



Integrated Care for Medicare- Medicaid Enrollees

Cindi B. Jones, Director
Virginia Department of Medical
Assistance Services

March 21, 2012





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.



Virginia's Progress to Date

- Virginia has taken great strides to integrate care for the State's complex and vulnerable populations.
- Several successful initiatives ensure recipients receive the services and supports that they need in the setting of their choice.
- Extensive stakeholder input sought into the design and implementation of these initiatives.
- Building off these experiences and stakeholder input as we move forward.



Virginia's Progress to Date

- 2006 Virginia Acts of the General Assembly directed DMAS to develop and implement a community and regional model for the integration of acute and long-term care services.
- December 2006, DMAS released the Blueprint for the Integration of Acute and Long Term Care Services that included community (PACE) and regional (VALTC) models.
 - Community model: 8 PACE sites in Virginia; 6 additional sites planned.



Virginia's Progress to Date

- Regional Model:
 - ALTC (2007): Individuals who are in a managed care organization (MCO) prior to HCBS waiver enrollment remain in the MCO for primary/acute care services and receive waiver services through fee-for-service (prior to ALTC, these individuals were disenrolled from the MCOs).
 - VALTC (2009): Provide acute and long term services through MCO; due to budget constraints and other limitations, did not move forward.



Virginia's Progress to Date

- Regional Model:
 - 2009, DMAS released Request for Information (RFI) for input into the design of a care coordination program for EDCD waiver participants (including dual eligibles) as a next step toward developing an integrated delivery system.
 - DMAS decided not to pursue the EDCD care coordination RFP because the population that would be covered were included in other care coordination implementation projects.



Recent Legislative Activity

- The 2011 Acts of Assembly, Chapter 890, Item 297 MMM 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 or Managed Fee for Service.
 - Demonstrations last 3 years.
- Open to all interested states; targeting 1-2 million duals nationwide.
- State letter of intent was due October 1, 2011.
- DMAS will pursue the capitated model.



Capitated Model

- Three-way contract (State, CMS, health plan).
 - CMS and State joint procurement of “high-performing health plans”.
 - Integrates all Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term care services under one delivery system.
 - Strong beneficiary protection and network adequacy requirements.



Capitated Model

- Three-way contract (State, CMS, health plan).
 - Ongoing, meaningful stakeholder involvement.
 - Aligned financial incentives; prospective, blended capitated payment using past Medicaid and Medicare FFS data from eligible population.
 - Single set of rules for appeals, marketing, and monitoring.
 - Care Coordination.



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.



Department of Medical Assistance Services



Financial Alignment Demonstration

Thank you