

Integrating Care for Dual Eligible Medicare and Medicaid Recipients

*Proposal Development Considerations for
Wisconsin's Virtual PACE Grant Project*

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Background...

- Nearly 8 million Americans are eligible for both Medicare and Medicaid programs.
- The majority of people who are dually eligible receive fragmented and poorly coordinated care across the programs.
- More than 80% of dual eligibles remain in fee-for-service arrangements.
- Health care costs for adults who are dually eligible for Medicare and Medicaid are nearly five times those of other adults covered by Medicare.



Dual Eligibles...

- Are the most chronically ill patients within both Medicare and Medicaid, requiring a complex array of services from multiple providers.
- Are three times more likely to be disabled, and have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer's disease.
- Represent 18% of Medicaid enrollees and 16% of Medicare enrollees, but account for 46% of total Medicaid expenditures and 25% of total Medicare expenditures.



Challenges Facing Dual Eligibles...

- Medicare and Medicaid are each governed by their own policies and procedures.
- Often, the policies and procedures within the two programs conflict.
- As a result, dual eligibles must navigate two sets of enrollment policies, providers, benefits, and payment systems.
- Health care decisions are most often uncoordinated and not made from a person-centered perspective. Further, these decisions are made by providers who rarely communicate with one another.



Challenges to Integrating Care

- **Administrative & Operational challenges.** The administrative complexities contained within Medicare and Medicaid regulations and policies make it difficult to integrate benefits.
- **Financial misalignment.** Difficulties in developing the payment systems required to integrate care, and in developing mechanisms to share in any short- and long-term savings associated with integrating care.
- **Low Enrollment.** Many programs have taken a voluntary approach to enrollment. Enrollments have been slow and at low levels.



Benefits of Integration...

- One ID card for recipients.
- One set of comprehensive benefits: primary, acute, prescription drug, and long-term care supports and services.
- One coordinated care team using a person-centered approach to care planning.
- Health care decisions made based upon the person's needs and preferences.
- Availability of flexible, non-medical benefits that help the person remain in his/her home.



Core Elements of an Integrated System

- Strong person-centered care based in accountable primary care homes;
- Multi-disciplinary care teams that coordinate the full range of medical, behavioral, and long-term supports and services needs;
- Comprehensive provider network capable of meeting that full range of needs;
- Enhanced use of home- and community-based long-term care services;



Core Elements of an Integrated System

- Robust data sharing and information systems to promote care coordination;
- Strong consumer protections that ensure access to longstanding providers and involve consumers in program design; and
- Financial alignment that impels integration of care.




Current Options for Integration

- Special Needs Plans (SNPs)
- Program for All-Inclusive Care for the Elderly (PACE)
- Shared Savings Models
- States as Integrated Care Entities



Special Needs Plans (SNPs)

- With the passage of the Medicare Modernization Act of 2003, Medicare Advantage health plans could be designated as SNPs.
- Paved the way for states to integrate Medicare and Medicaid for those who were dually eligible.
- SNPs can target one of three high-need populations: (1) dual eligibles; (2) beneficiaries requiring an institutional level of care; and (3) beneficiaries with chronic conditions.
- True value of SNPs is their relationship with state Medicaid agencies, whereby they can offer a single, integrated benefit plan to enrollees.



Program for All-Inclusive Care for the Elderly (PACE)

- PACE serves people who are age 55 and older, are certified to need nursing home care, are able to live safely in the community, and live in a PACE service area.
- Provides enrollees with all Medicare and Medicaid medical and supportive services.
- PACE program enters into an agreement with the Centers for Medicare and Medicaid Services (CMS) and the state Medicaid agency.
- May be a entity of a city, county, state, or tribal government, or a private 501 (c)(3) not-for-profit organization.



Shared Savings Model

- The primary focus of this model is aligning incentives and eliminating cost shifting between Medicare and Medicaid.
- Integrated health systems, physician groups, or regional coalitions join together and create a tailored alternative payment system to support integration of services for dual eligibles.
- Any savings realized from the model are reinvested in the program or used for expansion purposes.



State as Integrated Entity

- Emerging model for integrating Medicare and Medicaid benefits for dual eligibles.
- The Medicaid program would receive an agreed upon amount of Medicare funding for participating dual eligibles and would assume responsibility for the Medicare benefit.
- Mirrors state role in managing Medicaid benefits.
- States could either manage the integrated benefit themselves or establish contracts with Managed Care (Administrative) entities or health plans (on a risk or non-risk basis) to do so.



Wisconsin's Virtual PACE Grant

- State received a \$1 million grant to design a program to integrate Medicare and Medicaid funding.
- Will serve dual eligibles with a nursing home level of care and who present the most acute and complex care needs, with the greatest opportunities to improve care coordination.
- Will attempt to improve care coordination and alignment of funding incentives.



Wisconsin's Virtual PACE Proposal

- Combines Medicare Parts A, B, and D, and Medicaid funding into one plan for all services and administration.
- Addresses problems such as: (1) differing benefit package and access rules; (2) program enrollment and eligibility determination; (3) contracts; (4) appeals and grievances; and (5) quality metrics and standards, among others.
- Sets as goals: (1) increased service/care coordination; (2) reduced administrative barriers; and (3) elimination of misaligned funding barriers.



Wisconsin's Virtual PACE Proposal

- Designed with an all-in enrollment process, with opt-out opportunities after six months.
- Combines Medicare and Medicaid funding into one capitated payment to promote cost incentives.
- Proposes to contract with entities to provide all Medicare and Medicaid services to reduce the administrative burden.
- Implementation is expected by July 1, 2012 with pilot project development in four parts of the state, and an initial anticipated enrollment of 20,000 participants.