



Department of Medical Assistance Services



Integrated Care for Medicare- Medicaid Enrollees

Virginia Department of Medical
Assistance Services
March 28, 2012

State Agencies & Contractors



www.dmas.virginia.gov

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Why Focus on Integrating Care?

- For the chronically ill, the U.S. health care system is:

Fragmented
Discontinuous
Difficult to access
Inefficient
Unsafe
Expensive

“A nightmare to navigate”

Institute of Medicine, Crossing the Quality Chasm, 2001



Why Focus on Integrating Care?

- Medicare and Medicaid - two distinct programs:
 - Care is fragmented Between Federal and State programs that are not designed to work together.
 - Care is generally inefficient with poor service delivery incentives, poor clinical outcomes, cost shifting and confusion for beneficiaries.
 - Integrated care is a step toward bridging Medicare and Medicaid and providing services across the spectrum of care and in the setting of choice.



Why Focus on Integrating Care?

- Without partnering with Medicare, states can do little to impact primary and acute care for dual eligible individuals.
 - States have no control over services paid by Medicare;
 - Efforts to coordinate care increase states' costs but much of the savings go to Medicare.
- Primary and acute care decisions paid under Medicare also drive Medicaid and long-term care costs.
 - Lack of coordination of acute care can result in poor outcomes that accelerate the need for long term services and supports.



How integration can improve quality for people with chronic conditions

- Create a seamless point of access for all services.
- Create one accountable entity to coordinate delivery of primary, preventive, acute, behavioral, and long-term services and supports.
- Blend services and financing to streamline care, eliminate cost shifting and provide resources to deliver care coordination.



How integration can improve quality for people with chronic conditions

- Promote and measure improvements in health outcomes.
- Promote individual choice regarding where care is received.
- Provide high-quality, patient-centered care for dual eligibles that is sensitive to their needs and preferences.



Recent Legislative Activity

- The 2011 Acts of Assembly, Chapter 890, Item 297 MMMM directed DMAS to develop and implement a care coordination model for individuals dually eligible for services under both Medicare and Medicaid.
- Language reinforced in 2012 Governor's proposed budget and additional language to strengthen the integration initiative.



Medicare-Medicaid Coordination Office

- Created by Section 2602 of the Accountable Care Act.
- Focuses on: 1) Medicare and Medicaid Program Alignment, 2) Data and Analytics, and 3) Models and Demonstrations.
- Improves coordination between the Federal government and States for dual eligibles.
 - State Demonstrations to Integrate Care for Dual Eligibles (15 States, \$1M each).
 - Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees.



Financial Alignment Demonstration

- State Medicaid Director Letter July 8, 2011 outlining demonstration opportunity for states to blend Medicaid and Medicare services, rules and funding.
- Offers States two paths:
 - Capitated Model
 - Managed Fee for Service.
- Open to all interested states; targeting 1-2 million duals nationwide.
- State letter of intent was due October 1, 2011 –about 26 states currently pursuing a demonstration.
- DMAS will pursue the capitated model where MCOs provide all Medicare and Medicaid covered services.



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 Oct – Dec 2013;
- Demonstration start January 1, 2014– runs three years;
- National evaluation of demonstration;
- If successful, program can be made permanent.

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.



MCO Requirements - Model of Care

- Description of target population
- Measurable goals
- Staff structure and care management goals
- Interdisciplinary care teams
- Provider networks with specialized expertise and use of clinical practice guidelines and protocols
- Model Of Care training for personnel and network
- Health risk assessment
- Individualized care plan
- Integrated communication network
- Care management for most vulnerable subpopulations
- Performance and health outcomes measurement
- State specific requirements (optional)
- Plans granted approval for 1 – 3 years, based on MCO score (85% + = 3 years; 75%-84% = 2 years; 70%-74% = 1 year; <70% not approved).
- Opportunity to improve score based on feedback.



Features of Successful Care Coordination Programs*

- Coordination of all services using team approach and capitated payment from Medicare and Medicaid.
- Whole person focus on preventing disease and managing services.
- Medical advice from care coordinator available 24/7.
- Assessment of patient risk and development of individualized care plan.
- Medication management, adherence and reconciliation.

* Kenneth E. Thorpe, Building Evidence Based Models to Avert Disease and Reduce Health Care Spending, Emory University, July 2011.



Features of Successful Care Coordination Programs, Cont'd.

- Transitional care.
- Regular contact with enrollees
- Centralized health records.
- Close integration of care coordination function with primary and specialist physicians.



Evidence of success*

- Duals enrolled in Massachusetts health plans have lower rates of institutionalization.
- Duals with complex needs enrolled in Texas Medicaid health plans experienced lower rates of emergency room and inpatient admissions.
- Comprehensive discharge planning coupled with post-discharge support for patients hospitalized for congestive heart failure reduced readmissions by 25%.
- Overall spending among medically adherent Medicaid patients was 23% lower than non-adherent patients.

*Kenneth E. Thorpe, Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles, Emory University, September 2011.



Financial Alignment Demonstration

- Overcomes financial barriers to implementing systems for providing seamless, coordinated care.
- Is an opportunity to improve the lives of individuals who are among the most vulnerable citizens of the Commonwealth.

Dual Demonstration Impact

- **State/Local Agencies:**

- Initial preadmission screenings will continue to be done by a nurse from the local health department, a social worker from the local department of social services and hospitals.
- Screenings will determine eligibility for NF level of care, offer choice of institution, PACE, or waiver services.
- Re-screenings will be MCOs' responsibility.

Dual Demonstration Impact

- **State/Local Agencies:**

- VDH MCHIP regulation compliance.
- Bureau of Insurance – possibility of new plans.
- CSBs – all services provided by MCOs.
- AAAs - possible involvement for outreach and education.

- **DMAS Contractors:**

- Enrollment broker/call center increase in volume;
- Transportation will be provided by MCOs;
- Printing and mailing - additional MCO enrollment letters, comparison charts, etc.

Dual Demonstration Impact

- **DMAS Contractors:**

- MMIS

- New benefit package and enrollment algorithm;
- Transition reports;
- Decreased invoices, no crossover claims, increased encounters;

- Fiscal Employer Agent

- MCOs will provide CD facilitator, EDCD transition coordination, payroll and tax services.
- Individuals getting services through MFP are not included in demonstration;

Dual Demonstration Impact

- **DMAS Contractors:**

- External Quality Review Organization – increased quality review and monitoring;
- Actuary – calculation of capitation payments in conjunction with CMS actuary;
- Dental ASO – no impact, children are excluded;
- Rx - enrollees get drugs via MCOs (currently in Part D);
- Behavioral health ASO - All behavioral health services provided by MCOs, including community mental health and substance abuse services.
- Service Authorization – MCOs will authorize all services, including LTC.



Dual Demonstration Impact

- What are the issues that impact your organization and how should they be addressed?

- Will MCOs contract with F/EA? TN good model to look at
- Concern about what definition of person centered planning/care entails – may be shift for some – collaborative efforts with AAAs and hospitals going on now
- What parts of EDCD waiver processes go into new plan and what stays the same, e.g., enrollment, utilization – will services available to those in the waiver be available only to them in the program, e.g., EDCD receiving personal care – will personal care only be available to them



Dual Demonstration Impact

- What will be needed during the transition of enrollees to or from your organization?

Dual Demonstration Impact

- What additional operational issues need to be considered/addressed?
- What recommendations do you have as DMAS moves forward?

- Providing for preservation of current relationships with providers and caregivers – standard for requirement for showing progress under Medicare needs to be taken into consideration so as not to be a barrier, e.g., physical therapy due to multiple chronic conditions – misinterpretation of standard has negative impact
- Working closely with VICAP through AAAs and the ombudsman programs to help individuals get info and deal with problems
- AAAs have good inroads into population targeted
- Reach out to agencies that work directly with population for education purposes



Letters of Support

The proposal will be posted by DMAS for a 30-day public comment period mid-April and is due to CMS by May 31, 2012. CMS will post the proposal for an additional 30-day public comment period June - July.

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

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

Send proposal comments and letters of support to DMAS electronically at dualintegration@dmas.virginia.gov or to DMAS 600 East Broad Street, Richmond, VA 23219. Your support is greatly appreciated.