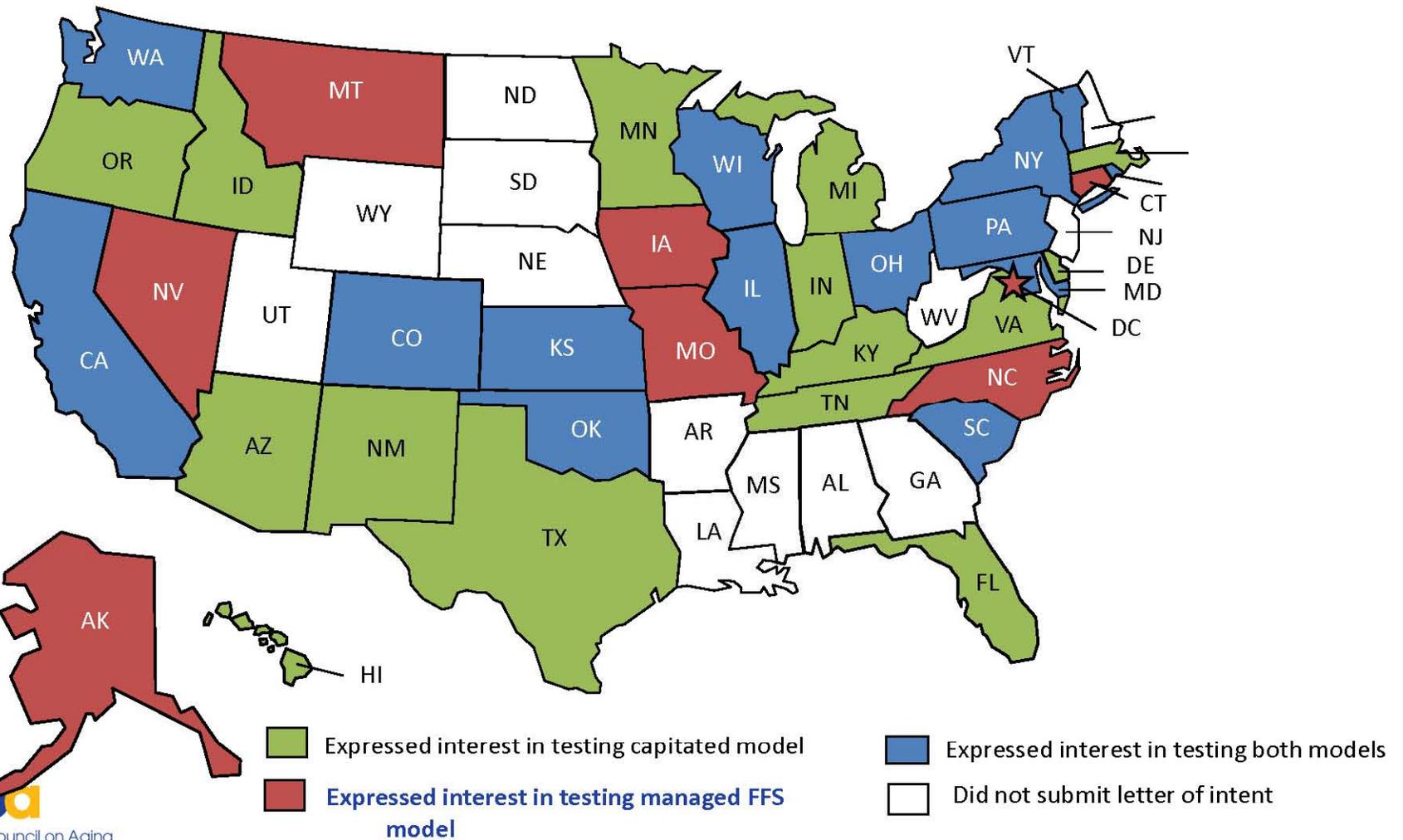
Combined Funding Streams: Federal Financial Alignment Models

- Allow for the Medicare and Medicaid funding streams to be combined.
- Allow states to share in savings that accrue to the Medicare “side.”
- Support investment in Medicaid-funded LTSS services (e.g., personal care, adult day care, facility-based care (when preferred), and others).
- Gives integrated care programs greater flexibility to offer “non-traditional” benefits.

Increasing Demand for Services



States Interested in Duals Integration Models



State Interest: Demonstration Contracts

- \$1 million contracts to support integrated care program design

15 State Design Contracts (Awarded April 2011)	
California	Oklahoma
Colorado	Oregon
Connecticut	South Carolina
Massachusetts	Tennessee
Michigan	Vermont
Minnesota	Washington
New York	Wisconsin
North Carolina	

Financial Alignment Participation

(as of March 13, 2012)

State	Model	Posted?	State	Model	Posted?
Alaska	FFS	No	Indiana	Capitated	No
Arizona	Capitated	No	Iowa	FFS	No
California	Capitated	No	Kansas	Capitated	No
Colorado	FFS	No	Maine	FFS	No
Connecticut	FFS	No	Maryland	Both	Retracted
Florida	Capitated	Retracted	Massachusetts	Capitated	State/CMS
Hawaii	Capitated	No	Michigan	Capitated	State
Idaho	Capitated	No	Missouri	FFS	No
Illinois	Both?	State			

Financial Alignment Participation

continued (as of March 13, 2012)

State	Model	Posted?	State	Model	Posted?
Montana	FFS	Retracted	Rhode Island	Capitated	No
Nebraska	FFS	Retracted	South Carolina	TBD	No
New Mexico	Capitated	No	Tennessee	Capitated	No
New York	Capitated	No	Texas	Capitated	No
North Carolina	FFS	No	Vermont	Capitated	No
Ohio	Capitated	State	Virginia	Capitated	No
Oklahoma	FFS	No	Washington	Capitated	State
Oregon	Capitated	State	Wisconsin	Both	No
Pennsylvania	TBD	No			

Stakeholder Involvement is Crucial!

- During design phase (April 2011 – May 2012)
 - ▶ 15 states received \$1M contracts and 22 additional states submitted Letters of Intent to pursue an integrated model
 - ▶ All States must submit a design proposal to CMS this spring
 - ▶ A robust stakeholder engagement process is required by CMS
 - ▶ Two public notice requirements for design proposals (30 days by state, 30 days by CMS)
- During implementation (May 2012 – January 2013) stakeholders contribute to outreach and real-time feedback on MOU with CMS; and
- Post implementation, stakeholders contribute to monitoring and evaluation.



Focus Areas for Stakeholders

Core Elements of Integrated Care Models

- Person-centered plan of care
- Adequate consumer protections
- Strong primary care base
- Multidisciplinary care team
- Comprehensive provider network
- Robust data-sharing and communications system
- Aligned financial incentives

Source: A. Lind, S. Gore. *From the Beneficiary Perspective: Core Elements to Guide Integrated Care for Dual Eligibles*. Center for Health Care Strategies, December 2010. Available at: www.chcs.org/usr_doc/TCDE_Core_Elements_122010.pdf.

How States Have Involved Stakeholders

- Enrollment
 - ▶ Member materials (WA)
 - ▶ Outreach and education
 - ▶ Use of consumer advocates
- Rate Development
 - ▶ Risk adjustment (MA)
 - ▶ Risk mitigation
- Benefits
 - ▶ Supplemental (AZ)
 - ▶ Delivery options (self-direction, individualized budgeting)



Stakeholder Involvement Opportunities

- **Oversight and Accountability**
 - ▶ Quality measures
 - ▶ Reporting requirements
 - ▶ Ombudsman (MN)
 - ▶ Quality improvement projects
 - ▶ Periodic health plan audits
 - ▶ Readiness review
 - ▶ Report on sentinel events



Promoting Choice of LTSS in Medicaid Managed Care

Mechanism	State
Plans responsible for NF and HCBS under blended capitation rate (full risk, full profit)	MN, NJ, WI
Plans responsible for NF and HCBS under blended capitation rate (risk and profit shared with state)	AZ, HI, TN
HCBS available as an entitlement (enrollment not capped) for NF level of care	TN, TX, WI
Higher rate for HCBS services	MN
Transition allowance benefit	TN
Plans required to work with consumers who want to transition	HI, MN, TN, TX
Performance measures require service timelines for sentinel events	AZ, TN, TX
Performance measure with penalty for NF utilization	TX

Source: Mildred Consulting -- Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services -- Recommendations for California. 2012. http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/Mildred_Flexible_Accounting.pdf

Conclusion

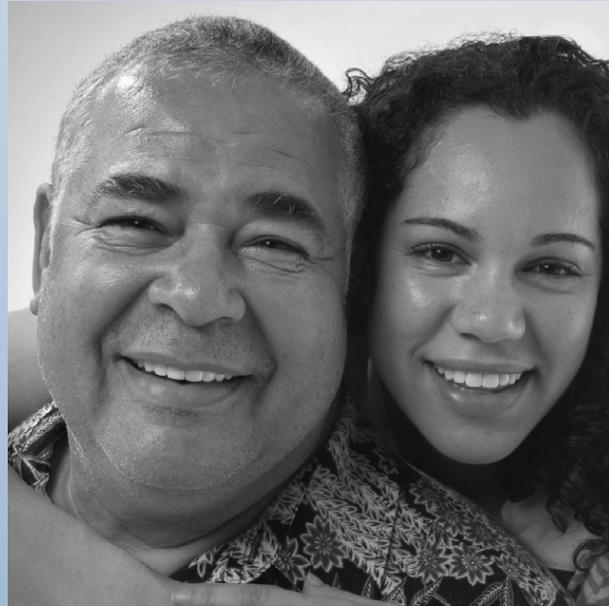
- Collaboration is key!
- Concrete and actionable recommendations are most effective.
- Be candid.
- Talented and quality-driven staff in Virginia.
- Unprecedented opportunity to build on the positive aspects of the current system to improve choice, control, quality of care, and most importantly the quality of life for beneficiaries.

Resources

- The ***Integrated Care Resource Center*** was established by CMS to help states develop and implement integrated care models for Medicaid beneficiaries with high-cost, chronic needs
- Focus on integrating care for: (1) individuals who are dually eligible for Medicare and Medicaid; and (2) high-need, high-cost Medicaid populations via the Health Homes state plan option as well as other emerging models
- Individual and group TA coordinated by Mathematica Policy Research and CHCS
- For more information, visit:

www.integratedcareresourcecenter.com

Thank you!



Questions?