

Idaho Demonstration Proposal

Initiative to Integrate Care for Dual Eligibles

Medicare Medicaid Coordinated Plan

Background

Adults who are dually eligible for Medicare and Medicaid are among the nation's most chronically ill and costly patients. They account for close to 50 percent of all Medicaid spending and 25 percent of all Medicare spending. Idaho Medicaid currently has a Medicare-Medicaid Coordinated Plan (MMCP) for dual-eligible individuals enrolled in a Medicare Advantage plan offered by Blue Cross of Idaho. This model is a voluntary Medicaid program that permits a dual-eligible beneficiary to enroll in a single managed care organization (MCO) that receives capitation payments to deliver both Medicaid and Medicare services to the individual. This Coordinated Special Needs Plan (SNP) is designed to improve coordination between Medicaid and Medicare service provision.

Idaho Medicaid realized some success with enrollment in 2007 when the MMCP was implemented. However, enrollment stands at approximately seven percent of the dual eligible population and has remained flat since December of 2007. There are currently 17,172 dual-eligible individuals, with 1,031 enrolled in the MMCP in the 30 participating counties. The expenditures for the dual eligible participants who qualify for Coordinated Plan benefits totaled \$277 million with an average monthly expenditure of \$1,800 for those not enrolled in the plan and \$1,500 for those who are enrolled in the plan.

The Centers for Medicare and Medicaid services (CMS) is combining Medicare and Medicaid authorities to test two new payment and service delivery models to reduce program expenditures under Medicare and Medicaid and to better align the financing of these two programs and integrate primary, acute, behavioral health and long term services and supports for their Medicare-Medicaid enrollees. The two models are a Capitated model and a Managed Fee-for-Service model. In the Capitated model the State, CMS, and health plans enter into a three-way contract, and the plans receive a prospective blended payment to provide comprehensive, coordinated care. In the Managed Fee-for-Service the State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid. The Department has decided to pursue the capitated approach for this project.

Purpose of the Work

The overall goal of this work is to develop, test and validate a fully integrated delivery system and care coordination model for dual eligible Medicaid-Medicare enrollees. A fully integrated program refers to one that encompasses all the medical, behavioral health, and long-term services and supports needed

by an individual eligible for both Medicare and Medicaid. Such a comprehensive approach will ensure that the individual will have a seamless care experience and that one entity is accountable for the full continuum of care for the Medicare-Medicaid enrollee. This initiative is intended to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid enrollees, enhance quality of care and reduce costs for both the State and the Federal government. To achieve this Medicaid is partnering with CMS, health care providers, health plans, caregivers and beneficiaries to design and implement a program that will improve quality, reduce costs and improve the dual eligible beneficiary experience utilizing a capitated payment approach.

Desired Outcomes

- Provide dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs
- Improve beneficiary experience in accessing care
- Improve the quality of health care and long-term services for dual eligible individuals
- Increase dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.
- Eliminate regulatory conflicts between rules under the Medicare and Medicaid programs.
- Improve care continuity and ensure safe and effective care transitions for dual eligible individuals.
- Eliminate cost-shifting between the Medicare and Medicaid program and among related health care providers
- Collect and provide to CMS individual-level quality, cost, enrollment and utilization data for the purposes of comparing the effects of these models across sub-groups of Medicare-Medicaid enrollees, including those that participate in the integrated model being tested and those that do not.
- Achieve shared cost savings for the State and CMS

Project Objectives

Objective 1

Design and implement a fully integrated system of services and supports for individuals eligible for both Medicare and Medicaid, including primary, acute, prescription drug, behavioral health and long term supports and services. All individuals with full dual eligibility for Medicaid and Medicare living in the state of Idaho would be eligible to participate in the proposed demonstration. This includes individuals receiving Home and Community-Based Services through a waiver. The proposed model would not take away any current State plan services for eligible individuals. It would add Medicaid waiver services covered by the Aged and Disabled Waiver, as well as the Developmental Disabilities Waiver.

Exit Criteria:

- Three way contracts have been signed between the State, CMS and selected health care plans to provide a fully integrated system of services and support that meets the requirements described in SMDL 11-008
- Authority for implementation has been secured and approved by CMS (either through a 1932(a) State Plan Amendment, 1915(a) contracting authority, or through a 1915(b) waiver)
- Appropriate statutes and IDAPA rules are in place

- System modifications have been completed
- MMIS processes claims accurately and timely
- Infrastructure is created and operational (Division of Medicaid staffing support MCO administration of program)

Objective 2

Assure effective partnership with and meaningful engagement with health care and service providers that support and care for Medicare-Medicaid enrollees, health plans, Medicare-Medicaid enrollees, their families and consumer organizations working with them.

Exit Criteria:

- Website developed and maintained for use as vehicle to share information and solicit input
- Participating plans are required by contract to establish meaningful beneficiary input processes that may include beneficiary participation on participating plans governing boards and/or establishment of participating plan beneficiary advisory boards.
- Input has been solicited, considered for design and incorporated
- Key stakeholders have been involved early in the process and kept informed of all opportunities for input.
- The health care plans under contract offer a sufficient provider network as to ensure access to services in all regions of the state

Objective 3

Implementation of this program begins by the end of 12/31/2013.

Exit Criteria:

- Participant materials have been developed that are accessible and understandable to the beneficiaries who will be enrolled in the plans
- Beneficiary outreach/notification of enrollment processes etc is complete
- Enrollment allows for a single, seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the Participating Plan at any time