# Update on Medicaid Reform & Long Term Care Initiatives

*Presentation to the*

## Joint Commission on Health Care Long-Term Care and Medicaid Reform Subcommittee

Department of Medical Assistance Services August 16, 2007

# Presentation Outline

- ■ ***Update on Agency Efforts in Response to Citizenship and Identity Provisions of the DRA***
- ☐ Update on Recommendations of the Medicaid Revitalization Committee
- ☐ Status of the Long-Term Care Partnership Project
- ☐ Status of the Integration of Acute and Long-Term Care Project

# Citizenship and Identity Requirements of the DRA

- Section 6036 of the DRA mandates a new provision, effective July 1, 2006, that requires individuals claiming U.S. citizenship to provide satisfactory documentary evidence of citizenship and identity when:
  - initially applying for Medicaid, or
  - at the first re-determination of eligibility completed on or after July 1, 2006.
- This is a one-time activity; once documented in a case file, the information will not have to be provided again.



# Citizenship and Identity Requirements of the DRA

**(continued)**

- Prior to July 1, 2006, the only requirement for citizenship was that an individual declare, under penalty of perjury, that he is a United States citizen. No verification was necessary.
- Beginning July 1, 2006, self-attestation of citizenship is no longer acceptable. Individuals have to provide documentary evidence of their citizenship and identity.
  - For some recipients (such as SSI and Medicare eligibles), verification is not required because citizenship and identity has already been documented for those programs.

# Citizenship and Identity Requirements of the DRA

**(continued)**

- There are two general ways to meet requirements to provide satisfactory evidence of citizenship and identity:
  - present ***original*** document that proves both citizenship and identity (a US Passport, for example); or,
  - present two ***original*** documents: one that establishes citizenship (e.g. an official birth certificate) and one that establishes identity (e.g. an official picture identification).
- The CMS guidance lists a hierarchy of acceptable documentation ranging from most reliable (a US passport), to least reliable (a written affidavit of citizenship) and requires States to seek the most reliable information prior to acceptance of written affidavits as evidence of citizenship.



# Citizenship and Identity Assistance by the State

- If the individual indicates difficulty in obtaining the required documentation, assistance must be provided. To this end, DMAS has:
  - Developed affidavits for citizenship
  - Developed an affidavit for identity for children (as part of the Medicaid application) and for disabled individuals residing in institutions
  - Developed process for use by certain outreach entities, FQHC, hospital social workers and discharge planners, and health departments to view and copy original documentation and submit the annotated copy to the appropriate LDSS or CPU.
- Medicaid applicants and recipients must be given a reasonable opportunity to provide documentation. If needed, policy allows extensions after normal processing timeframes.

# Citizenship and Identity Assistance by the State
**(continued)**

- In coordination with the VDH Office of Vital Records, the Local Departments of Social Services (LDSS) and the DMAS FAMIS Plus Unit can accept copies of Virginia birth records and immediately enroll eligible individuals pending the certification of the birth record by Vital Records.
  - Immediate enrollment is limited to those with copies of Virginia birth records; for those who assert a Virginia birth with no copy, data is submitted to Vital Records for verification, but enrollment is delayed until the certification is received (usually 1-2 days from receipt of the request).
- For individuals born outside of Virginia, eligibility workers submit out-of-state birth verification requests to the State DSS, which coordinates the requests to the various states.
  - Enrollment does not occur until the out-of-state birth is verified.

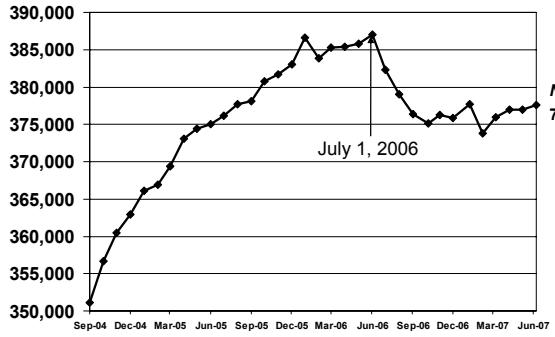


# Impact of the New Requirements

- The requirements have already had a significant impact on the enrollment statistics for the Medicaid program:
  - The requirement for original documentation severely limited the ability of the eligibility workers to process applications to completion
  - As a result, a significant portion of new applications for children have been placed in a "pending" status awaiting documentation, delaying enrollment in Medicaid
  - This has resulted in a ***net decrease*** in Medicaid enrollment of children of approximately **9,500** since the new requirements were implemented (through June, 2007)
    - Continued growth in FAMIS enrollment (SCHIP is not currently affected by the citizenship and identity rules), would indicate that the true effect is even higher than the measurable reduction.

# Impact of the New Requirements
(continued)

**Monthly Enrollment of Children in FAMIS Plus Medicaid & SCHIP Medicaid Expansion (subject to C & I requirement)**

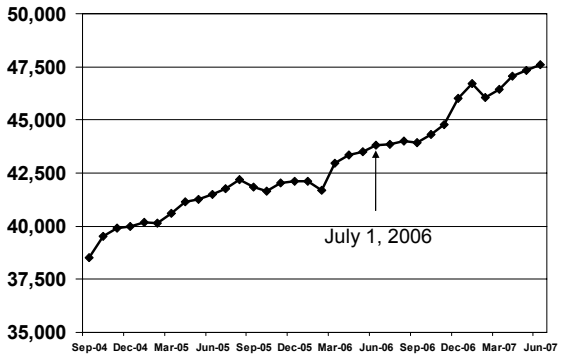



***Net decrease*** **since 7/1/06 = 9,527**



# Impact of the New Requirements
(continued)

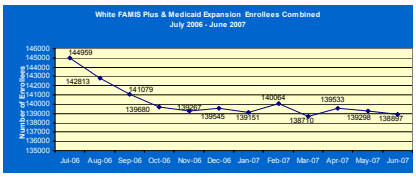
**Monthly Enrollment of Children in FAMIS Separate SCHIP (not subject to C & I requirement)**

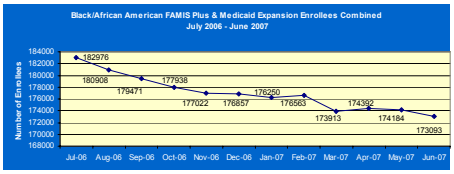


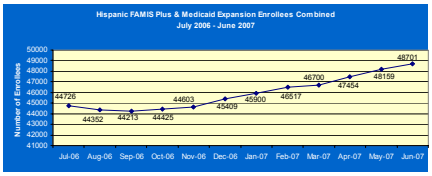

***Net increase*** **since 7/1/2006 = 3,818**

# Impact of the New Requirements
**(continued)**

- Enrollment data by race/ethnicity appears to support a contention that the Citizenship and Identity requirements have had a more significant negative enrollment effect on the African American and White populations






# Impact of the New Requirements
**(continued)**

- While DMAS can measure the effect of the new requirements in terms of enrollment declines, the true effect of this new barrier to coverage for otherwise eligible individuals is the inability to receive needed medical care in the proper setting:
  - For its report titled *Unintended Consequences: The Impact of New Medicaid Citizenship Documentation Requirements on Virginia's Children*, the Virginia Health Care Foundation (VHCF) surveyed 800 adults who had applied for Medicaid coverage of their children since July 1, 2006 (the implementation date of the new requirements). VHCF found that:
    - 65 percent of children with no other health care coverage had some type of health care need while the Medicaid application was pending
    - Of these children, 41 percent were not able to get the care they needed, including dental care and even childhood immunizations
    - VHCF also found that a significant increase in the use of hospital Emergency Rooms for primary-type care resulted from the lack of coverage in a more appropriate setting.

# Citizenship & Identity: Next Steps

- DMAS continues to look for ways to streamline the process with our partner agencies:
  - DSS and VDH Vital Records are developing an on-line batch process to further streamline Virginia birth verifications
  - DMAS and DMV are exploring the feasibility of data matches to properly establish identity of applicants/recipients
  - DMAS and DSS continue to facilitate the sharing of birth record data between states
  - DMAS and our partner agencies continue to participate in national discussions of the unintended consequences of the requirements, in hopes that additional modifications to the provisions can occur.



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- ☐ Update on Agency Efforts in Response to Citizenship and Identity Provisions of the DRA
- ■ ***Update on Recommendations of the Medicaid Revitalization Committee***
- ☐ Status of the Long-Term Care Partnership Project
- ☐ Status of the Integration of Acute and Long-Term Care Project

# The Origin of the Medicaid Revitalization Committee

- House Bill 758 (HB758), passed by the 2006 General Assembly and signed by Governor Kaine on April 5, 2006, set into motion a self-examination of Virginia's primary healthcare delivery mechanism for the State's most vulnerable citizens – the Medicaid program.

- The legislation directed the Department of Medical Assistance Services (DMAS) to create a group consisting of patient advocates, healthcare providers, health insurers, program administrators, and other stakeholders – the Medicaid Revitalization Committee – to examine alternative and innovative approaches to healthcare delivery under Medicaid, with a focus on client-centered planning, individual budgeting, and self-directed quality assurance and improvement.



# The Mission of the Medicaid Revitalization Committee

- The Committee's mission is to consider potential revisions to the program as identified in HB758, and based on its deliberations, to make recommendations regarding the future structure of Virginia's Medicaid program. The Committee's recommendations should focus on:
  - emphasizing the state's role in purchasing healthcare services,
  - leveraging market forces to customize services to meet the diverse needs of Virginia's Medicaid population,
  - enhancing personal responsibility and empowering individuals who desire to manage their healthcare,
  - bridging public and private coverage,
  - maximizing access, and
  - containing the growth of Medicaid expenditures in the Commonwealth.

# Overview of the Medicaid Revitalization Committee's Mandate

- The Medicaid Revitalization Committee is directed to consider several potential reforms to the Medicaid program, including:
  - the creation of an incentive structure to promote increased personal responsibility in the healthcare decisions of Medicaid recipients
  - increased enrollment from "un-managed" delivery models to care-coordination programs – Medicaid managed care, primary care case management, and disease management
  - the creation of voluntary enhanced benefit accounts, or health opportunity accounts, to facilitate healthy behavior and training in effective and appropriate self-care
    - to facilitate a recipient's ability to purchase qualifying services or items outside the scope of basic coverage thereby further promoting the well-being of the Medicaid recipient and potentially diminishing future utilization of acute care services



# Overview of the Medicaid Revitalization Committee's Mandate
**(continued)**

  - the creation of additional mechanisms for purchase of employer-sponsored health insurance through health benefits accounts funded at the actuarially defined risk-based premium cost that would otherwise be borne by the Medicaid program as a direct insurer
  - phased implementation of direct electronic access to the enhanced benefit accounts for recipients and fully implemented electronic funds transfer technology for providers and participating managed care organizations.

- In October 2006, DMAS submitted a report of the Committee's findings and recommendations to the Governor, the House Committees on Appropriations and Health, Welfare and Institutions, and the Senate Committees on Finance and Education and Health.

## MRC Recommendation #1: Disease Management

***The Department of Medical Assistance Services should seek funding and approval (both state and federal) to expand population-based disease management programs to target high cost and/or high prevalence disease states for which nationally accepted evidence-based care guidelines exist. The Department should develop a list of such disease states and estimate the costs associated with program administration for each disease. This expanded program should also include aspects of provider-centric models where the healthcare provider plays a more direct and active role in the care management. The Department shall determine the scope of the expanded disease management program, including the possibility of one or more pilot programs, based on funding made available for this purpose.***



## DMAS Progress on: Disease Management

- Item 302 FFF of the 2007 Appropriation Act provided authority and funding for DMAS to add Chronic Obstructive Pulmonary Disease (COPD) to the *Healthy Returns*[SM] disease management program. This new disease state is currently being managed in this FFS program, as well as by the participating health plans under the Medicaid Managed Care program.

- DMAS staff continues to examine ways to improve and expand the *Healthy Returns*[SM] program for Medicaid recipients.

## MRC Recommendation #2:
## Enhanced Benefit Accounts

***The Department of Medical Assistance Services should seek funding and approval (both state and federal) to provide access to enhanced benefit accounts, or a similar mechanism, in which recipients are rewarded for compliance with aspects of their care plan through financial incentives that can be used to purchase healthcare related goods and services not otherwise covered by the Medicaid program (including patient cost sharing responsibilities). These accounts would be accessed through an electronic debit card or similar electronic mechanism. The Department shall determine the scope of the program based on funding made available for this purpose and should include provisions for recipient education regarding these accounts and their use.***



## DMAS Progress on:
## Enhanced Benefit Accounts

- Item 302 GGG directed DMAS to request funding in the 2008-2010 biennial budget to fund the implementation of Enhanced Benefit Accounts. DMAS is currently developing incentive models for Medicaid recipients in the *Healthy Returns*[SM] program, which will be considered during the upcoming Executive Budget development process.

## MRC Recommendation #3:
## Electronic Funds Transfer

***The Department of Medical Assistance Services should require electronic funds transfer for payment of healthcare services to all enrolled Medicaid providers. This requirement should also be enforced though participating managed care organizations and other contractors facilitating or directly providing healthcare services in the Medicaid program. This would include consumer directed services within long-term care where feasible.***



## DMAS Progress on:
## Electronic Funds Transfer

- There was no legislation from the 2007 Session supporting a mandate for Electronic Funds Transfer as a condition of participation with the Virginia Medicaid program.
- Despite the lack of a mandate, FY07 data indicate that 83 percent of Medicaid claims payments (dollars) made by DMAS are remitted electronically
  - This is up from 71 percent in FY06
  - However, we still have many smaller volume providers receiving paper checks.

# MRC Recommendation #4:
# Web-Based Claims Submission

**The Department of Medical Assistance Services should seek funding (both state and federal) to implement a web-based claims submission system available free of charge to all healthcare providers for use in the submission of Virginia Medicaid claims and for the receipt of electronic remittance advices. The Department should require participating managed care organizations and other contractors facilitating or directly providing healthcare services in the Medicaid program to offer such electronic capabilities as well. This would exclude consumer directed care services within long-term care services. The Department and its contractors should encourage provider usage of this web-based system and any currently approved electronic claims submission mechanisms for Virginia Medicaid. The Department should monitor the usage of electronic claims submission relative to paper claims submission and make further recommendations to achieve a virtually paperless claims process.**



# DMAS Progress on:
# Web-Based Claims Submission

- DMAS applied for a federal Systems Transformation Grant to fund the development of a web-based claims submission platform that would have been made available to providers free of charge. Unfortunately, the grant was very competitive and the Virginia Proposal did not receive funding.
- DMAS has applied for a second round of the Systems Transformation Grants with the assistance of staff from the Office of the Secretary of Technology. The new proposal includes outreach for broadband network development, ePrescribing in Medicaid, and administrative data exchange (including Medicaid claims submission).
  - The second round of grants has not yet been awarded by the federal government (expected by October 1, 2007).

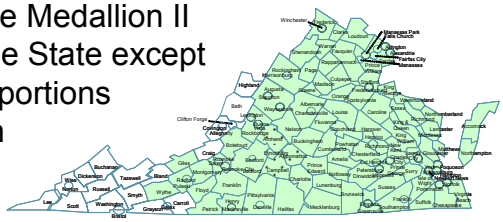
# MRC Recommendation #5:
# Managed Care

**The Department of Medical Assistance Services should continue working toward the goal of expanding managed care into new regions and across additional eligibility categories where feasible. Expansions should only take place if the program can ensure no diminished access to quality care for recipients. The Department should take great care to assure that if included within a managed care program, recipients with disabilities and special needs have access to needed services. The Department should not be limited in its program design utilized for expansions to the current model, but should explore other potential models of care coordination and delivery, including greater use of local health agencies, telemedicine and defined-contribution models, to fulfill the unique needs of recipients in the new regions and eligibility categories. The Department should not impose monetary benefit caps or benefit restrictions (relative to current policy) under existing or expanded managed care programs without a provision for catastrophic coverage maintained within the Medicaid program.**



# DMAS Progress on:
# Managed Care

- DMAS is pleased to announce that the Medicaid managed care program, Medallion II, will go live in the Lynchburg region beginning October 1, 2007. Three managed care organizations will cover approximately 14,000 eligible enrollees there.
- This expansion will provide Medallion II coverage in all areas of the State except for the deep southwest & portions of our western border with West Virginia.



## DMAS Progress on:
## Managed Care

- Future expansions into the remaining geographic regions of the State are in development and planning.
- However, immediate expansion efforts after the Lynchburg launch will shift to the Acute/Long-Term Care (ALTC) integration efforts currently underway (which will be discussed later in this presentation).



## MRC Recommendation #6:
## Private Insurance Subsidy

**The Department of Medical Assistance Services should study the potential impact of modifications to existing programs for public subsidy of employer-sponsored or other private health insurance coverage for Medicaid-eligible individuals, including the impact of switching from mandatory to voluntary enrollment in these subsidy programs. To the extent the public subsidy is cost effective / cost neutral relative to the cost of direct Medicaid coverage, and based on the Department's analysis and input from stakeholders, the Department should consider modifications to these subsidy programs to further encourage the use of available private insurance coverage options. Any modifications to or expansions of these programs should include consumer protection mechanisms.**

## DMAS Progress on:
## Private Insurance Subsidy

- Legislation considered in the 2007 General Assembly calling for a DMAS study of public subsidy programs for private insurance (HJR 653) was not passed.
- However, DMAS is examining the current Health Insurance Premium Payment (HIPP) program to determine its cost effectiveness relative to Medicaid coverage, and to identify potential modifications to the program to increase its effectiveness as an option for private coverage for certain Medicaid eligibles. This examination will include a discussion of the FAMIS *Select* premium assistance model (under SCHIP) as an alternative to the current HIPP model.
  - FAMIS Select is a voluntary program with a capped assistance level, while HIPP is a mandatory (when "cost effective") model with assistance levels based on existing Medicaid managed care capitation rates.



## MRC Recommendation #7:
## Public Insurance Buy-In

**The Department of Medical Assistance Services should seek federal approval to expand, where feasible, "buy in" programs to allow expanded participation in the Medicaid and FAMIS programs, including the program authorized as the Family Opportunity Act, to the extent such expanded participation can be shown to be cost effective / cost neutral to the Commonwealth.**

# DMAS Progress on:
# Public Insurance Buy-In

- DMAS conducted a study of buy-in options under the FAMIS Program last year (House Document 48, 2006), which identified several competing factors that would influence the take-up rate and cost of a buy-in option.
  - Currently, it is difficult to model the structure of a buy-in in either Medicaid or FAMIS with the uncertainty surrounding the SCHIP reauthorization currently in consideration by the federal government, and its potential impact on coverage levels.
  - Once SCHIP funding levels are established for future years, DMAS intends to re-examine buy-in to determine their potential as a coverage option in Virginia.



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# Overview of Long-Term Care Partnership Programs

- Long-Term Care (LTC) partnerships are public-private ventures to address the financing responsibility of LTC.
  - LTC partnerships are designed to encourage individuals to purchase private LTC insurance in order to fund their LTC needs, rather than relying on Medicaid to do so.
  - LTC partnerships combine private LTC insurance with special access to Medicaid for individuals who use their LTC insurance benefits.
- Four states developed LTC partnerships in the 1980's, however in the 1990's laws were changed that removed the estate recovery disregards, essentially eliminating the "partnership" component for new programs and rendering the development of a program inconsequential.



# Long-Term Care Partnership Opportunity Under the DRA

- The Deficit Reduction Act of 2005 (DRA) lifted the moratorium on estate recovery disregards thereby encouraging new development of LTC partnerships as an option for state Medicaid programs.
- Virginia had been interested in a partnership program for some time, but pre-DRA rules did not allow Virginia Medicaid to implement a program
  - In 2004, Senate Bill 266 amended the *Code of Virginia* for the development of a LTC Partnership (contingent on allowance under federal law)
  - In 2006, House Bill 759 further amended § 32.1-325 of the *Code* specifically directing the Department of Medical Assistance Services to implement a LTC Partnership once federal law allowed such programs.

# Long-Term Care Partnership Program Design Under the DRA

- Under the DRA, states are now allowed to develop LTC partnerships using what is termed the "dollar-for-dollar" model.
  - Dollar-for-dollar policies protect a specific amount of personal assets. For every dollar that a LTC Partnership insurance policy pays out in benefits, a dollar of assets can be protected during the Medicaid eligibility determination.
  - These assets would also be protected from estate recovery upon the recipient's death.



# Progress Toward a Long-Term Care Partnership Program In Virginia

- DMAS and the Bureau of Insurance (BOI) have held a series of meetings to discuss and delineate the shared responsibilities for implementing a partnership program:
  - Regulatory language to implement the LTC partnership program (for both DMAS and BOI) is in place and our State Plan Amendment has been approved by the federal government
  - DMAS and the Department of Social Services continue to work out eligibility determination procedures relative to the LTC Partnership.

## Progress Toward a Long-Term Care Partnership Program In Virginia

**(continued)**

- All HHR agencies are collaborating on the public awareness campaign, Own Your Future, which will include the new LTC Partnership as a feature of the campaign.
- The Virginia Insurance Counseling and Assistance Program (VICAP) is the lead resource for consumer information on the Partnership.
- Virginia was one of ten states awarded the Center for Health Care Strategies LTC Partnership Expansion Grant ($50,000).
  - Virginia is using the grant funding to develop a website (www.valtcpartnership.org), brochure, and provide extra support for the VICAP program.



## Long-Term Care Partnership Launch

- Virginia will be the third state (since the DRA) to launch its LTC Partnership and the first state to launch its Partnership with a coordinated consumer outreach campaign.
- The Virginia LTC Partnership launches **September 1, 2007**.
- The Own Your Future – LTC Partnership press conference with Governor Kaine is scheduled for September 27 at 10:30 a.m. in the Cabinet Conference Room at the Capitol.

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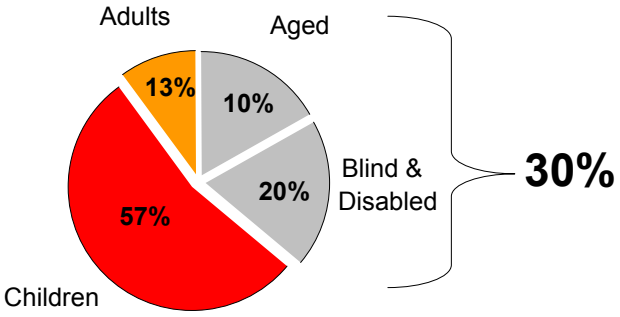
# Demographics Of Recipients In Virginia's Medicaid Program

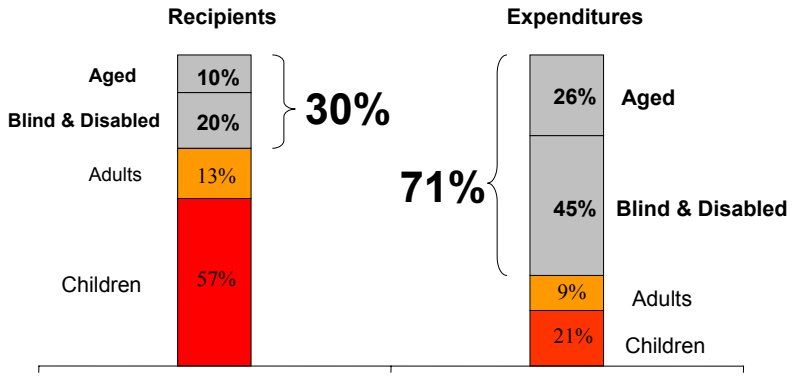
- The Elderly And Persons with Disabilities Represent 30 Percent of Medicaid Program Recipients




Note: Unduplicated count of recipients in FY 2005

# Demographics Of Recipients In Virginia's Medicaid Program
(continued)

- Yet they account for 71 percent of program expenditures

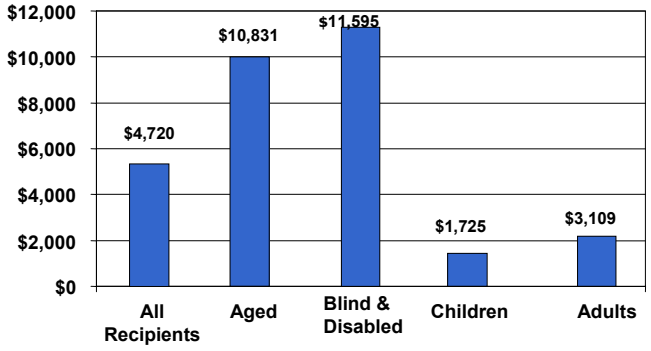



Notes: FY 2005 recipient and expenditure data



# Demographics Of Recipients In Virginia's Medicaid Program
(continued)

- Meaning the cost of serving the elderly and disabled is substantially greater than the cost of care for children




Notes: FY 2005 recipient and expenditure data

# The Blueprint for the Integration of Acute and Long Term Care

2006 Virginia Acts of the General Assembly **(Item 302, ZZ)**

Completed last December, this plan:

- explains how the various stakeholders are involved in the development and implementation of the new program models;
- describes the various steps for development and implementation of the program models;
- includes a review of other States' models, funding, populations served, services provided, education of clients and providers, and location of programs; and
- describes the evaluation methods that will be used to ensure that the program provides access, quality, and consumer satisfaction.



# The Blueprint for the Integration of Acute and Long Term Care

**(continued)**

- DMAS held a series of three meetings on acute and long term care integration models and issues (during Summer/Fall 2006):
  - First Meeting: Provided an overview of Medicaid funded acute and long term care services in Virginia and across the United States.
  - Second Meeting: Facilitated a meeting with stakeholders so they could provide input on the options for developing an integrated acute and long term care program in Virginia.
  - Third Meeting: Heard public comment on the integration of acute and long term care.

# The Case for Integration

**Current System: Fee-for-Service and Fragmented**

- Primary and Acute Care Services
  - Physician
  - Hospital
  - Pharmacy
  - Labs
  - Disease Management
- Long Term Care Services
  - Nursing Facilities
  - Home and Community Based Care Waiver programs (7)
  - Case Management

**New System: Capitated and Coordinated Care**

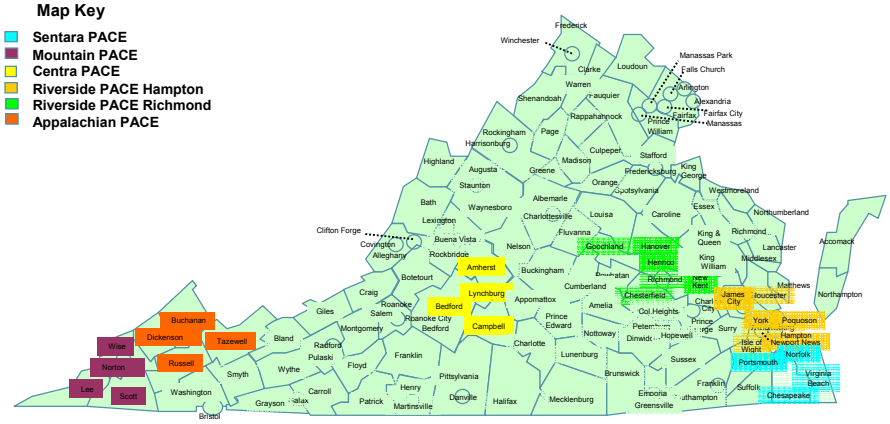
- Combines acute and long term care services (except for certain waiver programs) under one capitated rate
- Combines Medicare and Medicaid funding
- **ONE CALL—ALL CARE NEEDS**
- **Right Services at Right Time**



# Two Models for Integration- Community Model: PACE

- **Community Model:** Program of All Inclusive Care for the Elderly or PACE. Combines Medicaid and Medicare funding to provide all medical, social, and long term care services through an adult day health care center.
  - Limited to persons who are nursing facility eligible
  - Voluntary enrollment
  - Sites serve no more than 200 enrollees
  - Site receives both a Medicaid and Medicare capitated rate and pays for all services
- Six communities actively pursuing PACE—6 were awarded start up grants ($250,000 each). Implementation 2007-2008.
  - Hampton Roads (2)
  - Richmond (1)
  - Lynchburg (1)
  - Far Southwest (2)

# PACE in the Commonwealth of Virginia




# PACE of SENTARA: Likely First PACE Site in Virginia

- Successful Pre-PACE program for 10 years
- Has served over 500 recipients since 1996
- Capacity to enroll 130 recipients with attendance up to 100 daily
- CMS response date for approval is September 25, 2007
- **Targeted operational date is October 2007**

## PACE of Riverside at Hampton

- Hampton site is a community re-development project; housed in a building which has been vacant for 10 years
- RHS is highly regarded, extremely visible and dedicated to the population to be served
- Anticipate an average daily attendance of 90
- CMS has just completed their first 90-day clock review of provider application
- **Targeted operational date is November 2007**



## PACE of Mountain AAA at Big Stone Gap

- One of two rural PACE sites in the Commonwealth; has been working on PACE for the past 10 years with feasibility study conducted in 1996
- Will make use of telemedicine at this site
- Serving one of the poorest regions of the U.S.
- Most conservative estimates place a sustainable program at 124 recipients
- PACE provider application submitted to CMS on July 2, 2007; Currently under first 90-day clock review by CMS that will end on October 3, 2007
- Construction for new PACE site is slated to begin late 2007
- **Targeted operational date February 2008**

## PACE of Appalachian Area Agency on Aging at Cedar Bluff

- Second of two rural PACE sites in the Commonwealth
- Four counties over 1800 square miles, 676 persons per square mile, Per capita income $15,000
- Long history of working to improve the lives of the elderly
- Will utilize the Hub and Spoke service delivery model of care for PACE participants
- PACE provider application is currently under review by DMAS; will be sent to CMS Summer 2007.
- **Targeted operational date is April 2008**



## PACE of Riverside at Richmond

- RHS will employ an aggressive targeted marketing strategy in Richmond
- Challenge in developing in a market with no current facilities, programs or services
- 15 months following start-up of the Hampton site
- PACE eligibles in Richmond over 2,500
- Geographic considerations – 2 PACE centers within 5 years
- First center will be operating in Southside Richmond
- **Targeted operational date June 2008**

# PACE of Centra at Lynchburg

- Began in 2000 from a grassroots citizen's group concerned with health care for the elderly
- July 2006, Centra Health, local non-profit hospital system took over
  - Centra has a long-standing history of community stewardship
  - Centra Health is growing regionally with new affiliations with hospitals and health centers
- PACE site will be located in the center of the City of Lynchburg in an area that is part of the revitalization efforts of Lynchburg
- **Targeted operational date June 2008**



# What's Next with PACE

- DMAS published a Request for Application on July 23, 2007 for the development of a PACE site for underserved areas of Northern Virginia.
- This site will also be awarded a $250,000 start-up grant.
- Letter of Intent and questions due August 23, 2007
- Application deadline September 24, 2007
- Implementation 2008-2009

## Two Models for Integration – Regional

- **Regional Model:** Could range from a capitated payment system for Medicaid (potentially integrating Medicare funding) for acute care costs with care coordination for long term care services, to a fully capitated system for all acute and long term care services



## Regional Model: Populations Covered

**All 234,945 Low-Income Seniors and Persons with Disabilities (ABD)**

- **Medicaid Only (non-duals) 86,732 clients**
  - Don't use long term care services (79,045 clients)
  - Use long term care services (7,687 clients)
- **Medicaid and Medicare (dual eligibles) 148,213 clients**
  - Don't use long term care services (115,152 clients)
  - Use long term care services (33,061 clients)

## Regional Model: Services Included

- All Medicaid and Medicare primary, acute and long term care services (including some nursing facility care and home and community based waiver services, such as the Elderly or Disabled with Consumer Direction and AIDS waiver services)
- Services carved out:
  - Behavioral Health Services (state plan option only)
  - Certain waiver programs (MR, DS, DD, Technology Assisted, Alzheimer's Assisted Living)



## Regional Model: Enrollment Options

- Medicaid Managed Acute and Long Term Care: Enrollment will be mandatory with opt-out provisions
- Medicare Managed Acute and Long Term Care (Special Needs Plans or Medicare Advantage Plans). Voluntary and based on Medicare rules.

## Regional Model: Providers

- Medicaid Managed care organizations (Virginia and National plans) and Medicare Advantage Plans, Special Needs Plans



## Regional Model: Timeline

- **Current System:** Managed care for acute care needs only—49,000 low income seniors and individuals with disabilities (Aged, Blind, and Disabled) with no Medicare and with no long term care services.

- **Phase I (September 1, 2007):** Expands managed care for primary and acute care needs only to the ABDs with no Medicare but who have long term care needs. LTC services remain fee for service.

# Regional Model: Phase I Implementation

- Implementation date is September 1, 2007; CMS has approved.
- Will impact about 500 Medicaid only clients who are receiving managed care **first** and now need long term care services.
- Populations excluded:
  - Will not include dual eligibles (Medicaid and Medicare)
  - Will not include nursing facility residents
  - Will not include Technology Assisted Waiver clients
  - Will not move **current** LTC waiver clients into managed care.



# Regional Model: Phase II Implementation

- **Phase II (2008-2010):** Fully integrates acute and long term care services and combines Medicaid and Medicare funding.
  - **Excludes certain home and community-based care waiver program services (MR, DS, DD, Tech, Assisted Living)**
- In preparation for this phase, DMAS:
  - Made site visits to other States
  - Reviewed other States' integrated models
  - Consulted with experts, applied for technical assistance grant
  - Met with key provider groups

# Regional Model: Next Steps

- Will include stakeholder input throughout the development and implementation of this phase
  - DMAS has made presentations and met with several groups separately
  - Next general Stakeholder Meeting August 21, 2007 at DMAS, 10:00 a.m. to 12:00 p.m.
- Will develop a Request for Proposals in Fall 2007
  - DMAS will meet with various stakeholder groups for input
- Will submit 1915 (b) (c) waivers to CMS
- Will start as a pilot/regional program in Summer 2008
- Movement of geographic regions, populations, services, and funding sources likely to be phased in over time