DHS Virtual PACE Grant Exert of Proposal Section

Problem Statement

While the redesigned system has strengthened the long-term care system in many ways, the following weaknesses exist in the system.

- The large majority of beneficiaries are in the partially integrated Family Care program that does not include Medicare services. While the Family Care MCO coordinates with a member's primary and acute care providers and physician provided and inpatient mental health services, care coordination is incomplete and fragmented and the incentive for cost-shifting between the long-term care system and the primary, acute, and behavioral health care systems exists. A structure that brings all health, behavioral health, and long-term care services under care management can remove barriers, reduce fragmentation, reduce perverse financial incentives and produce better health and social outcomes and reduced costs for these high need beneficiaries.
- The Partnership program's existing administrative model combining Medicaid managed care with Medicare Advantage Specials Needs Plans creates administrative barriers to integration, and thereby impedes attaining the best possible member outcomes and the most cost-effective use of all funding resources. A new administrative structure can minimize features that lead to fragmentation, reduced access, diminished quality and increased cost, facilitating the operation of fully integrated programs and making them more attractive to dual eligible beneficiaries.
- The heavy Medicaid-funded investments in care management and expanded community-based, long-term service capacity produce better care and outcomes for clients, but a significant portion of the savings accrue to Medicare. To create the incentive and resources to invest in the Medicaid-funded components, the State needs to be able share in the savings produced for Medicare-funded services.

Proposal

Summary

Wisconsin DHS proposes to secure federal authority for the state to function as the Medicare/Medicaid entity, similar to PACE authority, to serve elders and adults aged 18 and over with physical and developmental disabilities who are at a nursing home level of care as determined through the state's long-term care functional screen. Unlike the current PACE model, service delivery will not be restricted to a specific physical site.

This approach will require authority from the Centers for Medicare and Medicaid Services (CMS), under authority(-ies) to be negotiated between the State and CMS. We expect the federal framework adopted to be something other than Medicare Special Needs Plan authority, which appears to be too restrictive.

Under the proposal, DHS will receive a Medicare capitation payment for each enrollee from the federal government. Subcontracts will be negotiated with entities to provide the full range of Medicare and Medicaid benefits to dual eligibles at the nursing home level of care based on risk-based capitated rates. The State will combine the Medicare capitation payment with a Medicaid capitation payment to generate a single, fully integrated capitation payment to the contracted entities. By making one entity responsible for all acute, primary and long-term care services, regardless of funding source, the model creates a framework to provide well-coordinated care and eliminates the incentive for cost-shifting between the acute/primary and long-term care system.

DHS Contract Entities and Alignment Opportunities

It is envisioned that DHS could contract with:

- the existing Partnership/PACE organizations;
- new entities that are composed of an existing Family Care MCO in collaboration with an acute/primary Health Maintenance Organization (HMO) or clinic; and/or
- Other types of entities.

In the case where a Partnership or PACE MCO is the contracting entity, the Partnership/PACE MCO would operate strictly as a contracted entity of the State, receiving a single capitated payment covering all Medicare and Medicaid services. The Partnership/PACE MCO would be relieved of the administrative requirements associated with being Medicare SNPs.

DHS will identify and implement measures to align Medicare and Medicaid administrative rules and processes both at the MCO and state level in such areas as enrollment, disenrollment, eligibility, marketing, appeals and performance reporting. The goals will be to minimize unnecessary administrative burden while preserving beneficiary protections, increase operational flexibility and, at the MCO level, minimize the negative effects of funding source rules on achieving member outcomes while also facilitating increased Partnership enrollment.

DHS also proposes to contract with new entities capable of administering a fully integrated Medicaid/Medicare benefit to dual eligibles. It is expected that at least some of the new entities will utilize the existing Family Care MCOs to leverage the experience and expertise of these organizations in providing cost-effective, person-centered long term care, particularly for complex populations, such as complex individuals with developmental disabilities.

DHS will encourage collaborations between Family Care MCOs and large, multi-specialty clinics or HMOs in their service areas.

Rate Method Development & Incentives

DHS will contract through a risk-based capitated agreement with the participating entity and provide a single capitated payment covering all Medicare and Medicaid services.

The model creates incentives for the participating entity to improve medical care for enrollees, through such mechanisms as longer physician visits, improved physical

accessibility of physician offices, increased emphasis on prevention measures, better management of hospital to home and other care transitions, and cultivation of specialized expertise in working with this complex population with multiple chronic conditions.

Better coordination and management of medical services is expected to reduce the need for Medicaid-funded long-term care and potentially reduce Medicaid costs for Medicare acute care cost-sharing.

The participating entity will provide comprehensive, coordinated care management, utilizing electronic records that include an individual's clinical, functional, and utilization data for all Medicare and Medicaid services.

Based on national research on fully-integrated Medicaid/Medicare program models, Wisconsin expects the proposed model to generate cost savings. Wisconsin will identify the baseline Medicare and Medicaid expenditures for the demonstration population. As part of this demonstration, Wisconsin proposes to establish a formula in which both the state and the federal government share savings that are achieved relative to the baseline. The contracted entities may also benefit through this shared-savings model, as in CMS's Physician Group Practice Demonstration project.

Timeline

DHS proposes to engage in analysis, development of program design, and planning during the remainder of 2011 and the first six months of 2012. Subject to the necessary federal approval, Wisconsin intends to implement three to four pilot sites beginning in mid-2012 with different types of contracted entities.

Enrollment

The Aging and Disability Resource Centers in the pilot sites will play the key role of informing current and prospective long-term care clients of the new program option. Informational material and enrollment counseling training that clearly describes the new program will be developed.

In the pilot sites, Wisconsin plans to adopt an "all-in" enrollment for dual eligibles into the new, fully-integrated program, with the opportunity to opt out after six months. Wisconsin currently uses the "all-in/opt-out" approach for Medicaid-only non-nursing home level of care SSI beneficiaries into managed care.

Evaluation

DHS will develop metrics to monitor the health, social and cost outcomes of the new model compared to the current Partnership/PACE and Family Care programs and will contract for an evaluation to be completed by an independent, external entity.

Virtual Pace Town Hall Meeting

2011 Forums

Madison 10/12/11, La Crosse 11/11/11

Amherst 11/11/1, Milwaukee 12/1/11

Welcome & Introductions

- Panel & Other Department Participants

- Audience Identification

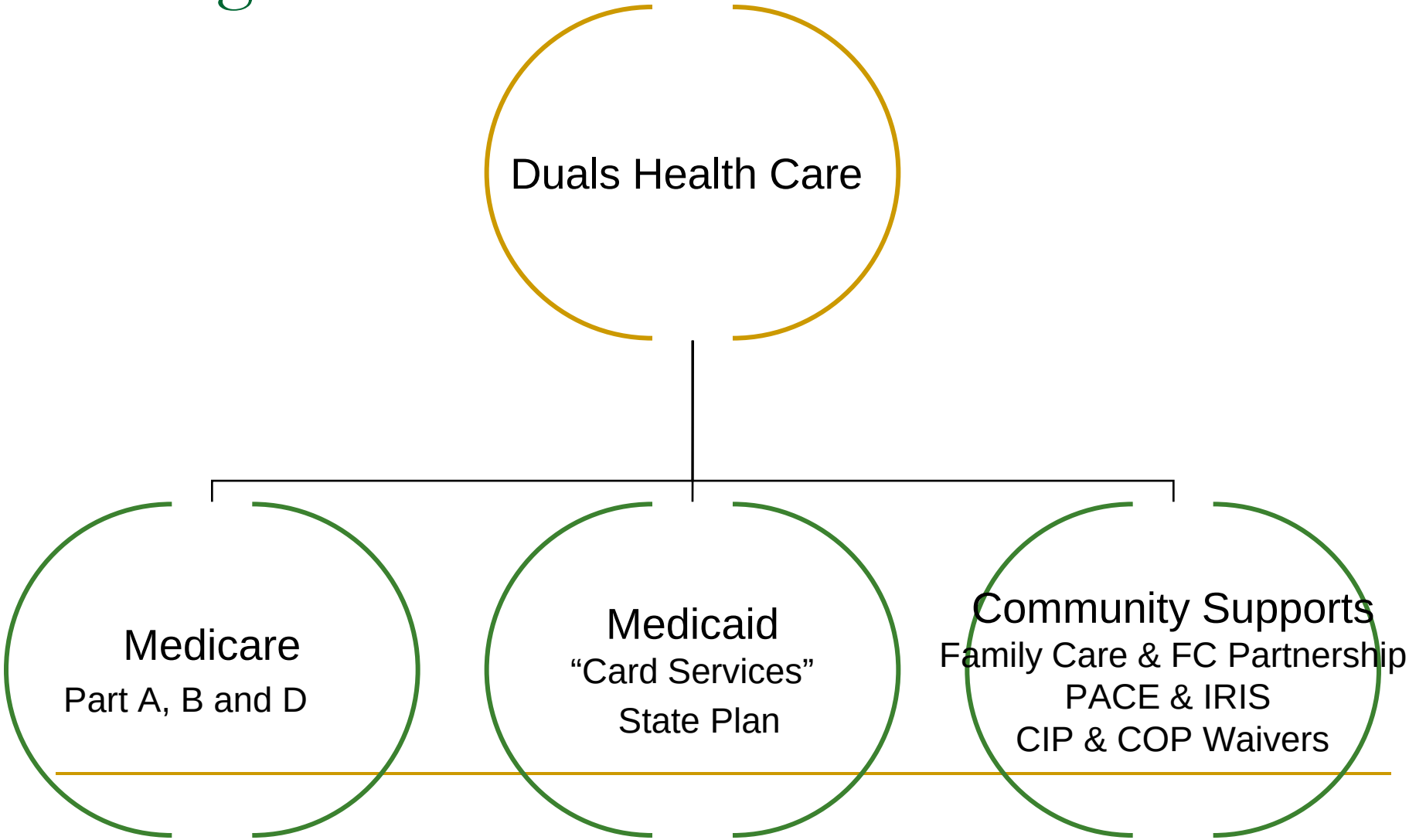
Objectives for Forum

- Hear your ideas for ways to improve coordination and delivery of services to duals
  - Improve Quality
  - Reduce Cost Inefficiencies
- Gain input into Virtual PACE proposal
  - Strengths
  - Areas to Improve
  - Components to Add

State Demonstrations to Ingrate Care for Dual Eligible Individuals

- Federal Grant of $1 million to design a program to integrate Medicare and Medicaid funding and service coordination
- Serve duals:
  - individuals receiving services from both Medicaid and Medicare.
- Improve care coordination and align the funding incentives

The Current Health Care System Duals Navigate



Examples of Areas of Navigate Across these Programs

- Separate Administrative Processes
  - Provider Credentialing
  - Program Enrollment
  - Eligibility Determination
  - Contracts
  - Appeals and Grievances
  - Quality Metrics & Standards
- Differing Benefit Package and Access Rules
  - Different rates and reimbursement criteria
- Result
  - Administrative burdens for states, providers, and consumers
  - Lack of service coordination
  - Misalignment of funding and reimbursement

Dual Eligibles National Statistics

- Individuals enrolled in both Medicare and Medicaid
- 9 million Americans participate in both Medicare and Medicaid in FFY 2007
- Higher medical needs than general enrollment population
  - Medicare: 21% of enrollees; 36% of expenditures
  - Medicaid: 15% of enrollees; 39% of expenditures

Dual Eligibles in Wisconsin

- Among 4 states with the highest proportion of Medicaid enrollees that are dual eligible (22%+)
- Over 120,000 Wisconsin residents access health care through both Medicare and Medicaid
- Approximately $2.4 billion spent annually on Medicaid benefits to duals
- 67% of Wisconsin expenditures on duals paid for long-term care services

Virtual PACE

Integrating Care Across Medicare and Medicaid

Virtual PACE Pilot: Program Goals

- Increase Care Coordination
- Reduce Administrative Barriers
- Eliminate Misaligned Funding Barriers

Virtual PACE: Proposed Enrollment

- Dual Eligibles with Nursing Home Level of Care
  - Most acute and complex care needs
  - Greatest opportunities to improve care coordination
- All-in Enrollment, Opt-out After 6 Months
  - Spreading the financial risk and up-front fixed costs across a larger population.
  - Time and experience for enrollees to assess value

Virtual PACE: Administration

- Combine Medicare and Medicaid funding into one capitated payment to promote cost efficiencies incentives
- Contract with entities to provide all Medicare and Medicaid services to reduce administrative burden

Progress to Date & Implementation Plan

- Receipt of Grant
- Initial Workplan
- Hired Dedicated Staff
- Obtaining Medicare Data
- Current Status: Seeking Stakeholder Input

- July 1, 2012
- Four regions of Wisconsin
- Immediately enroll 20,000

Input from Stakeholders

- Opportunities to Improve Service Coordination for Duals
  - How can acute, primary, behavioral, and long-term care services be more integrated?
- Input on Virtual PACE
  - What are your expectations and recommendations for the proposal?
  - Are there funding, contracting, or program design strategies that should be included?
- How do your recommendations add quality and reduce cost inefficiencies?

Conclusion/ Wrap Up

- Additional Input
  - Send in input form
  - Web survey
  - Additional Forums
- Next Steps
  - Data
  - Program Design

Overview of Medicare- Medicaid Coordination Office
Center for Medicare & Medicaid Services (CMS) Medicare-Medicaid Coordination Office established by Section 2602 of the Affordable Care Act in December 2010 to:

- More effectively integrate the Medicare-Medicaid (MC-MA) benefit,
- Improve coordination between federal and state governments for duals

Medicare and Medicaid were originally created as distinct programs with different purposes. They have different rules for eligibility, covered benefits, and payment. For over 40 years MC & MA have remained separately, despite an increasing overlap in people accessing both programs, duals. Today, over 9 million Americans are enrolled in both programs; these individuals are referred to as 'duals' or dual eligibles. [1]

Goals of Medicare-Medicaid Coordination Office (MMCO)
Better alignment of

- Administrative
- Regulatory
- Statutory
- Financial

Overview of Duals
Duals tend to be the most complex, chronically ill and therefore some of the highest cost.

- Total annual spending $300 billion across both programs.
- Medicaid- Duals are 15% of enrollees and 39% of spending 6xs higher than Medicaid only enrollees
- Medicare- Duals 16% of enrollees 27% of expenditures. 5 xs higher than Medicare only enrollees
- Three times more likely to have a disability
- Higher rates of diabetes, pulmonary disease, stroke, Alzheimer's and mental illness

1 DHS USA Statement on Dual-Eligibles: Understanding this vulnerable population and how to improve their care before the US House Committee on Energy & Commerce Subcommittee of Health, June 21, 2011
http://democrats.energycommerce.house.gov/index.php?q=hearing/hearing-on-dual-eligibles-understanding-this-vulnerable-population-and-how-to-improve-care

Wisconsin Statistics [2]

- Wisconsin approximately 120,000 residents are dual eligible
- Among 4 states with the highest proportion of Medicaid enrollees that are dual eligible (22%+)
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- 67% of Wisconsin expenditures on dual eligible's paid for long-term care services

2 Henry J Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007, December 2010: http://www.kff.org/medicaid/7846.cfm

Three Areas of Focus for Medicare-Medicaid Coordination Office

- **Program Alignment**
    - Care Coordination
    - FFS benefit
    - Prescription drugs
    - Cost sharing
    - Enrollment
    - Appeals

- **Data and Analytics**
    - MMCO developing a process to provide states with access to Medicare data to support care coordination for individuals enrolled in both Medicare & Medicaid.

- **Models and Demonstrations**
    - Wisconsin among 15 states with demonstration grant to design person-centered approaches to coordinate care across the primary, acute, behavioral health and long term care supports and services.

Letter of Interest

Subsequent to Wisconsin's receipt of planning grant for Virtual PACE, the Office of the Duals collaborated with the Center for Medicare and Medicaid Innovation (the "Innovation Center") to provide all states with an opportunity to pursue two financial models for better integrating care for dual eligibles. These two models include:

- **Capitated Model**: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.

- **Managed Fee-for-Service Model:** A 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.

CMS is interested in testing these models across the country in programs that collectively serve up to 1-2 million Medicare-Medicaid enrollees. States interested in the new financial alignment opportunities were required to submit a letter of intent (LOI) by October 1, 2011. CMS is offering streamlined approaches for States interested in testing these two models and technical assistance to support necessary planning activities. This information can be found at CMS Website. Wisconsin submitted a letter of interest for both of the models. http://www.dhs.wisconsin.gov/wipartnership/pace/loi.pdf

Work Plan Categories

- CMS Grant Administration
- DHS Grant Administration
- Staff Recruitment
- Outreach
- Medicare Data
- Proposal Design
    - *Programmatic*
    - *Fiscal*
    - *Infrastructure*
- Evaluation Mechanisms
- State Regulatory & Administrative Implication

Current DHS Activities

CMS Grant Administration
Ongoing dialogue with CMS for reporting, collaboration, resource sharing and technical assistance

- Site visit
- Interim progress report
- Monthly conference calls
- CHCS monthly TA & sharing calls

Staff recruitment
Three positions identified in the proposal for the initiative. Recruitment and hiring completed October 10th and October 31st.

- Project Director
- 2 Analyst

Stakeholder Outreach
The objectives for stakeholder outreach are to provide education and information on the MMCO and DHS partnership for our demonstration initiative, share our grant proposal and seek feedback on the design elements proposed in the grant.

- Town Hall Forums
- Survey

Program Design- Infrastructure

- IT Systems Planning – CARES systems analysis

Data Access & Analysis Planning

- Acquiring historical Medicare data (2008-2010)
- DUA for ongoing Medicare A&B data
- Planning for Medicare Part B data

Stay Up on Virtual PACE
http://www.dhs.wisconsin.gov/wipartnership/pace/index.htm