

Idaho Division of Medicaid Demonstration Proposal to Integrate Care for Dual Eligibles

Stakeholder Update
December 10, 2012

Idaho Division of Medicaid Demonstration Proposal to Integrate Care for Dual Eligibles

- To more effectively integrate the Medicare and Medicaid programs, CMS is partnering with states, health care providers, caregivers and beneficiaries to improve quality, reduce costs and improve the dual eligible beneficiary experience.
- Coordinated effort seeks to transcend boundaries and facilitate a national conversation with stakeholders to identify opportunities for alignment and improvement.

Medicare-Medicaid Coordination Office Goals

- Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.
- Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.
- Improving the quality of health care and long-term services for dual eligible individuals.
- Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

Medicare-Medicaid Coordination Office Goals

- Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.
- Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.
- Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.
- Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

Dual Definitions

- Duals can be categorized into 3 groups, based on the level of benefit they receive from Medicaid:
 - **Full Benefit** enrollees receive the full array of Medicaid benefits available in the state
 - *Qualified Medicare Beneficiaries (QMBs)* are **Partial Benefit** enrollees who receive assistance from Medicaid to pay their Medicare premiums and cost-sharing obligations
 - *Specified Low Income Medicare Beneficiaries (SLMBs), Qualified Individuals (QIs) and Qualified Disabled and Working Individuals (QDWIs)* are **Partial Benefit** enrollees who receive assistance from Medicaid to pay Medicare premiums only.

Summary of the Idaho Initiative to Integrate Care for Dual Eligibles

- **Target Population**
 - All full benefit Medicare-Medicaid enrollees over 21 years of age
- **Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide**
 - 22,548 – as of July 2012
- **Geographic Service Area**
 - Statewide

Summary of the Idaho Initiative to Integrate Care for Dual Eligibles

- **Summary of Covered Medicaid Benefits through Coordinated Plans - 2014**
 - All Medicaid services will be available to qualifying participants including State Plan, Basic Plan, Enhanced Plan and HCBS waiver services based on their needs.
- **Financing Model**
 - Full Capitation
- **Proposed Implementation Date(s)**
 - January 1, 2014

	Dual Eligibles	Dual Eligibles Receiving Long Term Support Services (LTSS) in Institutional Settings			Individuals receiving LTSS in Home and Community Based Service Settings			Individuals not Receiving LTSS Services
		ICF/ID	SNF	ICF/IDs + SNF	A&D Waiver	DD Waiver	Total	
Total	22,548	234	2,725	2,959	6,659	1,494	8,153	11,436
Individuals age 65+	10,171	32	2,302	2,334	4,084	95	4,179	3,658
Individuals ages 21 -65	12,377	202	423	625	2,575	1,399	3,974	7,778
Individuals with serious mental illness (SMI)	2,268	13	193	206	701	83	784	1,278
Individuals with SMI, age 65+	354	2	127	129	176	2	178	47
Individuals with SMI, under age 65	1,918	11	66	77	525	81	606	1,235

High-level Dates for 2014 Plan Selection Process

Date	Milestone
November 2012	Notice of Intent to Apply for 2014 Web Tool released
November 14, 2012	Recommended date by which Applicants should submit their Notice of Intent to Apply (NOIA) Form to CMS to ensure access to HPMS by the date applications are released
Winter 2012/3	CMS User ID form due to CMS
Winter 2012/3	Final Application posted by CMS and available in HPMS
Winter 2012/3	Applications due to CMS
Spring 2013	Formularies due to CMS
Spring 2013	Medication Therapy Management Programs due to CMS
Summer 2013	Plan Benefit Packages due to CMS

2014 Notice of Intent to Apply (NOIA) and Application Information for Medicare-Medicaid Plans

- Eleven interested organizations submitted NOIA to participate in the capitated Financial Alignment demonstration beginning in 2014.

Proposed Draft Documents

- Materials are drafts for 2013 states and may change for 2014 implementation
- CMS will work with Idaho to make these documents state-specific
- Documents posted and discussed in during October webinar:
 - CMS Quality Measures
 - Summary of Benefits
 - Notice of Denial of Medical Coverage
 - Pharmacy Provider Integrated Directories
 - List of Covered Drugs

Demonstration Proposal Feedback

- Email

[*LTCmanagedcare@dhw.idaho.gov*](mailto:LTCmanagedcare@dhw.idaho.gov)

- Website

[*http://www.MedicaidLTCManagedCare.dhw.idaho.gov*](http://www.MedicaidLTCManagedCare.dhw.idaho.gov)

Idaho Medicaid Health Home and IMHC Pilot

December 10, 2012

Brian Peace

Program Manager

What is a Health Home compared to a Patient Centered Medical Home?

- The Patient Centered Medical Home model is defined as medical care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate.
- The Health Home includes all the elements of Patient Centered Medical Home Models and includes better coordination and integration of primary and behavioral health care.

Idaho Medical Home Collaborative (IMHC)

- IMHC is a Governor appointed Collaborative which is a multiplayer collaborative including Regence, Blue Cross, Pacific Source and Medicaid.
- Simultaneous to the launch of the IMHC pilot, Medicaid will enhance its current Healthy Connections Primary Care Case Management System by launching the Medicaid Health Home Program.
- This program aligns closely with the requirements of the IMHC pilot.

Idaho Medical Home Collaborative (IMHC) Requirements

- Patient-Centered Medical Home (PCMH) Transformation Requirements:
 - Receive at least Level -1 NCQA Recognition by end of year two of participation.
- Data Reporting Requirements (Reports will be submitted to the Idaho Medical Home Collaborative Technical Assistance Team)
- Clinical Quality data will be reported for:
 - Two (2) clinical quality measures (Disease of choice from following list). If Asthma is selected, all three clinical quality measures must be reported.
 - Two (2) preventive quality measures.
 - Two (2) Practice Transformation Measures

Medicaid Health Home requirements:

- CMS approved the Idaho Medicaid State Plan Amendment to commence January 1, 2013.
- Each Healthy Connections primary care provider within the clinic/practice service location shall participate in the Health Home Program.
- The clinic/practice shall have a minimum of 46 hours access per week for health home participants as outlined in the upcoming IDAPA rule 16.03.09.

Medicaid Health Home Requirements

- The clinic/practice shall establish a continuous quality improvement program, and collect and report required data to the department for evaluation.
- Clinic/practice shall develop and maintain a systematic follow-up protocol to ensure timely access to follow-up care after inpatient/hospital discharge and emergency room visits. Timely access is defined as within one working day after discharge.
- Consistent communication with patients on test results, appointments, etc. electronically.

Medicaid Health Home Requirements

- The clinic/practice shall receive at least Level -1 National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Recognition within two years of the date of this agreement.
- Clinic/practice shall use a structured chronic disease patient information system to track and manage health home participants (often called a registry).

Medicaid Health Home Qualifying Conditions

- Asthma with comorbidities
- Severe and Persistent Mental Illness (Adult)
- Severe Emotional Disturbance (SED Pediatric)
- Diabetes with comorbidities

Idaho Medicaid Duals and PCMH Model of Care

- Since Health Homes are a state plan benefit, any patient that qualifies needs to be offered a health home through the plan.
- For all other duals, health plans will contract with a care management team that will cover and coordinate services in a care model that follows PCMH principles. This allows for better alignment with the Idaho Medical Home Collaborative, but is very similar to the health home model.
- The PCMH model of care elements that will be included for the duals include the following:
 - Coordinated Care
 - Enhanced Access
 - Continuous Relationship
 - Payment Reform
 - Quality and Safety
 - Whole Person Orientation
- The care management team will at a minimum consist of the participant, a care coordinator and a primary care physician (PCP).

Specific Model of Care Requirements for Duals

- The care management team must:
 - Develop a person centered care plan that focuses on preventive care and addresses medical needs, functional needs, and behavioral health needs.
 - Update the care plan on an ongoing basis as appointments occur, tests are completed, medications change, transitions are made; goals are added or completed, etc.
 - Provide comprehensive care coordination and management.
 - Offer access to services 46 hours per week as well as setting up the schedule to allow for at least some same-day appointments to meet acute care needs.

Specific Model of Care Requirements for Duals

- The care management team must:
 - Emphasize and implement principles of evidence-based practices, and offer/encourage preventive care.
 - Connect the participant with community-based resources when appropriate.
 - Attempt to schedule a minimum of one appointment with the PCP annually, even if there are no immediate health concerns.

Specific Model of Care Requirements for Duals

- The care management team must:
 - Provide timely clinical advice by phone during office hours.
 - Offer communication options by phone and email.
 - Counsel at least 50 percent of patients/families to adopt specific, healthy behaviors such as the value of staying active, meal planning considering nutritional needs or quitting smoking.

Specific Model of Care Requirements for Duals

- The care management team must:
 - Provide educational resources for at least 50 percent of patients/families to assist in self-management.
 - Have a notification process in place for when an individual is not participating in the established care plan (i.e. missed appointments, discontinuation of services, etc.).

Questions?

Demonstration Proposal Feedback

- Email

[*LTCmanagedcare@dhw.idaho.gov*](mailto:LTCmanagedcare@dhw.idaho.gov)

- Website

[*http://www.MedicaidLTCManagedCare.dhw.idaho.gov*](http://www.MedicaidLTCManagedCare.dhw.idaho.gov)