



Department of Medical Assistance Services



Medicare-Medicaid Integration: Achieving Higher Quality and More Cost-Effective Care

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Senate Finance Committee

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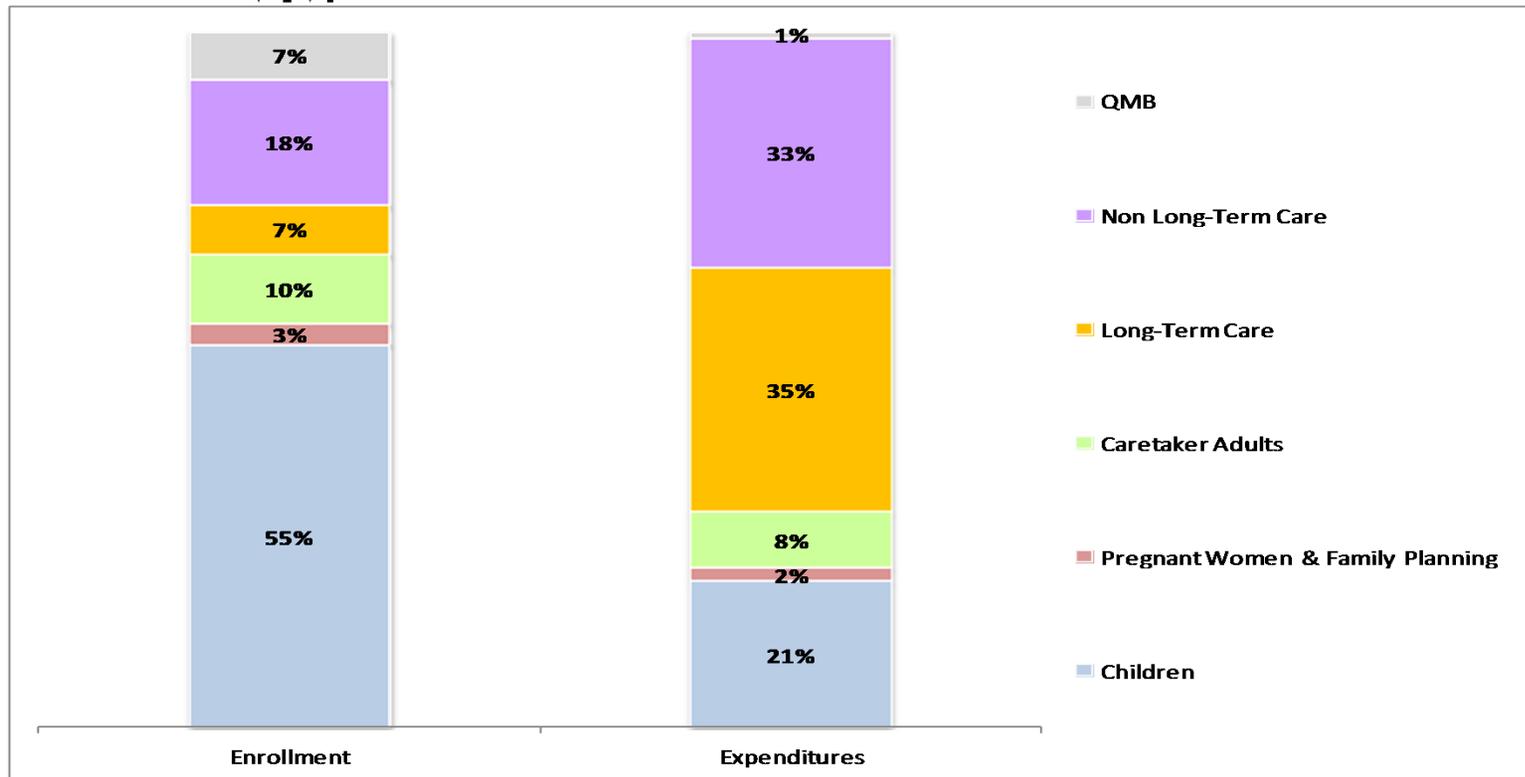


Why focus on integrating care?

- Medicare and Medicaid are two distinct programs, not designed to work together
- However, 9.2 Million Americans are eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees, also known as “dual eligibles”)
- Nationally, dual eligibles account for 15% of the Medicaid population and 39% of Medicaid spending.



Virginia Medicaid Enrollment v. Spending





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)
- ▶ Optional services (vary by state): dental, vision, home- and community-based services, personal care, and select home health care
- ▶ Some prescription drugs not covered by Medicare
- ▶ Durable medical equipment not covered by Medicare



DISTINCT PROGRAMS, NOT DESIGNED TO WORK TOGETHER

- Very confusing for beneficiaries
- Benefits are not aligned
- Program rules are not aligned
- Program financing promotes “cost shifting” between states and federal government
- Current financing arrangements limit financial innovation

DESIGNED TO SUPPORT CARE IN FACILITIES VS. COMMUNITIES

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



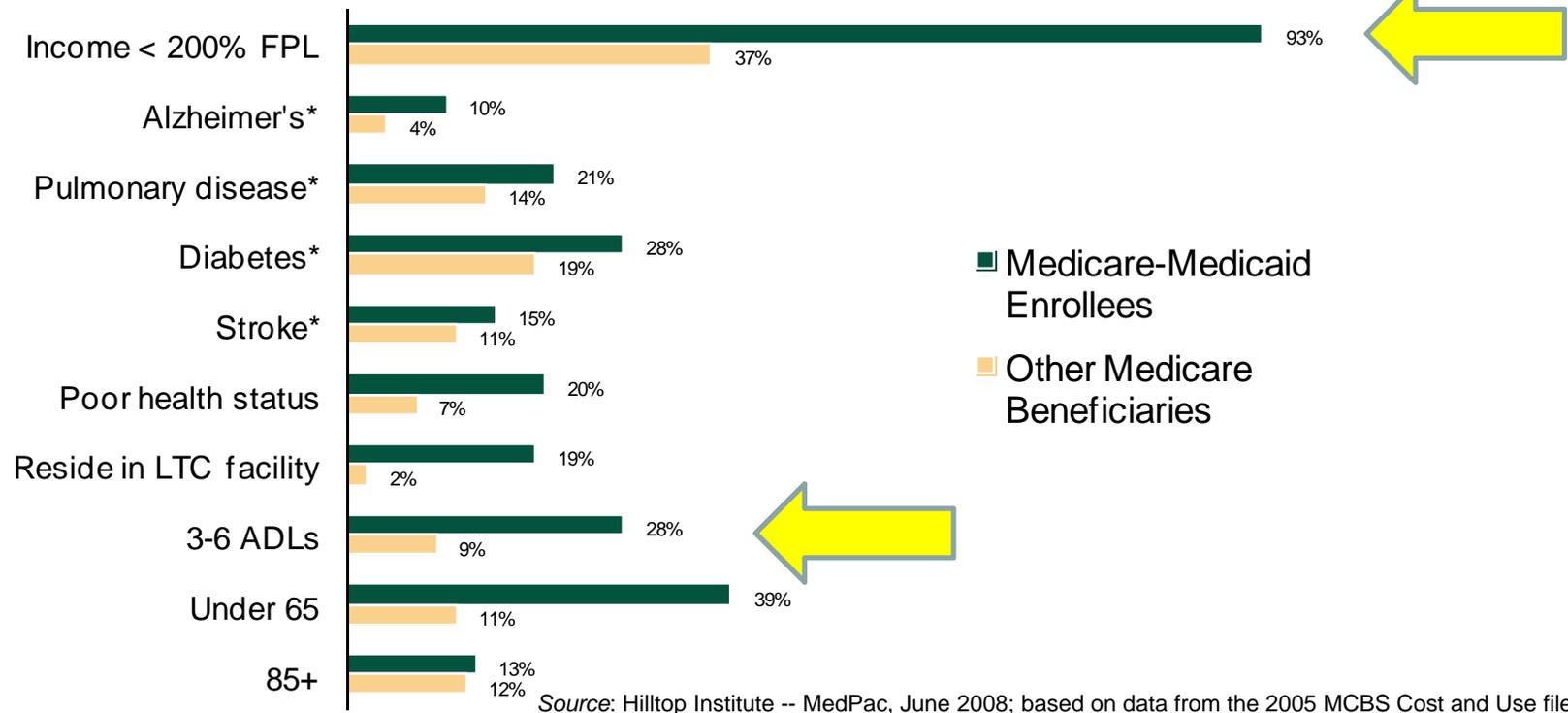
Who are Medicare-Medicaid enrollees?

- 62 percent age 65 or older, 38 percent under 65
- 77 percent are “full duals” receiving Medicaid benefits; 33 percent are “partial” duals for whom Medicaid pays only Medicare Part A and/or B premiums and – for some but not all -- Medicare beneficiary cost sharing (deductibles, coinsurance, copayments)



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

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



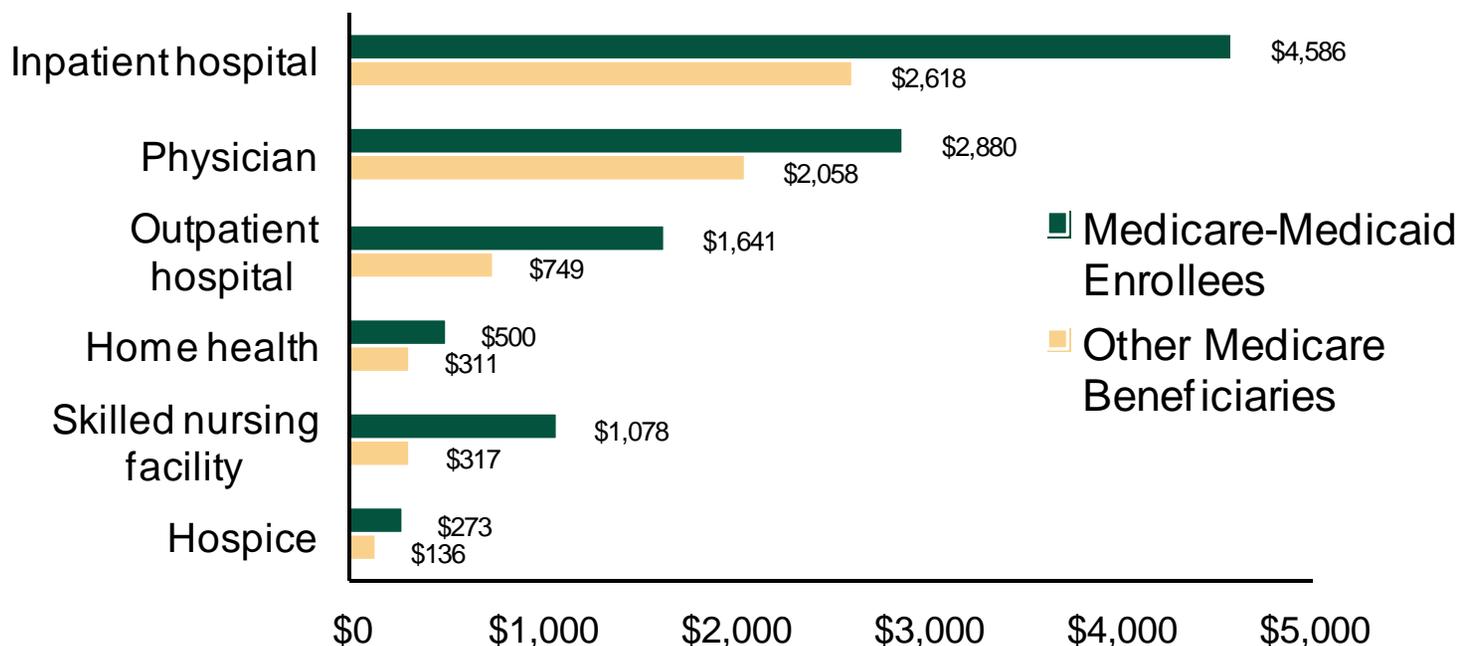
Source: Hilltop Institute -- MedPac, June 2008; based on data from the 2005 MCBS Cost and Use file

*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**



Average Medicare Payment Source: Hilltop Institute -- MedPac, June 2008



What is integrated care?

- Creates one accountable entity to coordinate delivery of primary/preventive, acute, behavioral, and long-term services and supports
- Promotes and measures improvements
- Promotes the use of home- and community-based behavioral and 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
- Provides high-quality, patient-centered care for Medicare-Medicaid enrollees that is sensitive to their needs and preferences



New Medicare-Medicaid Coordination Office

- MMCO created by Section 2602 of the ACA
- Improve coordination between the Federal government and states for Medicare-Medicaid enrollees
- Focuses on:
 - Program alignment; data and analytics; and models and demonstrations
- Developed two initial opportunities for states:
 - State Demonstrations and Financial Alignment Models





Financial Models to Integrate Care for Medicare-Medicaid Enrollees – State Support

- Item 297 MMMM (1)(g) of the 2011 Appropriations Act and Item 307(RR)(1)(g) of the 2012 Appropriations Act directs DMAS to implement a care coordination model for dual eligible individuals.
- The 2013 Governor's Budget includes administrative funding in FY 2014 for the Dual Eligible Financial Alignment Demonstration



Financial Alignment Models

- State Medicaid Director Letter, July 8, 2011
- Offers states two paths (aka “Financial Alignment Models”):



- Open to all states – but must pursue one of the two models
- 38 states (including Virginia) submitted a letter of intent by Oct. 2011



Core Elements of Integrated Care Models

Integrated care models arrange for all Medicaid and Medicare services (including long-term services and supports and behavioral health services). Core elements include:

- Strong primary care base – promote health homes
- Comprehensive provider network
- Multidisciplinary care teams integrating medical and social models
- Service coordination and case management
- Person-centered plan of care
- Robust data-sharing and communications system
- Adequate consumer protections
- Aligned financial incentives – eliminate cost shifting
- Expectation of savings – a CMS program requirement



CMS Savings Expectations

- CMS requires that the program result in savings to both Medicare and Medicaid
- Savings upfront factored into capitation rates
- Quality withholds that health plans can earn back
- DMAS expects savings resulting from better care/service coordination/case management, etc. - decrease hospital, emergency room use, delay of nursing facility admissions



Why Virginia Seeks Shared Medicare Savings

- Service coordination not a Virginia State Plan Service nor a EDCD Waiver service
- Due to high acuity level criteria for nursing facility eligibility, most savings expected to come from Medicare-paid services
- Without shared savings, DMAS would spend more on service coordination but savings would go to Medicare
- With shared savings, DMAS can provide service coordination and improve outcomes



Dual Demonstration Virginia –Includes:

- Approximately 65,000 full dual eligible individuals
- Age 21 and over
- Five regions: Central Virginia, Northern Virginia, Tidewater, Charlottesville, and Roanoke (regions phased in)
- Those in the Elderly and Disabled with Consumer Direction Waiver
- Nursing Facility residents
- Hospice beneficiaries



Dual Demonstration Virginia –Excludes:

- Other Home and Community Based Waivers:
 - ID, DD, Day Support, Alzheimer's, Technology Assisted
- In state MH/ID facility
- In ICF/IDs
- In PACE (although they can opt in)
- Residential Treatment or Long Stay Hospitals



Virginia's Proposal Outline

- Virginia's model:
 - **Geographic areas** - Five regions of the state in 2014
 - **Delivery Model** – Capitated; 2-3 Managed Care Organizations in each region
 - **Services** – Medicare Benefits (A, B, D); state plan primary and acute care services, including behavioral health; person-centered care coordination; LTSS waiver services; supplemental or enhanced benefits (e.g. vision, hearing) will be at MCO's option



Virginia's Proposal Outline Cont'd

- Virginia's model:
 - **Reimbursement** – Blended, risk adjusted rate based on Medicaid, Medicare, and Medicare Advantage data. Savings adjustments taken 'off the top' and premium withholds to be paid to MCOs that meet quality performance thresholds
 - **Enrollment** – Voluntary – Passive enrollment process with opt out option
 - **Stakeholder involvement** – Meetings, emails, public comments, and website. Advisory Group required through 2012 legislation



States and CMS are working thoughtfully and carefully

- Engage stakeholders at every level in both design and implementation
- Ensure beneficiary protections guaranteed under the Medicare program
- Incorporate payment strategies that encourage provider participation and offer potential savings for state and federal partners





Timeline: Next Steps

- February 2013 Sign MOU with CMS/DMAS
- Winter 2013 Release CMS/DMAS Request for Applications
- Summer 2013 MCOs Selected
- October 2013 Open Enrollment Starts
- January 1, 2014 Demonstration Starts