**REPORT OF THE**
**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

# Blueprint for the Integration of Acute and Long-Term Care Services

**TO THE GOVERNOR AND**
**THE GENERAL ASSEMBLY OF VIRGINIA**


# HOUSE DOCUMENT NO. 86

**COMMONWEALTH OF VIRGINIA**
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## EXECUTIVE SUMMARY

Governor Timothy Kaine, with support from the 2006 General Assembly, set in motion a major reform of the Virginia Medicaid funded long-term care services program, which will focus on care coordination and integration of acute and long-term care services for our most vulnerable citizens—low-income seniors and individuals with disabilities. The legislation (*Special Session I, 2006 Virginia Acts of Assembly, Chapter 3*) directed the Department of Medical Assistance Services (DMAS), in consultation with the appropriate stakeholders, to develop a long range blueprint for the development and implementation of an integrated acute and long-term care system. In addition to this plan, the Department was directed to move forward with two different models for the integration of acute and long-term care services: a community model and a regional model, which are explained below and in the body of the report. Finally, the legislation provided $1.5 million in start-up funds for six potential PACE sites.

The degree of chronic illness and disability among seniors and individuals with disabilities is a key policy and budget issue for the Commonwealth. Seniors and individuals with disabilities make up 30 percent of the Medicaid population in the state, but 70 percent of the costs of a budget that now exceeds $5 billion annually. The challenge is how to curb Medicaid growth in the long run without compromising access to services for vulnerable populations. While Virginia has been successful in implementing managed care for low-income children and families, it has not applied the same successful principles to programs specifically designed for the long-term care populations. Currently in Virginia, most Medicaid seniors and individuals with disabilities receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care is provided in a fee-for-service environment with no chronic care management. Long-term care is provided in a nursing facility or by a variety of home and community-based care providers with no overall care coordination or case management. In addition, most Medicaid seniors and individuals with disabilities qualify for both Medicare and Medicaid, which further complicates the access, quality, and funding of an integrated system.

In response to the legislation, DMAS held three meetings during the Fall 2006 to involve the community and state level stakeholders in the development of the Blueprint. The meetings provided an overview of other states' integration models and the opportunity for the public to comment and provide input into the design of the program. DMAS intends to involve the stakeholders throughout the design and implementation of the integrated acute and long-term care models to ensure that consumer protections, consumer choice, consumer direction, quality of care, and access to needed services are maintained. DMAS supports the vision of *One Community, the Olmstead Initiative* to allow individuals to live as independently as possible and in the most integrated setting.

This report provides the Blueprint for moving forward with the community and regional models for the integration of acute and long-term care services. The overall goal for this Blueprint is to offer some form of coordinated or managed care for the entire

spectrum of seniors and individuals with disabilities (also known as Aged, Blind, and Disabled under federal terminology) from the well to the frail. The focus will be on providing the "right services at the right time" and eliminating healthcare delivery systems based solely on funding sources and the need for long-term care services.

**Integration of Acute and Long-term Care Services for Seniors and Individuals with Disabilities: Community Model**

The community model is the Program of All Inclusive Care for the Elderly (PACE). PACE serves persons 55 and older who meet nursing facility criteria. All health and long-term care services are provided in the community, centered around an adult day health care model, and with Medicaid and Medicare funding combined. This is a voluntary program and is one community alternative to nursing facility care. DMAS intends to move forward with this model in two phases.

The current system is one pre-PACE site that has been in existence more than ten years, serving Hampton Roads (Sentara Senior Community Center). Phase I is the implementation of seven full PACE sites across the Commonwealth. Phase II will be the implementation of additional PACE sites in underserved areas of the state.

**Integration of Acute and Long-term Care Services for Seniors and Individuals with Disabilities: Regional Model**

The regional model could range from a capitated payment system for Medicaid and/or Medicare for acute care costs only and care coordination services for the home and community-based services, to a fully capitated system for all acute and long-term care services. Unlike the PACE model, where all health care professionals and all services center around an Adult Day Health Care Center, a regional model utilizes a variety of community health care providers. By design, regional models will coordinate the care needs of both seniors and individuals with disabilities and are not limited to only those with long-term care needs. While DMAS fully supports integrated and coordinated care, it is likely that one model will not meet the needs for all seniors and individuals with disabilities. DMAS also intends to move forward with a regional model in two phases.

The current system provides managed care for primary and acute care needs for more than 49,000 seniors and individuals with disabilities who are not Medicare eligible and who do not have any long term care needs. However, once these clients need long-term care services and/or become both Medicaid and Medicare eligible (known as dual eligibles), they are moved out of a managed care environment into a fragmented fee-for-service environment with little or no coordination of their health care needs. Phase I is a preliminary step to expand managed care for seniors and individuals with disabilities for at least their primary and acute care needs. Instead of moving Medicaid only seniors and individuals with disabilities into fee-for-service when they need long-term care services, DMAS intends to keep them in the coordinated care system for at least their primary and acute care needs, while keeping their long-term care services fee-for-service. Phase II is the most dramatic phase of the integration because the true integration of services

(primary, acute, and long-term care services) and funding (both Medicaid and Medicare) takes place. This model develops a seamless system of care that adjusts with clients as their care needs change over time. This model intends to include all long-term care services, except for certain home and community-based care waiver services.

The integration of acute and long- term care services should be successful in Virginia because:

1. The Governor and the General Assembly have provided a clear mandate that an integrated primary, acute, and long-term care service delivery system is what they envision for Virginia's seniors and individuals with disabilities.

2. Virginia has successfully utilized Medicaid managed care principles for its children, families, seniors, and individuals with disabilities for many years.

3. The Department of Medical Assistance Services has a good track record for ensuring the smooth transition to new programs by involving the stakeholders throughout the development and implementation process.

## INTRODUCTION

Governor Timothy Kaine, with support from the 2006 General Assembly, set in motion a major reform of the Virginia Medicaid funded long-term care services program, which will focus on care coordination and integration of acute and long-term care services for our most vulnerable citizens—low-income seniors and individuals with disabilities. The legislation (*Special Session I, 2006 Virginia Acts of Assembly, Chapter 3*) directed the Department of Medical Assistance Services (DMAS), in consultation with the appropriate stakeholders, to develop a long range blueprint for the development and implementation of an integrated acute and long-term care system (Item 302, ZZ). In addition to this plan, the Department was directed to move forward with two different models for the integration of acute and long-term care services: a community model (Item 302, AAA) and a regional model (Item 302, BBB). Finally, the legislation provided $1.5 million in start-up funds for six potential PACE sites (Item 302, AAA). The complete legislation for these items can be found in Appendix A.

Based on the legislation, the Department of Medical Assistance Services (DMAS), in consultation with the appropriate stakeholders, was directed to develop a long-range blueprint for the development and implementation of an integrated acute and long-term care system that included:

- an explanation on how the various community and state level stakeholders will be involved in the development and implementation of the new program models(s);
- a description of the various steps for development and implementation of the program model(s), including a review of other states' models, funding populations served, services provided, education of clients and providers, and location of programs;
- a description how the existing system is funded and how integration will impact funding; and
- a description of the evaluation methods that will be used to ensure that the program provides access, quality, and consumer satisfaction.

### Brief Summary of Acute and Long-Term Care Integration Meetings

To fulfill this mission, DMAS held three meetings from September through October 2006 to involve community and state level stakeholders in the development of the Blueprint. More than 75 stakeholders representing consumers, providers, legislature, and other state agencies attended the meetings. The following is a summary of the topics covered at each of the meetings (the agendas for the meetings can be found in Appendix B). All meeting materials (including presentations and summaries) may be found on the DMAS website at http://www.dmas.virginia.gov/altc-home.htm.

*September 7, 2006.* The first meeting was designed to provide information to all the stakeholders on Virginia's Medicaid funded acute and long-term care services and the national perspective on the integration of acute and long-term care services. The guest

speakers were from a national consulting firm, national long-term care organizations, and Virginia managed care organizations. The meeting also identified integrated care program design issues that Virginia needs to consider.

*September 26, 2006*. The second meeting was designed to allow the stakeholders to have input into three key program design issues for developing an integrated acute and long-term care program: (1) what populations should be covered in the integrated system, (2) what services should be included, and (3) what enrollment methodology should be used. The first part of the meeting, sponsored by the AARP, focused on the issue of consumer protections, choice, and direction that is needed for any integrated model of care. The second part focused on options for developing an integrated model for acute and long term care services.

*October 18, 2006.* The final meeting was to hear public comment on the integration of acute and long-term care services. Five individuals representing various stakeholders presented their comments at this meeting. Other written comments received were handed out at the meeting. All comments can be found in Appendix C.

In addition, DMAS posted a draft version of the Blueprint report on its website to allow various stakeholders the opportunity to comment on the report itself prior to final submission to the Governor and the General Assembly. Those comments are also included in Appendix C.

## Organization of the Report

This report is organized to mirror the order of discussions held during the three "Development of a Blueprint for the Integration of Acute and Long-term Care Services" meetings. For contextual purposes, the report will begin with an overview of the current Virginia Medicaid program (including long-term care and managed care services), followed by other state and federal efforts for the integration of acute and long-term care services. Finally, a Blueprint will be presented on the development of an integrated care system in Virginia.

## Statement of the Issue

The degree of chronic illness and disability among seniors and individuals with disabilities is a key policy and budget issue for the Commonwealth. Seniors and individuals with disabilities make up 30 percent of the Medicaid population in the state but 70 percent of the costs of a budget that exceeds $5 billion annually. Because of the high cost of institutionalization (exceeding $50,000 a year in some nursing facilities) and the lack of coverage for this type of care through the federally funded Medicare program, Medicaid pays for two-thirds of all nursing home care in the Commonwealth. Most people who enter a nursing facility in Virginia are either Medicaid recipients or become Medicaid recipients once they have "spent down" their assets paying for the nursing home care they need. For many persons, this can take less than two years. In fiscal year

2006, the Commonwealth spent more than $923 million in Medicaid-funded institutional care and $552 million for home and community-based waiver services.

Curbing Medicaid growth in the long run without compromising access to services for vulnerable populations represents a significant challenge for the Commonwealth. While Virginia has been successful in implementing managed care for low-income children and families, it has not applied the same successful principles to programs specifically designed for the long-term care populations. Currently in Virginia, most Medicaid seniors and individuals with disabilities receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care is provided in a fee-for-service environment with little or no chronic care management. Long-term care is provided in a nursing facility or by a variety of home and community-based care providers with little or no overall care coordination or case management. In addition, most of the Medicaid seniors and individuals with disabilities qualify for both Medicare and Medicaid, which further complicates the access, quality, and funding of an integrated system.

Somewhat unique among states, Virginia already successfully utilizes managed care principles to coordinate the health care needs of more than 49,000 persons who are seniors or individuals with disabilities (including those on SSI) but who do not yet need long-term care services. These clients have benefited from the various chronic disease management programs and coordinated health benefits that have traditionally been available to only low-income children and families. However, once these clients become Medicare eligible or require long-term care services they are moved out of the managed care program into the fee-for-service program. This disruption of care is not good for the client and is costly for the Commonwealth

Nationally over the past 20 years, the Medicaid managed long-term care market has grown very little, with less than three percent (fewer than 70,000 people) of the potential (national) market enrolled in managed care today. In spite of high interest among States in these types of programs, there have been numerous barriers in their efforts and many initiatives have been terminated during the development process. The two key barriers –(1) inability to combine Medicare and Medicaid funding for the dual eligible populations and (2) lack of interest of large, national providers -- are being lessened with the implementation of new features of the Medicare Modernization Act. Through this act, States are provided with new opportunities to more easily integrate Medicare and Medicaid covered benefits for the dually eligible populations and more national providers are considering entry into this market. At a recent meeting of all Medicaid directors, both the federal government and states listed integrated care models as their top priority. In Virginia, several of the current managed care organizations have expressed interest in pursuing an integrated care program for long-term care recipients.

Ultimately, Virginia's Medicaid Reform will focus on the coordinated management of acute and long-term care services for seniors and individuals with disabilities as this group will have the fastest growth rate in population over the next 10

years and the largest impact on the Commonwealth's Medicaid budget. Managed long-term care programs that integrate the full range of Medicaid benefits (and Medicare benefits for those that are dually eligible) into a single program for seniors and individuals with disabilities utilize resources more effectively, improve outcomes, achieve cost containment goals, and enhance budget predictability. The movement in the direction of the integration of acute and long-term care services will be completed with careful deliberation and include the participation of all the community and state stakeholders throughout the process.

This report highlights the current national and state trends in exploring the development of an integrated care approach for seniors and individuals with disabilities. It also identifies the phases that Virginia will take to integrate its Medicaid participants into a better managed, care coordination system.

## VIRGINIA'S MEDICAID PROGRAM

In order to propose the development of a Medicaid-funded integrated care system for Virginia's seniors and individuals with disabilities, it is first important to understand how Virginia's Medicaid program works, who the program serves, and how the program is financed. This discussion will also facilitate the understanding of the scope of integrated care efforts underway at the federal level and in other states and their relevance or application to the Virginia program.

### Background on Virginia Medicaid

Medicaid is an entitlement program authorized under Title XIX of the Social Security Act that provides coverage of medical services for certain disabled and low income individuals. Medicaid is financed jointly by the state and federal governments and administered by the states, within guidelines established and approved at the federal level. Federal financial assistance is provided to states and the federal match rate is based on the state's per capita income. The federal match rate for Virginia is currently 50 percent, meaning that for every dollar expended in the Medicaid program, 50 cents is from the federal government and 50 cents is from the state's general fund.

Medicaid, the largest healthcare program in Virginia, serves five distinct and important healthcare policy roles:

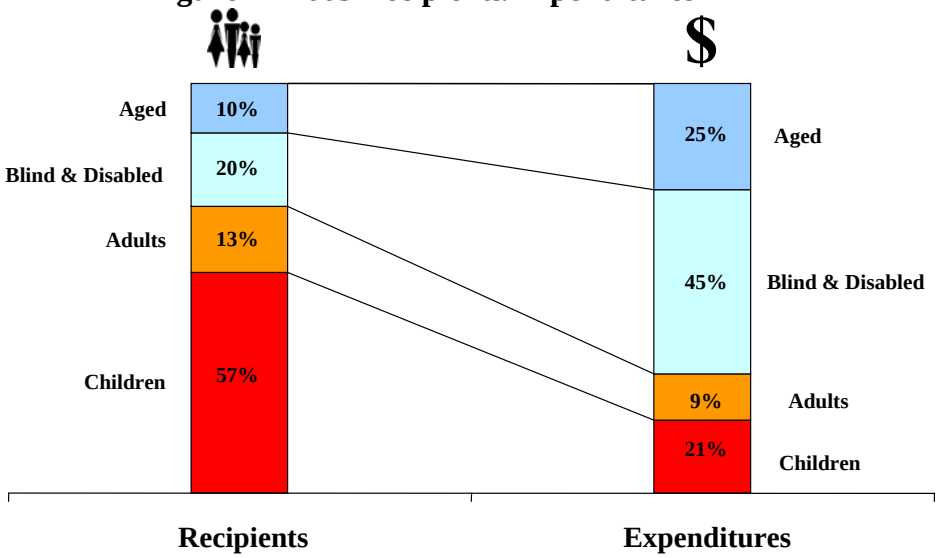
1. Ensure access to healthcare for low-income pregnant women and children through prenatal care and delivery and comprehensive coverage for children.
2. Provide access to care for low-income adults with children by establishing a set of mandatory and optional health care benefits.
3. Provide for the chronic and long-term care needs of seniors and individuals with disabilities through institutional and community-based care services.

4. Finance the safety net for the uninsured who are not Medicaid eligible through community health centers and disproportionate share funding to hospitals.
5. Fill gaps in Medicare coverage for "dual eligibles" through payment for Medicare premiums and deductibles, nursing home benefits, medical equipment, and some pharmacy costs.

While Medicaid was created to assist individuals with low incomes, coverage is dependent upon other criteria as well. Eligibility is primarily for people who fall into particular groups such as low-income children, pregnant women, the elderly, individuals with disabilities, and parents or caretaker relatives of dependent children. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid. This results in a great variation of eligibility criteria among the states.

In state fiscal year (FY) 2005, the Virginia Medicaid program served an average of nearly 691,000 recipients per month with annual expenditures of $4.4 billion (approximately one-half from federal funding). Children and adult caretakers make up about 70 percent of the Medicaid beneficiaries, but they account for only 30 percent of Medicaid spending. Seniors and individuals with disabilities, while a minority in terms of recipients served (30 percent), account for the majority (70 percent) of Medicaid spending because of their intensive use of acute and long-term care services (Figure 1).

**Figure 1 - 2005 Recipients/Expenditures**




The Virginia Medicaid program covers a broad range of services with nominal cost sharing for some of the beneficiaries as permitted under federal law. The Virginia Medicaid program covers all federally mandated services, including but not limited to:

- Inpatient and outpatient hospital care
- Physician, nurse midwife, and pediatric and family nurse practitioner services

- Federally qualified health centers and rural health clinic services
- Laboratories and x-ray services
- Prenatal care
- Family planning services
- Transportation services
- Skilled nursing facility and home health care services for persons over age 21
- Early and periodic screening, diagnosis, and treatment program for children ("EPSDT")

Additionally, Virginia Medicaid also provides some services at the state's option, including but not limited to:

- Dental services for persons under 21
- Prescribed drugs
- Rehabilitation services such as occupational, physical, and speech therapy
- Intermediate care facilities for persons with mental retardation (MR) and related conditions
- Mental health services
- Home and Community-Based Services as an alternative to institutionalization

Health care services are provided to Medicaid recipients through two service delivery models:

- Fee-for-service (FFS) - the standard Medicaid program where providers enroll and are reimbursed directly from DMAS for services rendered
- Managed Care Organizations (MCOs)- utilizing contracted managed care organizations that pay providers directly. Virginia pays MCOs a "per member per month" fee (PMPM or capitated payment) through a full risk contract to manage the majority of the recipients' care. Some services are carved out of managed care, such as dental care for children and community behavioral health care services (known as state plan options mental health services).

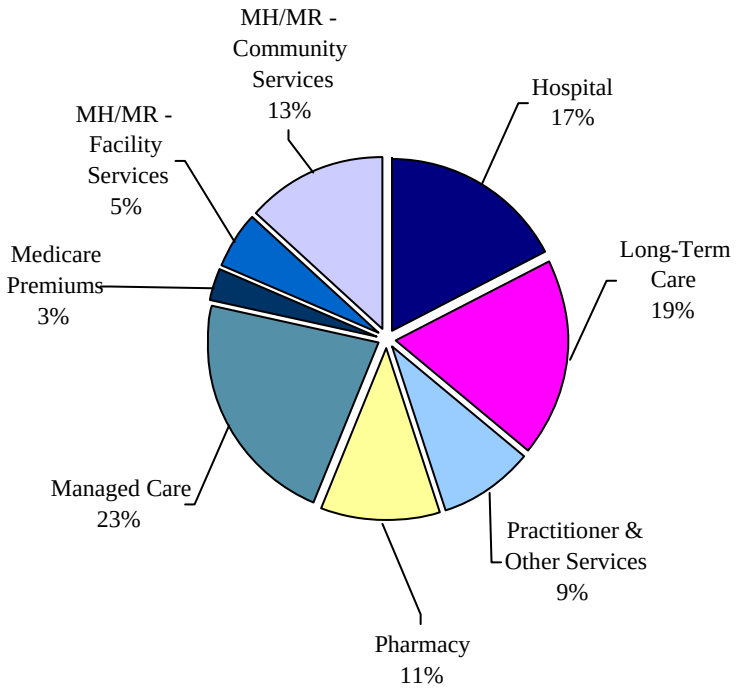
As of November 2006, nearly 55 percent of Medicaid/Family Access to Medical Insurance Security Plan (FAMIS) recipients are enrolled in the MCO program, with approximately 45 percent of recipients in the FFS program. Certain recipients (most notably those in long-term support programs and institutions) are currently excluded from participation in the MCO program. Additionally, Medicaid managed care is not yet available statewide due to market conditions. Recipients who would otherwise be eligible for managed care if plan coverage existed in their region are enrolled in a primary care case management program, but services remain reimbursed under the FFS methodology.

Figure 2 below presents the proportion of healthcare expenditures by the major service area in FY 2005. It is important to note that the "Managed Care" expenditure total represents the expenditure to the participating health plans, with plans paying providers for services to their participants.

Despite Virginia's relative affluence (7th in the nation in per capita income), Virginia remains ranked near the bottom among states in terms of the number of Medicaid recipients as a percentage of the population (47th in the nation) and the Medicaid expenditure per capita (49th in the nation). Based on these and other statistics, Virginia's Medicaid program has long been described as a very lean program with very strict eligibility criteria and modest payment rates for services. Administrative costs of the Virginia Medicaid program represented only 1.8 percent of total Medicaid expenditures in 2005.

**Figure 2**

**FY 2005 Expenditures, by Service Category**




## Medicaid-Funded Long-Term Care Services

Medicaid is Virginia's major source of financing for long-term care services, covering services for low-income seniors and individuals with disabilities in both institutional and community-based settings. Most of these services are not covered by either Medicare or private insurance. While the majority of people who receive long-term care are over 65 years of age, more than 30 percent are younger adults and children with severe physical impairments, developmental disabilities, or a degenerative disease

that may require a lifetime of care. In 2005, more than 27,000 Virginians received care in a nursing facility and more than 19,000 received long-term care services in the community.

Medicaid is intended to assist low-income seniors and individuals with disabilities with long-term care needs, but it is not available to everyone who needs some level of long-term care services. Those who need long-term care services must meet both financial and functional eligibility criteria to qualify for Medicaid funded long-term care.

- **Financial Eligibility**. In Virginia, the income limit for the Aged, Blind, and Disabled is set at 80 percent of the Federal Poverty Limit (FPL), which is $654 for an individual and $880 for a couple in 2006. In addition, Virginia is one of 33 states that has a "medically needy" program, which allows recipients with high medical bills to spend down to the state eligibility standard - 80% of FPL. In addition, because so few seniors and individuals with disabilities can afford the high cost of long-term care, individuals who meet the functional criteria (explained below) for long-term care can qualify under the "300 percent rule." Under this option, individuals with up to 300 percent of SSI ($1,806 per month in 2006) can qualify for Medicaid assistance with long-term care (Virginia is one of 38 states that allow this for at least institutional care).

- **Functional Eligibility Criteria.** Virginia has one of the most stringent functional eligibility criteria in the nation. Virginia's criteria for long-term care services is based on the clients' level of functioning for performing daily personal care activities, such as bathing, toileting, dressing, and eating, and their medical and nursing needs. Virginia utilizes a standardized and comprehensive assessment, known as the Uniform Assessment Instrument (UAI), to assess the need for long-term care services, both for admission to a nursing facility and to receive services in the community.

The Virginia Medicaid Program has been the leader in many long-term care initiatives over the years. Four key initiatives were:

(1) Virginia was the first state to offer a nursing facility pre-admission screening program to delay or divert people from institutions to community care. Based on this program, thousands of people are served in the community each year.

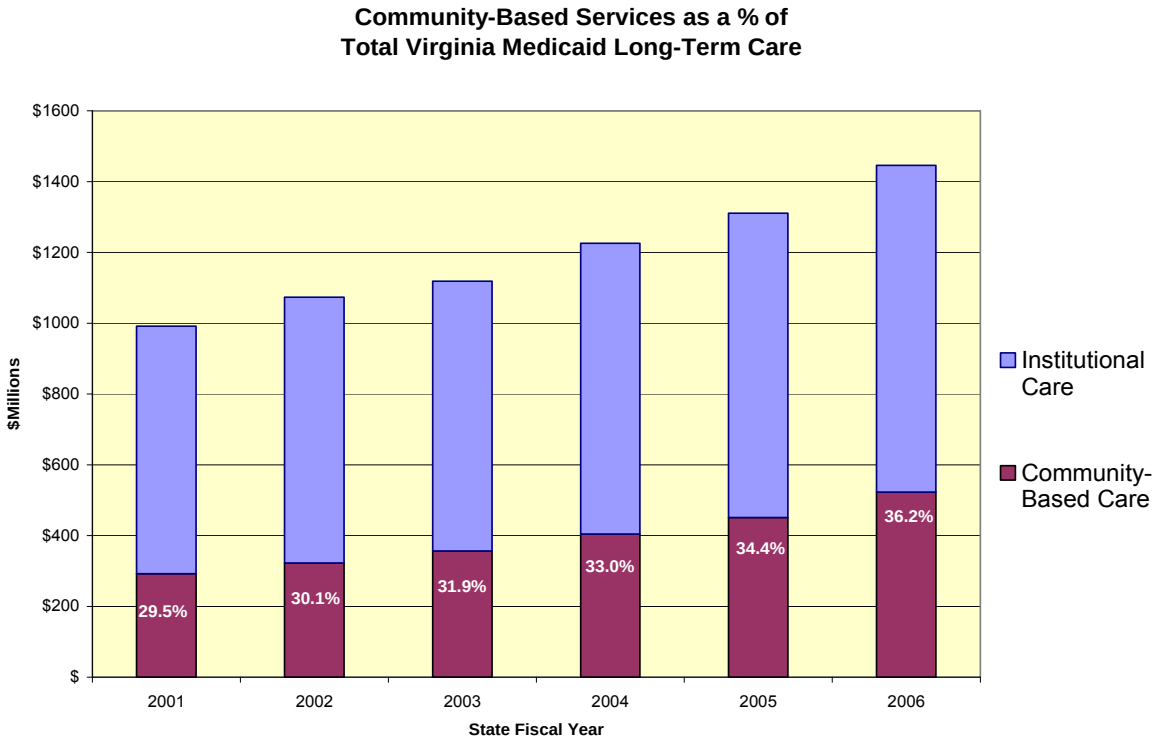
(2) Virginia was the second state to offer a home and community-based waiver program as an alternative to institutionalization. In 1982, DMAS started with one waiver program offering one service, personal care. Today, DMAS offers seven community-based waiver programs with a full spectrum of long-term and supportive services.

(3) DMAS, along with its sister state agencies, developed and implemented the UAI to assess care needs across publicly funded long-term services.

(4) Virginia is one of the first states to offer consumer direction (which allows clients and their caregivers to hire, supervise, and fire their own personal care attendants) in its Mental Retardation and Developmentally Disabled waiver programs.

DMAS actively supports the vision of *One Community, the Olmstead Initiative* to allow individuals to live as independently as possible and in the most integrated setting. The Department's key long-term care performance measure focuses on increasing the percentage of expenditures for community-based care services as a proportion of all long-term care expenditures. Figure 3 below provides the progress towards that goal. At the present time, Virginia is ranked 29th in its level of expenditures for community-based care services.

**Figure 3**



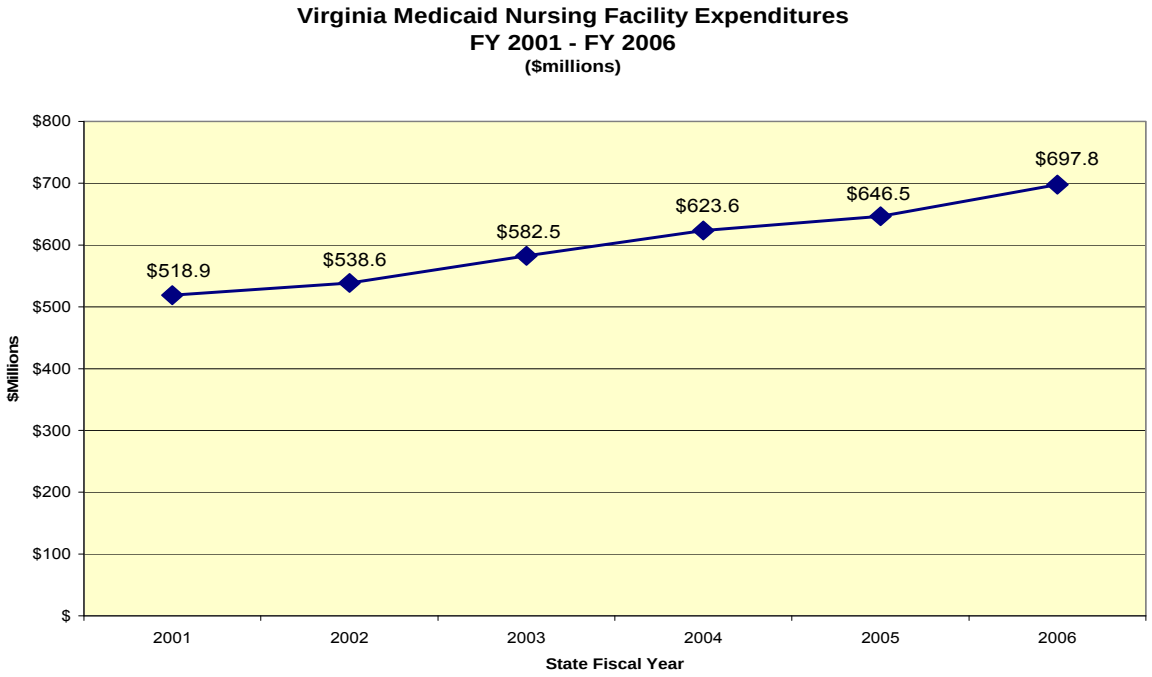

### *Institutional Services*

One of the Medicaid-covered institutional settings is a nursing facility. Nursing facility care is designed to provide a lesser level of care as compared to a hospital for those needing long-term nursing or convalescent care due to aging, injury, or illness. In recent years, the number of nursing facility (NF) residents has remained relatively constant. In 2005, there were 27,729 recipients of nursing facility services who qualified for Medicaid. According to the Joint Legislative Audit and Review Commission

(JLARC), as of June 2005, there were 270 nursing facilities and 31,279 beds in Virginia certified for Medicare and Medicaid reimbursement and licensed by Virginia Department of Health. In 1990, nursing facility care became a federally mandated Medicaid service for persons who meet eligibility requirements based on medical need. Medicaid also covers long-term care services provided in intermediate care facilities for persons with mental retardation (ICFs/MR) and care provided in long-stay hospitals.

Medicaid essentially pays for two-thirds of all nursing facility beds in Virginia. Medicaid reimbursement for nursing facilities has improved over the last several years. From 2001 to 2006, reimbursement increased more than $180 million in spite of the fact that number of nursing facility residents has remained relatively constant at about 27,000 residents. While part of this increase can be attributed to normal cost inflation, the Governor and General Assembly have also funded several enhancements to nursing facility ceilings and rates. Figure 4 provides the trend for nursing facility reimbursement.

**Figure 4**




### *Home and Community-Based Services*

The federal government allows Medicaid to pay for community-based services in lieu of institutional care through the use of 1915(c) home and community-based care service (HCBS) waivers. These waivers allow states to target services to specific populations that are at risk of institutional placement. Virginia currently operates seven HCBS waivers: the HIV/AIDS, Elderly or Disabled with Consumer-Direction (EDCD), Individual and Family Developmental Disabilities Support Waiver (DD), Mental Retardation (MR), Technology Assisted (Tech), Day Support (DS), and Alzheimer's.

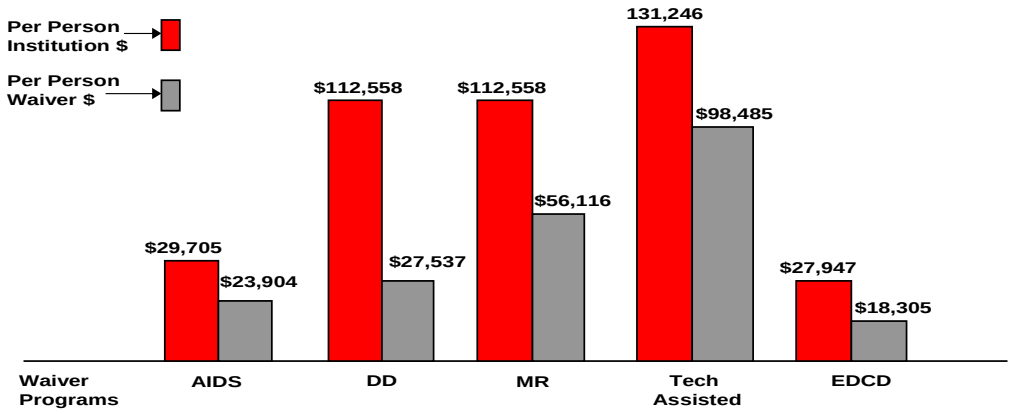
These waivers provide a number of community-based services such as personal care, respite care, skilled nursing, day support, environmental modifications, and assistive technology. Individuals receiving waiver services may also consumer-direct some services, which mean the recipient is the "employer" and is responsible for hiring, monitoring and firing the care attendants. Services that allow for consumer-direction include personal care, respite, and companion care. Appendices D and E provide a comprehensive list of services provided and expenditures for each waiver. Seniors and individuals with disabilities who receive long-term care services via one of the Medicaid HCBS waivers also have access to the full array of Medicaid covered services.

Virginia's waiver programs for seniors and individuals with disabilities are expensive, but still cost less than comparable institutional care (See Figure 5). A key factor that allows the community-based care alternative to be less expensive than institutional care is that there are family and friends willing to supplement the care provided through the waiver program. These clients are still at risk for nursing facility placement but are avoiding the care through unpaid family care, community support, and the delivery of the various home and community-based waiver program services.

**Figure 5**

**Comparison of Institutional and Home and Community-based Program Costs**

**(State Fiscal Year 2005)**




***Programs of All-Inclusive Care for the Elderly (PACE)***

In addition to institutional care and HCBS waivers, Virginia currently has a pre-PACE provider located in the Hampton Roads area. PACE programs target individuals who are 55 years of age and older and who meet the criteria to enter a nursing facility. A full PACE program features a comprehensive service delivery system and integrated Medicare and Medicaid financing; pre-PACE integrates primary and long term care services within Medicaid, but does not integrate Medicare financing and services (pre-PACE also excludes Medicaid funded inpatient and outpatient hospital, lab/x-ray, and ambulatory surgical costs). In Fiscal Year 2005, 125 beneficiaries were served through the pre-PACE program at an annual average cost of $29,500 per person. This site will

become a full PACE program in 2007, and several more PACE sites are expected to be developed over the next two years.

## Medicaid-Funded Managed Care

The managed care delivery system represents a care delivery model where the goal is to deliver quality, cost effective healthcare through monitoring and managing the utilization of services. These models became popular in the late 1980's primarily in the commercial insurance population. The system promised to contain costs and focus on preventive care, prior authorization and network development. While this traditional model floundered somewhat in the commercial market due to many factors, such as the consumers' desire for provider choice, the model succeeded in the Medicaid market and grew stronger in the 1990's. This model proved it worked better than the fee-for-service model in urban areas; states that implemented managed care experienced improved recipient health outcomes, stronger provider networks, and reduced utilization trends.

### *Virginia's Current Medicaid Managed Care Program*

In the mid 1990's, DMAS initiated a full-risk, Medicaid managed care program utilizing managed care organizations (MCOs) for the delivery of health care to Medicaid recipients. The MCO program was created to improve Medicaid recipient access to medical care, promote disease prevention, ensure quality care, and affect savings. On January 1, 1996, the MCO program began in Tidewater as a pilot project that included four MCOs servicing seven localities in the Tidewater region. Since then, the program has experienced multiple regional and plan expansions and is currently serving more than 381,000 Medicaid/FAMIS recipients in 110 Virginia localities (see Figure 6 on the next page and Appendix F).

**Figure 6**

**Medicaid Managed Care Expansions, 1997-2006**

| Year | Locality | Lives Added |
|---|---|---|
| 1997 | Tidewater | 80,000 |
| 1999 | Central Virginia | 70,000 |
| 2000 | Areas Adjacent to Central Virginia | 10,000 |
| 2001 | Northern Virginia, Danville and Roanoke (Includes implementation of FAMIS into new areas and areas currently served by MCOs) | 103,000 |
| 2005 | Northern Virginia and Winchester | 40,600 |
| 2006* | Culpeper, Danville | 4,000 |

*In addition, the ABD 80% group was added July 1, 2006 (≈1,400 lives)

The program has also provided the Commonwealth with value and high quality healthcare via an integrated and comprehensive delivery system to Medicaid and FAMIS recipients. This includes disease and case management programs, enrollee outreach, and ongoing quality improvement. The Commonwealth also requires its MCOs to have national quality accreditation. This accreditation measures access to care, overall member satisfaction, prevention, and treatment. Five MCOs are currently National Committee for Quality Assurance (NCQA) accredited and have an "Excellent" rating while two MCOs are currently pursuing NCQA accreditation. Those two MCOs have existing quality accreditation through other quality organizations.

Virginia's MCO program is a full-risk managed care model in which a monthly per member per month (PMPM) capitation fee is pre-set, and the MCOs accept the PMPM as payment-in-full regardless of the cost of services actually incurred by the individual recipients. There are no monetary caps where once reached, services would be denied, nor are there risk-corridors or other re-insurance options in which the state would assume the cost of services beyond a certain monetary threshold. Thus, to the managed care participant, the program remains a defined-benefit approach, but the utilization is managed through typical MCO processes of prior authorization and quality management review.

DMAS operates its mandatory managed care program through a federal waiver and through state regulations. Certain Medicaid and all FAMIS recipients are required to access services through the MCO program if a choice of MCOs is available in the region. Benefits are mandated by DMAS in its MCO contracts. A few services like dental and certain mental health services are carved-out and remain the responsibility of the Medicaid FFS program. All other service and authorization requirements, claims, appeals, and marketing practices are handled by the MCOs in accordance with their operating requirements. Enrollment into managed care and program information dissemination is handled by DMAS through contracted enrollment brokers.

DMAS regulates the managed care program through: monthly MCO meetings, network reviews, on-site visits, pattern of care studies, ongoing assessment and approval of member documents such as MCO identification cards and member handbooks, annual revision of the MCO contracts, review of MCO enrollee communications, and significant complaint and report monitoring. DMAS contracts with an external quality review organization (EQRO) to examine each MCO's policies, procedures, and services with respect to enrollee rights and protections, quality assessment and performance improvement, and grievance systems. The Bureau of Insurance regulates the licensure and solvency of the MCOs in Virginia. This oversight has resulted in DMAS having MCOs that are fiscally strong and administratively efficient.

MCOs are successful in enhancing access and availability of care by requiring physician, hospitals, ancillary, transportation, and specialty provider networks that are more extensive than what was historically available in regular Medicaid. The program promotes preventive care services, continuity and appropriateness of care, extensive member services including 24-hour nurse advice lines, enhanced services and benefits (such as adult vision services, enhanced pre-natal programs, case management services,

and group and individualized enrollee health education and outreach). MCOs actively recruit providers, build networks, and credential providers to assure well-qualified providers are giving care to their enrollees.

In FY 2005, Medicaid managed care served 55% of Medicaid/FAMIS enrollees while the fee-for-service program served the remaining 44%. The program targets FAMIS recipients, families and children, some of the disabled and medically indigent populations in regions for which plan coverage exist. Certain recipient populations are excluded from MCO coverage even when plans are otherwise available in the region. Specifically, the FFS system, by design, still serves the long-term care population (both those institutionalized and those in the various home and community-based waiver programs), foster care children, and those with third party insurance (the largest group being the dually eligible Medicare/Medicaid population). Additionally, at any given point in time, a significant number of MCO-eligible new recipients will be in FFS for a month or two awaiting plan assignment to one of the MCOs in their region.

***Future Managed Care Expansion Efforts***

Managed care has played a prominent role in the reform efforts underway at the various state Medicaid programs across the nation as well as in Virginia. For example, DMAS is currently reviewing the efficacy of including other categorically excluded groups within a managed care model. A portion of the Aged, Blind and Disabled 80% group (incomes at 80% of the federal poverty limit) was just added to the managed care rolls in July 2006 (this group does not have Medicare and is not utilizing long-term care services). In the future, DMAS, the Virginia Department of Social Services, and the local departments of social services will discuss the potential inclusion of foster care children under the current MCO program. As the Department moves forward with eligibility category expansions to managed care, there is concern that the special needs of previously excluded populations be addressed in the program/benefit design, including a focus on concerns or complaints from these groups specifically as the managed care program evolves.

From a geographic perspective, DMAS is currently targeting expansion of the MCO program in areas that are now being served by only one contracted MCO. In those localities, managed care participation remains a voluntary choice by managed care eligible recipients. The Department wants to consider expansion of the MCO programs in these localities as a way to strengthen and stabilize the program.

Additionally, the Department is considering options for geographic expansion into areas where no Medicaid/FAMIS contracted MCOs currently operate. The future expansion of Virginia's managed care program into these areas may be very difficult for a variety of reasons. Most of the remaining areas currently without Medicaid managed care coverage are extremely rural, and it remains to be seen if the same model implemented in urban areas will work for rural areas, especially when there is a general lack of providers (not just Medicaid) and a lack of managed care experience (both commercial and Medicaid) in the region. There is also an increased cost to providing

outreach in rural areas. Additionally, the Department is experiencing some difficulty in expanding and in maintaining coverage in certain areas due to network development issues related primarily to reimbursement rates.

## OTHER STATE EFFORTS FOR INTEGRATION OF ACUTE AND LONG-TERM CARE SERVICES

### Overview of Integration Efforts

In 2003, 3.1 million seniors and individuals with disabilities received Medicaid-financed long-term support services in the United States. Of these individuals, only 2.3 percent received those services through managed care programs. The number of people needing long-term care and their public expenditures promise to rise more rapidly in the coming decades as the baby boomers age and the number of non-elderly adults with disabilities increases. To address this, states have been looking toward managed care as a way to slow the increasing expenditures for long-term care services while optimizing the services that are provided. Several states are accomplishing this by including long-term care in their Medicaid managed care programs in lieu of "carving out" these services or excluding these individuals.

The ability of states to provide managed care, which combines Medicaid and Medicare funding and/or fully integrate all health and long-term care services for its elderly and disabled clients, received a huge boost with the passage of the Medicare Modernization Act in 2003. Most people associate this legislation with the new pharmacy program for Medicare clients, known as Medicare Part D. However, it also provided the vehicle for states to more aggressively work with Medicare managed care plans and created a new program, known as Special Needs Plans, to provide integrated care to its Medicaid/Medicare clients. Now both the federal government and many state Medicaid agencies are listing integration of acute and long-term care services as one of their top priorities for the coming year. Congress and the federal Medicaid Commission are also examining ways to eliminate several administrative hurdles to make it easier for states to move forward with combining Medicaid and Medicare managed care programs into one seamless program.

#### *Integration for Individuals Eligible for Medicare and Medicaid (Dual Eligibles)*

Dual eligibles receive services through both the Medicare and Medicaid programs. These two programs are guided by different laws and regulations, are administered by different government entities, and cover a different set of services. These differences often lead to inefficiencies and fragmentation in health care delivery and financing. In addition, dual eligibles are more likely than other Medicare beneficiaries to be in poor health, be cognitively or functionally impaired, and have chronic conditions. Combining functional challenges with an extremely complicated service delivery system poses numerous challenges for these individuals, their providers,

and their caregivers. Possible results from this fragmentation can include providers lacking information about the full range of services for which a beneficiary is eligible; beneficiary confusion about care; cost inefficiencies; and poorer quality of care and health care outcomes for the beneficiary. (See Appendix G for a comparison of Medicaid and Medicare benefits).

To improve coordination between Medicare and Medicaid, some states (Massachusetts, Minnesota, and Wisconsin) have integrated these two programs through a coordinated managed care delivery system. Advantages cited by policymakers for integrating services under a managed care program include:

- Reducing fragmentation and improving service coordination;
- Removing the incentive to cost-shift from one program to another and increasing care accountability;
- Increasing flexibility in the types of services that can be provided to beneficiaries;
- Focusing on prevention and care coordination activities in the delivery of health care services;
- Reducing hospitalization and nursing home use with more emphasis on home and community-based supports; and
- Creating budget predictability for state Medicaid agencies.

There are numerous potential advantages to integrating long-term care services and dually eligible individuals into a managed care delivery system; however, managed care integration is not without opposition. Beneficiaries are concerned that their ability to select a provider will be restricted and that managed care plans will reduce the quality and availability of services. Providers are often concerned about the additional requirements or financial impact of operating under a managed care environment. Figure 8 (on the next page), developed by Amerigroup for Virginia's Blueprint meeting, lists some of the common myths and realities for an integrated model of care.

**Figure 8**
**Myths and Realities for Integrated Acute and Long-Term Care Models**

| Myths | Realities |
|---|---|
| ➢ Cost savings are achieved through cuts in services to consumers or rates to providers | ➢ Cost savings are achieved through decreasing avoidable episodes of care and increasing alternatives to institutionalization |
| ➢ Integration will add to the bureaucracy and make it more difficult to get services | ➢ Integration streamlines access to services making it easier for consumers to get timely care and services |
| ➢ Traditional community providers will be pushed out of business | ➢ Providers that understand the population and provide good service will see their market share grow |
| ➢ Consumers will have to change providers, accept new services, have fewer choices | ➢ Consumer protections leave individuals in the driver's seats with respect to providers and service plans |
| Provided by Amerigroup at the Development of a Blue Print for the Integration of Acute and Long Term Care Services, September 7, 2006 meeting. | |

## Federal Perspectives on Integrated Care

The federal agency, the Centers for Medicare and Medicaid Services (CMS), has made the coordination of Medicare and Medicaid services for seniors and individuals with disabilities a top agency priority. Through the formation of an internal workgroup, which consists of both Medicare and Medicaid staff, CMS is committed to streamlining and aligning both the Medicare and Medicaid regulations for managed care as much as possible. In addition, the Medicaid Commission recently released its recommendations for improving the process.

The integration of Medicare and Medicaid can occur through various contractual arrangements between the federal and state governments and the managed care plan. For a state Medicaid agency to implement a managed care program, most programs (including Medicare/Medicaid integration projects) require some form of federal approval from CMS under one of several possible authorities. Certain types of federal approval occur more quickly than others.

In addition to the state Medicaid agency obtaining federal approval to integrate new populations into managed care, managed care organizations must also obtain special federal approval if they chose to enroll Medicare enrollees. Medicare managed care programs must be voluntary for all beneficiaries and can be developed under several authorities:

- **Medicare Advantage:** Medicare Advantage (MA) is the voluntary managed care option under Medicare law (Part C of Title XVIII of the Social Security Act). Managed care plans that apply to CMS to become a MA plan must provide all Medicare-covered items and services. MA plans are unable to limit enrollment to only certain types of Medicare beneficiaries (e.g. dual eligibles). MA plans are becoming more popular with Medicare beneficiaries and the number of individuals enrolling in these plans is steadily rising. In July 2005, there were 247 MA plans with 4.9 million enrollees.

- **Medicare Special Needs Plans:** Medicare Special Needs Plans (SNPs) are a type of Medicare Advantage plan that are permitted to limit enrollment to certain types of Medicare beneficiaries (e.g. dual eligibles). On December 8, 2003, President Bush signed into law the Medicare Modernization Act (P.L. 107-193), which established the Medicare SNP option. SNPs are intended to improve care coordination and service delivery for certain groups of Medicare beneficiaries. Through the SNP legislation, a single managed care provider can receive two fixed, predetermined monthly payments (i.e., the capitation rates) from CMS and the state Medicaid agency to provide the Medicare and Medicaid services that a beneficiary needs. SNPs must follow all of the MA program rules, but are permitted to limit enrollment to certain categories of Medicare beneficiaries including dual eligibles, individuals with severe and disabling chronic health care conditions, and those who are nursing facility eligible. Before SNPs, Medicare managed care plans had to enroll all Medicare beneficiaries and could not limit enrollment to a certain population.

CMS projects that in 2007, there will be a total of 470 SNPs. Three-hundred and eleven of these will serve dual eligibles, and 85 SNPs will target individuals eligible to receive services in an institutional setting, and 74 will target individuals with chronic conditions. The SNP market is in the early stages of development; however, the federal legislation that established SNPs will essentially "sunset" and end in 2007 if Congress does not choose to reauthorize it. Policy and industry staffs expect the program to continue; however, if it does not, this would pose an obvious burden on the establishment of SNPs in Virginia.

## Overview of Other State's Efforts to Integrate Managed Care

Based on DMAS research, 36 states currently operate managed care programs within their Medicaid and S-CHIP programs. The 36 state programs range from full risk programs similar to Virginia's, to non-risk payment models. State managed care programs contain varying components (flexible benefits, cost sharing, enhanced services, behavioral health, and pharmacy carve outs). In some states (like Virginia), enrollment for certain populations is mandatory when plan choice exists, whereas other states utilize voluntary enrollment for certain populations.

Several states have also implemented integrated care programs or are in the process of developing integrated care programs for the elderly and persons with disabilities. At a November 2006 Medicaid Director's meeting, several states stated that they are examining ways to expand their current integration models, while others are examining the issue for the first time. A chart detailing several states' integrated care programs may be found in Appendix H. Several of these states are also highlighted below:

***Arizona: The first state to integrate Medicaid acute and long-term care***

Arizona was the first state in the nation to offer a capitated managed care program statewide that combined Medicaid acute and long-term-care services. Arizona began the Arizona Long-Term Care System (ALTCS) in 1989 and it has grown to be one of the largest programs in terms of enrollment. ALTCS requires mandatory enrollment and provides institutional, residential, and in-home services to elderly and disabled Medicaid recipients who meet the criteria for placement in a nursing facility. Program participants, however are not required to reside in a nursing home. Many ALTCS participants live and receive services in their own homes or an assisted living facility. ALTCS participants are also covered for medical care, including doctor's office visits, hospitalization, prescriptions, lab work, and behavioral health services.

Arizona's rural counties are generally limited to one ALTCS MCO, and it is almost always operated by a county government. ALTCS protected its original long-term care infrastructure to ensure that traditional providers (including localities) could become risk-bearing managed care organizations. Arizona gives its counties the first right of refusal to become managed care organizations (MCOs). The capitation payment structure creates incentives for contractors to serve members in their own homes or in residential settings rather than in nursing facilities. ALTCS' negotiated per member per month (PMPM) rates provide a financial incentive for its MCOs to increase community-based care. Arizona pays a fixed PMPM rate that assumes a specific mix of nursing facility care. MCOs that serve more enrollees in the community can achieve savings.

Highlights of the Arizona program include a robust home and community-based service delivery system that includes paid family care givers and assisted living options. Regular monitoring, case management oversight, and member satisfaction surveys assure that services are provided when needed in a cost-effective manner.

***Florida: Expanding options for integrated care***

Florida's Frail Elder Diversion Program began in 1998 and only includes individuals who meet the criteria for placement in a nursing facility. Florida's Diversion program offers a wide array of services including adult companion services, assisted living, nutritional assessments, unlimited nursing services, and family training. The Florida Diversion program grants MCOs extensive flexibility in their service delivery

system designs. In 2003, the Florida legislature granted funding to expand the voluntary Florida Diversion program to cover 25 counties.

Florida is currently developing an expanded integrated managed care program. In 2005, the Florida Legislature authorized further expansion of its integrated acute and long-term care services. It mandated the state to create an "integrated, long-term, fixed payment, delivery system for Medicaid beneficiaries age 60 and older." This new program will be known as "Florida Senior Care" and piloted in two areas using managed care organizations to provide health services to seniors. This program will use a care management model and fixed payment financing. Senior Care will be open to Medicaid eligible and dually eligible individuals (though it does not combine Medicaid and Medicare funding). All services will be provided through the beneficiary's MCO (including long-term care). Program services will include care coordination, Medicaid state plan services, home and community-based services, beneficiary cost sharing (except for home and community-based services), and consumer direction.

***Massachusetts: A CMS demonstration to fully integrate Medicare, Medicaid, acute, and long-term care***

The Massachusetts Senior Care Options (SCO) program began in 2004 and offers a full range of Medicare and Medicaid benefits to dually eligible beneficiaries in Massachusetts. SCO includes people with a wide range of functional needs, including those with no existing long-term care need. SCO serves community-well, community-frail, and institutionalized people ages 65 and over. Medicare-only beneficiaries are not eligible to participate. Medicaid benefits include dental care, podiatry services, non-Part D pharmacy, and transportation. Individuals participate voluntarily in Massachusetts Senior Care Options and receive care through a "geriatric model" that is financed by the pooling of all Medicare and Medicaid revenues at the health plan level.

Massachusetts Senior Care Options provides many benefits for its participants. SCO participants benefit from the programs strong partnerships with the Massachusetts Area Agencies on Aging. In addition, Massachusetts encourages MCOs to increase the amount of care it provides in the community by paying its MCOs the nursing facility rate or home and community-based rate for a period of time after the enrollee moves from one setting to another. Since nursing facilities have higher costs than community-based services, MCOs achieve short term savings if enrollees move to home and community-based settings and short-term losses if enrollees move to nursing facilities. This strategy has helped Senior Care Options delay placements to nursing facilities.

***Minnesota: Full integration of Medicare, Medicaid, acute, and long-term care***

Minnesota was the first state to implement a fully integrated model that combined both Medicare and Medicaid financing for the entire spectrum of older people, from well to frail. Minnesota Senior Health Options (MSHO) was implemented in 1997 and includes people with a wide range of functional needs, including those with no existing long-term care need. The program offers home and community-based services including

case management, companion services, caregiver training, extended home health aid, extended personal care assistance, and many others. Each senior has a "care coordinator" to assist with care planning and service access.

A key design feature of the Minnesota Senior Health Options program is the employment of a single contract between the state and the MCOs for both Medicare and Medicaid terms and conditions. A significant effort was made to align Medicare and Medicaid managed care requirements into a comprehensive and uniform contract. MSHO did not provide any policy protection for long-term care providers in regard to selection and payment of network providers, whereas most states have set more requirements to ensure an adequate supply of long-term care providers.

Minnesota's MSHO program is a strong example of effective Medicaid and Medicare integration. It has also shown success in improving the quality of care for individuals in a nursing facility setting. MSHO reduced the number of inpatient admissions from nursing facilities and improved the monitoring of nursing facility quality indicators. Minnesota encourages its MCOs to provide community-based care by paying a specific incentive for each enrollee moved out of a nursing facility and into the community.

CMS is utilizing the Minnesota program as a template for some of the streamlining administrative efforts between the Medicare and Medicaid managed care programs.

***New York: Adding long-term support services to managed care***

The New York Managed Long-Term Care (MLTC) program was developed through 1997 legislation and only focuses on Medicaid participants who are eligible for nursing facility placement. While several MLTC managed care organizations enroll younger members, most of the managed long-term care plan enrollees must be at least age 65. New York's MLTC MCOs are expected to coordinate services with primary and acute providers, but they do not receive a capitated payment for those services and are not responsible for them. New York's program allows MCOs to develop varying models of care delivery and financing. Currently, there are fifteen separate managed long-term care plans operating under the authority and the majority of New York's plans have fewer than 500 members. All but one of New York's plans are not-for-profits.

All of New York's MLTC MCOs emphasize the importance of psychological and social factors in the lives of people needing Medicaid long-term support services and the importance of addressing these needs when developing a service delivery model. New York's MLTC model allows plans to build on their existing areas of expertise and develop different ways of delivering services and provides consumers with a choice of different service delivery options.

***Texas: Integrating acute and long-term supports for Medicaid participants***

The Texas Star+Plus program is one of the most population-inclusive of the integrated programs. Star+ Plus includes all adults who qualify for Medicaid by virtue of SSI status (Aged, Blind or Disabled). Star+Plus includes people with a wide range of functional needs, including those with no existing long-term care needs. Star+Plus is one of the larger programs in terms of enrollment and requires mandatory enrollment for participants. Star+Plus began in 1998 and became the second program to require mandatory enrollment.

Star+Plus is a capitated Medicaid program; it does not directly address the integration of Medicare financing or delivery systems. It does, however, provide beneficiaries with incentives to join optional companion Medicare managed care plans. Participants may choose between two MCOs and a primary care case management program. A challenge for Star+Plus has been the unenthusiastic response from institutional long-term care providers. The nursing home occupancy rate is declining and concern exists that expanding the availability of community services will continue to decrease the demand for institutional care. Texas Star+Plus requires its MCOs to provide each enrollee with a care coordinator who is responsible for ensuring that the patient receives integrated acute and long-term care. Care coordinators make home visits and identify unmet needs. For example, some care coordinators authorize pest control in unhealthy home environments and others install smoke alarms.

## Consumer Protections: Federal Mandates and Best Practices

Consumer protections are considered a cornerstone in integrated care programs. States that develop these programs must design integrated programs in accordance with federal requirements. In addition, several best practices from other states that Virginia will examine for inclusion in its design are highlighted below.

***Federal Mandates for Consumer Protection***

The federal government has stringent consumer protection requirements for Medicaid managed care programs. Several selected examples of federal mandates that ensure consumers are protected are listed below.

- Managed care organizations are required to provide members with information about the plan that is timely, written in an understandable format, and available in English and other prevalent languages. These documents must include information about covered and non-covered benefits, service areas, cost sharing (if any), participating providers, member rights and responsibilities, grievance and appeal procedures, and emergency procedures.

- Managed care organizations may not disenroll a member because of an adverse change in his or her health status, utilization of health services,

diminished mental capacity, special needs, or uncooperative or disruptive behavior. The only exception to this mandate is when the plan can demonstrate that a member's behavior is an impediment to the plan's ability to provide services to that member or other members. Medicaid MCOs, however, must allow member-initiated disenrollment "without cause" during the 90 days following initial enrollment, and every 12 months thereafter. Members must also be allowed to disenroll for cause at other times for reasons such as the unwillingness of a provider to offer needed services due to religious or moral reasons; when a needed service is not available in the plan's network; or when the plan lacks providers experienced with the individual's health care needs. Dual eligibles may disenroll from Medicare Advantage plans without cause at any time.

In addition, each managed care organization is required to uphold a member Bill of Rights. Rights included in this document include that each member has the right to be treated with respect, dignity, and privacy. Each member has the right to participate in decisions regarding her or his health care, including the right to refuse treatment. Each member may request and receive a copy of his or her medical records and amend and correct the records if necessary and that each MCO must furnish health care services, which the organization has been contracted to provide.

Rules for *Medicaid* managed care are different than rules for *Medicare* managed care. To address these differences, CMS crafted "how to" guides for states to use when integrating dually eligible individuals into managed care. These guides help states align Medicare and Medicaid program rules for dual eligibles in three areas: marketing, enrollment, and grievance and appeals. As previously mentioned, CMS also established Special Needs Plans to allow states to "subset" dual eligibles- a special population that states would not have been able to target before the SNP program. CMS is working with the Center for Health Care Strategies to develop a model three-way agreement to formalize the relationship among the SNP managed care plan, the state, and CMS.

***Best Practices in Consumer Protections from Other States***

Virginia is planning to add new populations to managed care in order to improve the quality of and access to services. During the Blueprint meetings, advocates expressed concern that managed care would limit consumer options and ultimately hinder medical services for participants. In order to address these concerns, DMAS asked AARP to make a presentation on states that have best practices for consumer choice and protection. Their national speaker described best practices across several states, including Wisconsin, Massachusetts, and Minnesota that offer participants a carefully crafted system of consumer protections to ensure that participants receive the best care possible. Examples of state consumer protection best practices follow:

- The Wisconsin Family Care Program requires that its MCO governing boards consist of 25 percent seniors or persons with physical or developmental disabilities (or their representatives) and that each MCO

employ a member rights specialist (ombudsperson) who directly reports to top management. In addition, all participants must be actively involved in their care-planning process and participants may use the State's complaint, appeals, or grievances process instead of the MCOs.

- Massachusetts Senior Care Options program supports a toll-free customer service line, which goes directly to the Medicaid agency's Senior Care Options administrative unit, to handle any problems participants may encounter, including consumer protections. In addition, participants and/or representatives participate in care planning and affirmatively sign-off on personalized plans of care. Massachusetts also requires that participants are represented on MCO governing and advisory boards.

- In Minnesota, State lawmakers strengthened participant protections by mandating a faster response time from MCOs regarding coverage decisions, participant complaints, and grievances. The State also operates a managed care ombudsperson program and each county has an advocate ombudsperson to aid members. All nine of Minnesota's integrated plans are Special Needs Plans and members have the same protections through both plans.

Based on the above states and others, the AARP speaker summarized eight best practices that Virginia should consider.

1. Ensure expedited appeals;
2. Allow consumers to self direct and select own caregivers;
3. Have a consumer representative on MCO advisory board;
4. Promote the active use of ombudsperson;
5. Conduct consumer satisfaction surveys on access, quality, and dignity/respect;
6. Ensure the consumers' right to participate and sign off their plan of care;
7. Require MCOs to report adverse decisions to the states; and
8. Require MCOs and their providers to be mandatory reporters for adult protective services.

## DEVELOPMENT OF THE BLUEPRINT FOR INTEGRATION OF ACUTE AND LONG-TERM CARE SERVICES

The integration of acute and long-term care services should be successful in Virginia because:

(1) The Governor and the General Assembly have provided a clear mandate that an integrated primary, acute, and long-term care service

delivery system is what they envision for Virginia's seniors and individuals with disabilities.

(2) Virginia has successfully utilized Medicaid managed care principles for its children, families, seniors, and individuals with disabilities for many years.

(3) The Department of Medical Assistance Services has a good track record for ensuring the smooth transition to new programs by involving the stakeholders throughout the development and implementation process.

This section provides the Blueprint for moving forward with the community and regional models for the integration of acute and long-term care services. The overall goal for this Blueprint is to offer some form of coordinated or managed care for the entire spectrum of low-income seniors and individuals with disabilities (also known as the Aged, Blind, and Disabled under federal terminology), from the well to the frail. The focus will be on providing the "right services at the right time" and eliminating healthcare delivery systems based solely on funding sources and the need for long-term care services. This section will first provide an overview on three key design issues: populations covered, services included, and enrollment options, followed by a discussion of the two models (community and regional) and the proposed evaluation of the new program.

## Key Program Design Issues

### *Populations Covered*

DMAS reviewed several design options for integrating primary, acute, and long-term care services. In order to design a system, one must first determine what populations should be covered in the integrated system. As stated above, DMAS is interested in covering all seniors and individuals with disabilities, regardless of age, funding sources, or need for long-term care services. As shown in Figure 9 (next page), DMAS is planning on covering more than 230,000 seniors and individuals with disabilities in some form of coordinated managed care for acute and/or long-term care (at this time, 49,000 or 21% of this group is already in managed care for their primary and acute care needs only, which is a portion of Group A). To provide clarification, the chart is further divided into whether seniors or individuals with disabilities are classified as Medicaid only (non-duals) or Medicaid and Medicare (dual eligibles). The final sorting of the population is on whether the groups receive long-term care services or not.

By design, the community model or PACE program is limited to either Medicaid only or Medicaid and Medicare clients who meet nursing facility criteria, which would be Group B and/or Group D in Figure 9. The regional model will include Groups A through D.

**Figure 9**

| **All Seniors and Individuals with Disabilities (known as Aged, Blind, and Disabled) 234,945 Recipients (in State Fiscal Year 2006)** | | | |
|---|---|---|---|
| **Medicaid Only (Non-Dual Eligibles) 86,732 recipients** | | **Both Medicaid and Medicare (Dual Eligibles) 148,213* recipients** | |
| ***Group A*** **Do Not Use Long-term Care Services** | ***Group B*** **Use Long-term Care Services** | ***Group C*** **Do Not Use Long-term Care Services** | ***Group D*** **Use Long-term Care Services** |
| **79,045 recipients** | **7,687 recipients** | **115,152** | **33,061** |
| *107,218 recipients receive full Medicaid benefits and payment of Medicare costs; 40,995 receive only Medicaid payment of their Medicare costs. | | | |

***Services Included***

The second design issue is to determine what range of services will be included in the integrated system of care. DMAS' intent for the full integration of acute and long term care services is to include all services available in the Medicaid Managed Care program (both primary and acute services--behavioral health services remain carved out), nursing facility care, and the full range of home and community-based care programs (except certain waiver programs), as well as all the Medicare covered services. A program with a comprehensive benefit package is the most effective design for an integrated program. Within this full array of services, consumers can work with their care coordinator to achieve the consumer's goals. Carving out key benefits not only creates gaps in coordination and communication, but creates incentives to "cost shift" to the benefit that is carved out of the program.

The key to the success of the integrated program will be the care coordinators. These coordinators will work closely with providers to support the delivery of care. For community-based consumers with multiple chronic conditions, care coordinators will work closely with physicians to address the full range of needs in the enrollee's care plan. For nursing facility residents, care coordinators will work closely with physicians and nursing facility staff to prevent unnecessary hospitalizations and provide more care onsite.

All recipients in the Mental Retardation, Day Support, Individual and Family Developmental Disability Support, and Technology Assisted waiver programs will not be included in a fully integrated system of care. Instead, these clients will receive primary

and acute care services in a coordinated managed care system and continue to have their long-term care waiver services paid in a fee-for-service system. At this time, these home and community-based waiver program services are carved out of an integrated model because these are the waivers with waiting lists and/or are extremely expensive. Including these clients in a coordinated managed care for their health care needs is a major step forward to ensuring that these long-term clients benefit from care coordination and disease management programs. Existing case/care management services for the excluded waiver clients would need to be formally linked with the coordinated managed care organization.

***Enrollment Options***

The two choices for enrollment in an integrated acute and long term care program are mandatory or voluntary. Mandatory enrollment means that Medicaid beneficiaries are required to participate in a managed care program. Voluntary enrollment means that consumers are given the choice to affirmatively enroll in the program or they are automatically enrolled in the program with a choice to leave or "opt out" of the program if they are not interested. In terms of the development and administration of an integrated program, rate setting, generating managed care organizations' interest, and provider contracting are easier with mandatory programs. Clients and advocacy groups generally oppose mandatory enrollment.

For the community model or PACE, federal regulations require that enrollment be voluntary. For the regional model that is limited to coordinated care for primary and acute care services only, DMAS intends to require mandatory enrollment in one of the existing Managed Care Organizations (MCOs) in areas of the state that have two or more MCOs (this is similar to the current practice; clients have the right to choose a plan.) For regional models that fully integrate primary, acute, and long-term care services, enrollment will be voluntary with clients automatically enrolled in the program with the ability to "opt out" of the program.

A summary of the remaining program design decisions for both the community and regional models can be found in Figure 12 (page 33).

## Integration of Acute and Long-term Care Services for Seniors and Individuals with Disabilities: Community Model

The most straightforward and comprehensive integrated program is the community model. The community model is the PACE program, which serves persons 55 and older who meet nursing facility criteria. By design, this program may serve around 200 clients. All health and long-term care services are provided in the community, centered around an adult day health care model, and with Medicaid and Medicare funding combined. This is a voluntary program and is one community alternative to nursing facility care. Because this program is limited to those who meet nursing facility criteria, Medicaid only or Medicaid and Medicare clients with long-term care needs would qualify (Group B and Group D in Figure 9).

DMAS intends to move forward with this model in two phases over the next two years (Figure 10 on the next page summarizes the phases).

- **Current system:** Virginia has had one pre-PACE program for more than ten years, serving Hampton Roads (Sentara Senior Community Center). Pre-PACE means that all the Medicaid primary and long term care services (except inpatient and outpatient hospital, lab/x-rays, and ambulatory surgical centers) are paid with a capitated payment rate, but the Medicare costs and services are not included and remained fee-for-service. While this has been a successful model of integrated care, the next step is to fully combine Medicare and Medicaid funding and services to provide a complete spectrum of primary, acute, and long-term care services under one coordinated system of care.

- **Phase I (Timeline: 2007-2008):** DMAS and several communities have been working together over the past year to develop and implement more PACE sites across the Commonwealth. At this time, seven proposed PACE sites are working to become full PACE sites (all Medicaid and Medicare costs and services are paid with a capitated rate.) These sites are located in Hampton Roads (two sites), Richmond (two sites), Lynchburg, and the far Southwest (two sites). The two Southwest sites are unique because they are among 10 sites nationwide that are developing PACE sites in rural areas and both have received a rural PACE grant from the federal government.

- **Phase II (Timeline: 2007-2009):** DMAS will determine the underserved areas of the state and issue a Request for Applications for additional PACE sites. Notably, two communities in Northern Virginia and Charlottesville have been working on the PACE concept for several years but were not quite ready to move forward during Phase I.

**Figure 10**
**Integration of Acute and Long-term Care Services**
**for Seniors and Individuals with Disabilities: Community Model**

<table>
<tr><th colspan="3">Program of All Inclusive Care For the Elderly (PACE)</th></tr>
<tr><th>Current System<br><br>Pre-PACE<br>(Medicaid Capitated Rate Only)</th><th>Phase I (2007-2008)<br><br>Full PACE<br>(Medicaid and Medicare Capitated Rates)</th><th>Phase II (2007-2009)<br><br>PACE Expansion in Underserved Areas</th></tr>
<tr><td rowspan="7">Sentara Senior Community Center (serving Hampton Roads)</td><td>Sentara Senior Community Center (serving Chesapeake, Virginia Beach, Norfolk, Portsmouth)</td><td rowspan="7">Prior to accepting additional PACE sites, the Department of Medical Assistance Services will issue a Request for Applications for PACE projects for underserved areas.</td></tr>
<tr><td>Riverside Health System (serving Newport News, Hampton, Williamsburg, Yorktown, York and Poquoson)</td></tr>
<tr><td>Appalachian Agency for Senior Citizens (serving the counties of Buchanan, Dickenson, Russell, and Tazewell)</td></tr>
<tr><td>Mountain Empire for Senior Citizens (serving Lee, Wise, and Scott Counties, and the City of Norton)</td></tr>
<tr><td>Bon Secours (serving Richmond city, Chesterfield, Goochland, Hanover, New Kent, Henrico, Powhatan)</td></tr>
<tr><td>Riverside Health System (serving Richmond city, Chesterfield, Goochland, Hanover, New Kent, Powhatan, and Henrico)</td></tr>
<tr><td>Centra Health (serving Lynchburg, Bedford, Campbell and Amherst)</td></tr>
</table>

## Integration of Acute and Long-term Care Services for Seniors and Individuals with Disabilities: Regional Model

The regional model could range from a capitated payment system for Medicaid and/or Medicare for acute care costs only and care coordination services for the home and community-based services, to a fully capitated system for all acute and long-term care services. Unlike the PACE model, where all health care professionals and all services center around an adult day health care center, a regional model utilizes a variety of community health care providers. By design, regional models will coordinate the care

needs of both seniors and individuals with disabilities and are not limited to only those with long-term care needs. While DMAS fully supports integrated and coordinated care, it is likely that one model will not meet the needs for all seniors and individuals with disabilities. DMAS also intends to move forward with a Regional Model in two phases over the next two years (Figure 11 summarizes the phases).

- **Current System:** Virginia is one state that moved forward with moving seniors and individuals with disabilities into managed care years ago. At the present time, more than 49,000 elderly and disabled have their health care needs successfully managed by one of seven managed care organizations across Virginia. However, once these clients need long-term care services or become both Medicaid and Medicare eligible (known as dual eligibles), they are moved out of a managed care environment into a fragmented fee-for-service environment with little or no coordination of their health care and long-term care needs. This disruption of care is not good for the client and is costly for the Commonwealth. This is Group A (Medicaid only, no long-term care services) in Figure 9. Even though, 79,045 recipients are shown, some of these clients may reside in areas where there are not two or more managed care organizations. Managed care for primary and acute care needs for Group A is mandatory in areas of the state that have two or more MCOs.

- **Phase I (Timeline: 2007-2008):** This first phase is a preliminary step to expand managed care for seniors and individuals with disabilities for at least their primary and acute care needs. Instead of moving Medicaid only elderly and disabled clients into fee-for-service when they need long-term care services, DMAS intends to keep them in the coordinated care system for at least their primary acute care needs, while keeping their long-term care services fee-for-service. This moves Group B (in Figure 9) or 7,687 Medicaid only with long-term care services into one of the seven existing MCOs for coordinated care for their primary and acute care needs only. Coordinated managed care for primary and acute care needs for Group B will be mandatory in areas of the state that have two or more MCOs. This phase does not address the dual eligibles (Group C and D in Figure 9); these clients will still be moved out of managed care when they become Medicare eligible.

- **Phase II (Timeline: 2008-2009):** This is the most dramatic phase of the integration because the true integration of services and funding takes place. DMAS plans to develop regional models that will include all seniors and individuals with disabilities, regardless of whether they are Medicaid only or both Medicaid and Medicare (dual eligibles) and regardless of whether they are receiving long-term care services or not (This includes Group A-D in Figure 9). This model develops a seamless system of care that adjusts with clients as their care needs change over time. This model intends to include all long-term care services, except for

certain home and community-based care waiver services. Participation in this phase will be voluntary; the Department will passively enroll them into a plan and provide them the option to opt out.

All recipients in the Mental Retardation, Day Support, Individual and Families Developmental Supports, and Technology Assisted waiver programs will receive primary and acute care services in a coordinated managed care system and have their long-term care services in a fee-for-service system. At this time, these home and community-based care waiver program services are carved out because they are the waivers with waiting lists and/or are extremely expensive. Including the clients in coordinated managed care for their health care needs is a major step forward to ensuring that these long-term clients benefit from care coordination. Existing case/care management services for these waiver clients would need to be improved to have a formal link with the managed care organization.

**Figure 11**
**Integration of Acute and Long-Term Care Services**
**For Seniors and Individuals with Disabilities: Regional Model**

| **Medicaid Population** ***All Seniors and Individuals with Disabilities (also known as Aged, Blind and Disabled)*** **(234,732 recipients)** | **Current System** ***Limited Managed Care for Acute Care Only*** | | **Phase I** ***Expands Managed Care for Acute Care Only*** | | **Phase II** ***Fully Integrates Acute and Long-term Care Services and Combines Medicaid and Medicare Funding*** | |
|---|---|---|---|---|---|---|
| | **Services** | | **Services** | | **Services** | |
| | **Managed Acute Care*** | **Fee-for-service Long-term Care** | **Managed Acute Care*** | **Fee-for-service Long-term Care** | **Managed Acute Care*** | **Managed Long-term Care**** |
| **Medicaid Only (Non-duals)** **(86,732 recipients)** | | | | | | |
| **Group A: Without Long-term Care Services** **(79,045 recipients)** | ✓ | | ✓ | | ✓ | ✓ (available when needed) |

| Figure 11 Continued | | | | | | |
|---|---|---|---|---|---|---|
| **Medicaid Population** ***All Seniors and Individuals with Disabilities (also known as Aged, Blind and Disabled)*** **(234,732 recipients)** | **Current System** ***Limited Managed Care for Acute Care Only*** | | **Phase I** ***Expands Managed Care for Acute Care Only*** | | **Phase II** ***Fully Integrates Acute and Long-term Care Services and Combines Medicaid and Medicare Funding*** | |
| | **Services** | | **Services** | | **Services** | |
| | **Managed Acute Care*** | **Fee-for-service Long-term Care** | **Managed Acute Care*** | **Fee-for-service Long-term Care** | **Managed Acute Care*** | **Managed Long-term Care**** |
| **Group B: With Long-term Care Services (7,687 recipients)** | | ✓ | ✓ | ✓ | ✓ | ✓ (Except certain HCBC waiver programs)*** |
| **Medicaid and Medicare (Duals) (148,213 recipients)** | | | | | | |
| **Group C: Without Long-term Care Services (115,152 recipients)** | | | | | ✓ | ✓ (available when needed) |
| **Group D: With Long-term Care Services (33,061 recipients)** | | ✓ | | ✓ | ✓ | ✓ (Except certain HCBC waiver programs)*** |

* Acute Care Services include all Medicaid services, such as physician, pharmacy, hospital, labs (certain services, such as dental and several behavioral health services are carved out and remain paid on a fee-for-service basis)

** Long-Term Care Services include nursing facilities, certain home and community-based (HCBC) waiver programs (specifically, Elderly or Disabled with Consumer Direction, HIV/AIDS, and Alzheimer's), and care coordination.

*** All recipients in the Mental Retardation, Day Support, Individual and Families Developmental Supports, and Technology Assisted waiver programs will receive acute care needs in a coordinate managed care system and have their long-term needs provided in the fee-for-service system.

Figure 12 on the following page provides an overall summary of the program design questions and answers for the phases of the integrated care models. DMAS intends on working closely with national experts as the agency moves forward to ensure that this system benefits from the groundwork that has been laid by other states and to ensure the latest federal information is utilized.

**Figure 12**
**Integrated Care Program: Program Design**

| Questions | Community Model | Regional Model | |
|---|---|---|---|
| | PACE | Phase I | Phase II |
| **Population Covered?** | Seniors and Individuals with Disabilities who meet nursing facility criteria; must be 55 years and older | Seniors and Individuals with Disabilities, Medicaid only (non-dual), with and without long-term care needs | All Seniors and Individuals with Disabilities, both Medicaid and Medicare (non-duals and duals, with and without long-term care needs) |
| **Services Covered?** | All Medicaid and Medicare acute and long-term care services in a managed care environment, including care coordination by an interdisciplinary team | All Medicaid primary acute care in managed care; long-term care services fee-for-service | All Medicaid and Medicare acute care and long-term care in managed care, including care coordination (except certain HCBC waiver programs)* |
| **Enrollment?** | Voluntary, generally no more than 200 recipients per site | Mandatory in areas of the state where two or more Managed Care Organizations exist | Voluntary, passive enrollment with opt out option |
| **Providers?** | Federal and state approved PACE sites | Current Managed Care Organizations and Fee-for-service Home and Community-based Care Providers and Nursing Facilities | Current managed care organizations and/or Medicare Advantage Plans, Special Needs Plans |
| **How Select Providers?** | Seven PACE sites in process now; future sites through a Request for Application for underserved areas | Existing Managed Care Organizations, Home and Community-based Care Providers, and nursing facilities | Request for Proposals will be issued for providers |
| **Funding?** | Capitated Medicaid and Medicare payment rates | Capitated Medicaid funds for acute care; fee-for-service for long-term care | Capitated Medicaid and Medicare payment rates (except certain HCBC programs will remain fee-for-service)* |
| **Geographic Expansion?** | Statewide | Statewide | Regional and then statewide |
| **Time Frame?** | 2007-2009 | 2007-2008 | 2008-2009 |

**Acute Care Services** include all Medicaid services, such as physician, pharmacy, hospital, labs (certain services, such as dental and several behavioral health services are carved out and remain paid on a fee-for-service basis)
**Long-term Care Services** include nursing facilities, certain home and community-based (HCBC) waiver programs (specifically, Elderly or Disabled with Consumer Direction, HIV/AIDS, and Alzheimer's), and care coordination.
* All recipients in the Mental Retardation, Day Support, Individual and Families Developmental Supports, and Technology Assisted waiver programs will receive acute care needs in a coordinated managed care system and have their long-term care needs in fee-for-service.

## Evaluation of the Integrated Models

In order to address the final requirement of the Blueprint legislation, DMAS intends to require the necessary data requirements on the front end to allow a full

evaluation of the integrated models. The current managed care organizations provide encounter data and are monitored on a variety of performance measures.

DMAS will regulate the new programs in the same manner as the current managed care programs through: monthly MCO meetings; network reviews; on-site visits; pattern of care studies; ongoing assessment and approval of member documents such as MCO identification cards and member handbooks; annual revision of the MCO contracts; review of MCO enrollee communications and satisfaction surveys; and significant complaint and report monitoring. DMAS contracts with an external quality review (EQR) organization to examine each MCO's policies, procedures, and services with respect to enrollee rights and protections, quality assessment and performance improvement, and grievance systems. The Bureau of Insurance regulates the licensure and solvency of the MCOs in Virginia. This oversight has resulted in DMAS having MCOs that are fiscally strong and administratively efficient.

# Appendix A
# Legislative Authority

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

The Department of Medical Assistance Services, in consultation with the appropriate community and state stakeholders, shall develop a long-range blueprint for the development and implementation of an integrated acute and long-term care system. This plan shall:

(i) Explain how the various community and state level stakeholders will be involved in the development and implementation of the new program model(s);

(ii) Describe the various steps for development and implementation of the program model(s), include a review of other States' models, funding, populations served, services provided, education of clients and providers, and location of programs; and

(iii) Describe the evaluation methods that will be used to ensure that the program provides access, quality, and consumer satisfaction.

The Department of Medical Assistance Services shall report on its plan for integrating acute and long-term care services to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by December 15, 2006.

### 2006 Virginia Acts of the General Assembly (Item 302, AAA)

The Department of Medical Assistance Services shall implement one or more Program for All Inclusive Care for the Elderly (PACE) programs by July 2007. Out of this appropriation, $1,500,000 the first year from the general fund is provided to make grants of up to $250,000 per site for start-up funds for potential PACE programs. The grant funds may be used for staffing, development of business plans, and other start-up activities. To be eligible for grant funding, organizations must submit the following documentation to the Department of Medical Assistance Services no later than September 1, 2006:

(i) Completion of a market assessment that demonstrates sufficient potential PACE participants to develop a PACE program;

(ii) Demonstration of partnerships with acute care hospitals, nursing facilities, and other potential partners;

(iii) Designation of an adult day health care center from which to operate a PACE program; and

(iv) Identification of funding partners to sustain a PACE project.

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

The Department of Medical Assistance Services shall amend its State Plan for Medical Assistance Services to develop and implement a regional model for the integration of acute and long-term care services no later than July 2007. This model would be offered to elderly and disabled clients on a voluntary basis. The Department shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

# Appendix B
# Acute and Long-term Care Integration: Meeting Agendas

**DEVELOPMENT OF A BLUE PRINT FOR**
**THE INTEGRATION OF ACUTE AND LONG TERM CARE SERVICES**
**September 7, 2006**

**Virginia Department of Medical Assistance Services**
**600 East Broad Street, 7th Floor Conference Room, Richmond**

## AGENDA

- **9:00-9:30 a.m.** **Welcome/Overview of the Agenda**
  - ❖ Patrick Finnerty, Director, Department of Medical Assistance Services
  - ❖ Wayne Turnage, Deputy Chief of Staff, Office of the Governor
  - ❖ Cindi Jones, Chief Deputy Director, Department of Medical Assistance Services

- **9:30-10:20 a.m.** **Overview of Virginia Medicaid, Long Term Care, and Managed Care**
  - ❖ Overview of Virginia Medicaid and Long Term Care Services: Terry Smith, Director, Division of Long Term Care and Quality Assurance
  - ❖ Overview of Managed Care: Bryan Tomlinson, Director, Division of Health Care Services
  - ❖ Question and Answers

- **10:20 – 10:30 a.m.** **Break**

- **10:30-12:30 p.m.** **Panel Discussion: National Perspective on the Integration of Acute and Long Term Care Services**
  - ❖ **Moderator:** Steven Somers, Center for Health Care Strategies, Inc
  - ❖ Medicaid/Medicare Integration: Opportunities for States and Dual Eligibles: Steven Somers, CHCS
  - ❖ Myths and Realities of the Integrated Long Term Care Models: Cathy Rossberg/Laura Hopkins, Amerigroup
  - ❖ Medicare/Medicaid Integration Through Special Needs Plans: Mary Kennedy, Evercare
  - ❖ Program of All Inclusive Care for the Elderly (PACE): Peter Fitzgerald, National PACE Organization

**DEVELOPMENT OF A BLUE PRINT FOR**
**THE INTEGRATION OF ACUTE AND LONG TERM CARE SERVICES**
**September 26, 2006**

**Virginia Department of Medical Assistance Services**
**600 East Broad Street, 7th Floor Conference Room, Richmond**

# AGENDA

- **9:30-9:50 a.m.** **Welcome/Overview of the Agenda**
  **Summary of Last Meeting/Status of PACE**
  - ❖ Cindi Jones, Chief Deputy Director, Department of Medical Assistance Services

- **9:50-10:30 a.m.** **Best Practices for Consumer Protection in Managed Care (*speaker provided by AARP Virginia*)**
  - ❖ Charles J. Milligan, Jr., Executive Director, University of Maryland-Baltimore County, Center for Health Program Development and Management
  - ❖ Question and Answers

- **10:30-12:00 p.m.** **Options for Developing an Integrated Model for Acute and Long Term Care Services**
  - ❖ **Facilitator:** Mark R. Meiners, Director, George Mason University, Center for Health Policy Research and Ethics
  - ❖ Audience Participation/Discussion

**The final meeting will be held on October 18, 2006**

- At the Virginia Department of Medical Assistance Services, 600 East Broad Street, 7th Floor Conference Room, from 9:30 a.m. to 12:00 p.m.
- **Purpose of the Meeting:** To hear public comment on the Integration of Acute and Long Term Care. Written comment can also be sent throughout the process to altc@dmas.virginia.gov.

**Instructions for Public Comment on October 18, 2006**

The Department will be allocating time slots for interested parties to present public comment on the Integration of Acute and Long Term Care.

Each speaker will be allocated no more than **five (5)** minutes to present. Individuals representing similar organizations/interests should designate one speaker. Speakers **must receive a confirmation number** to verify that the presentation is scheduled.

**If you are interested in providing public comment** at the meeting, please submit a written request to speak with the name/title of the presenter and an electronic copy of comments to altc@dmas.virginia.gov by **COB Wednesday, October 11, 2006.** You will receive an email containing your confirmation number.

**If you are NOT interested in providing public comment,** but would still like to provide written comments, please send an electronic copy of your comments to altc@dmas.virginia.gov by **COB Wednesday, October 11, 2006.**

**DEVELOPMENT OF A BLUE PRINT FOR**
**THE INTEGRATION OF ACUTE AND LONG TERM CARE SERVICES**
**October 18, 2006**

**Virginia Department of Medical Assistance Services**
**600 East Broad Street, 7th Floor Conference Room, Richmond**

# AGENDA

**9:30 - 9:50 a.m.** **Welcome/Overview of the Agenda/Summary of Last Meeting/Status of PACE**

- Cindi Jones, Chief Deputy Director, Department of Medical Assistance Services

**9:50 - 10:15 a.m.** **Public Comment**

**Speakers:**

- Mary Ann Bergeron, Executive Director – VACSB
- Keren Ellis, Regional Administrator - Professional Healthcare Resources - Vice President of the Virginia Association for Home Care and Hospice
- Grace Starbird, President – Virginia Association for Area Agencies on Aging
- Linda Wilkinson, Director, Community Development & Education - National Multiple Sclerosis Society, Central VA Chapter
- Kathlyn Wee, Director, State Public Affairs - Evercare/Ovations

**Written Comments Submitted By:**

- Hobart Harvey, Vice President Financial Services - Virginia Health Care Association
- Henry Claypool, Director - Washington Office for Independent Care System - Advisor to the Administrator of the Centers for Medicare and Medicaid Service
- Dan H. Gray, President - Continuum Development Services, Inc.

**10:15 - 10:30 a.m.** **Next Steps**

- Next Steps: Cindi Jones

# Appendix C
# Part I
# Acute and Long-term Care Integration: Public Comments

**1. Mary Ann Bergeron, Executive Director – VACSB**

**2. Linda Wilkinson, Director, Community Development & Education - National Multiple Sclerosis Society, Central VA Chapter**

**3. Kathlyn Wee, Director, State Public Affairs - Evercare/Ovations**

**4. Grace Starbird, President – Virginia Association for Area Agencies on Aging**

**5. Hobart Harvey, Vice President Financial Services - Virginia Health Care Association**

**6. Dan H. Gray, President - Continuum Development Services, Inc.**

**7. Keren Ellis, Regional Administrator - Professional Healthcare Resources - Vice President of the Virginia Association for Home Care and Hospice**

**8. Henry Claypool, Director - Washington Office for Independent Care System - Advisor to the Administrator of the Centers for Medicare and Medicaid Service**

**COMMENTS OF THE VIRGINIA ASSOCIATION OF COMMUNITY SERVICES BOARDS (VACSB)
REGARDING LONG TERM AND ACUTE CARE INTEGRATION
TO BE DELIVERED ON OCTOBER 18, 2006**

On behalf of the Virginia Association of Community Services Boards (VACSB), the forty CSB/BHAs and the network of public and private providers serving individuals with serious mental illness, severe mental retardation, and addiction issues, we appreciate the opportunity to comment and offer the following:

- First, do no harm. The current services system in Virginia has grown and adapted to both the needs of individuals and the public policy decisions to support community participation, primarily with rehabilitation and social supports. It is the result of hard work and determination over the past 20-30 years on the part of agencies, providers, the individuals themselves, and their families.

  Traditionally Virginia has been invested in facilities. Public policy direction to serve individuals in the community came into sharpened focus with the creation of the MR Waiver for people with mental retardation as well as Department of Justice investigations that, for individuals with mental retardation or serious mental illness, called for discharge to the community or increased state facility spending. The resulting budget and public policy actions set up a lean framework for people to take their places in their communities with some of the cost covered by the Medicaid program, rather than full cost covered through state General Funds.

- A large part of the strength of Virginia's system of care for people with mental retardation, serious mental illness, and/or addiction issues is the role played by the local Community Services Board as advocate, manager, service provider, and the single point of entry into the publicly funded system. Further division of care systems by funding streams will fracture the system of care in a way that will be debilitating to both consumers and providers. For example, to move dual eligibles into a different "care management" system could result in splitting the population currently on the MR Waiver into two different systems for care/case management, prior authorization, and standards of care. With approximately 50% of those on the MR Waiver assigned to the "dual eligible" category, the risk would be that the same providers of services for both Medicaid and dual eligibles would have to work with and navigate through different systems of care and different "rules".

- Movement to coordinate long term and acute care for any vulnerable population should seek to retain and enhance the local relationships and support systems that have been developed and that have built confidence among consumers and their service providers by ensuring their lines of community support by family, friends, social organizations, and the like.

- Without careful crafting and deep understanding of the vulnerable people to be served by some kind of care coordination/management entity, there is a real danger of losing hard-fought ground to preserve a rehabilitation and social model of community living from which consumers receive high benefit. Managed care traditionally has focused on utilizing the

medical model to manage medical care and does not have the dimension or the importance of the rehabilitation model in its experience.

- For individuals with mental retardation and/or serious mental illness, **coordination** will be a better framework than integration. Coordination among care/case management entities may be more difficult and demand robust partnerships but the result for the individual consumers will be far more meaningful. In any instance of coordinating services and care management for those seriously disabled by mental illness, mental retardation and/or substance use disorders, the CSB/BHA system is the best alternative to ensure that the current rehabilitation/social model integrates/coordinates well with the medical model in order for the recipient of the services to more fully benefit from living in the community.

Finally, the VACSB and all its partners stand ready to assist in the coordination of long term and acute care and improving the lives of vulnerable citizens in the Commonwealth.

Contact: Mary Ann Bergeron, VACSB
mabergeron@vacsb.org
Phone: 804.330.3141
Fax: 804.330.3611

INTEGRATION COMMENTS FOR MS:

Thank you for the opportunity to comment on this most important undertaking. I am Linda Wilkinson, the Director of community Development Education for the Central Virginia Chapter of the National MS Society. I am representing the four NMSS Chapters serving Virginia. **Multiple Sclerosis (MS)** is a chronic, life-long, and often disabling disease of the central nervous system that is usually diagnosed in adults between the ages of 20-50. Symptoms can include debilitating fatigue, blurry vision, mobility difficulties and cognitive problems, and often come and go without warning or pattern.

Four chapters of the National Multiple Sclerosis Society serve Virginians living with multiple sclerosis. They include the Blue Ridge, Central Virginia, Hampton Roads and National Capital chapters. These chapters collaborate to address the advocacy needs of their members through the **Multiple Sclerosis Virginia Consumer Action Network (MS VA CAN)**. The MS VA CAN represents over 10,000 Virginians living with MS although there are likely many more Virginians living with MS than that number represents. Since MS is a disease that affects the entire family, we estimate the representation of MS VA CAN at approximately 30,000 *Virginians*. Furthermore, people with MS share physical and sensory disabilities, and therefore heath care concerns and legislation, of several other groups such as arthritis, spinal cord injury and vision impairment.

Improving the coordination of care and services through efforts to establish an integrated approach is viewed as critically important to those with MS and their caregivers. Viewing care as a comprehensive system aimed at the individual's unique situation can be a more efficient, effective and caring model than the fragmented system of care providers that patients see today. It is a patient-oriented model for healthcare that puts people at the center, rather than funding-oriented system that puts the funding bureaucracy as the center of focus.

As you look at community-based integrated care, the NMSS asks that you have as a tenet of the model the utilization of community-based organizations with proven track records working with the various populations including those with MS. People with MS and their caregivers look to us for information, referral and support. We work with them everyday and have strong relationships. We would ask that the support

services we provide and refer clients to be integral to the systems developed. We see everyday that access to care (including medications), mobility and good nutrition are essential to sustaining good health and allowing people with MS to remain as productive as possible. Patient options and access to choice is important a patient-center system.

We would ask that you recognize these realities in the structure of the benefits or financial incentives offered if you proceed with enhanced benefit account plans. It is vital that individuals have supporting services (transportation to healthcare, nutrition, emergency access through a telephone, etc.). Therefore, we would ask that these tools and services be considered and included for patients enrolled in such integrated care and flexible plans.

If the decision is made to consider special needs populations with chronic conditions, such as MS, and integrated plans for these patients, we would ask that integration of support services as well as utilization of community-based providers who work with these same patients be included. Virginia has many such service providers who work at the community level and these are services that are vital to maintaining the health of people with MS. Community resources across the Commonwealth are varied and each MS patient's needs are different and we work with many to help them mix and match the services available across what seems to them to be a fragmented system of care. Community-based coordination needs to be considered for plan requirements.

Again, thank you for this opportunity to offer our comments the NMSS supports your efforts for improved system integration and offer to participate as appropriate in these efforts.

**Evercare Comment**
**Acute and Long-Term Care Integration**
**October 18, 2006**

Evercare is a subsidiary of UnitedHealth Group that specializes in serving Medicare/Medicaid dual eligibles and individuals with long-term care needs. We serve over 50,000 enrollees in integrated Medicaid long-term care programs in Arizona, Florida, Massachusetts, Minnesota, Texas and Washington. In addition, we currently manage the chronic care and functional needs of more than 29,000 Medicare beneficiaries living in nursing homes, and 18,000 Medicare beneficiaries in the community through Dual Eligible Special Needs Plans.

## Advantages of Integrating Acute and Long Term Care (ALTC)

The current Medicaid system is fragmented, confusing and challenging for consumers to navigate. Dual eligibles and individuals requiring nursing facility level of care have intense and complex needs. These consumers must access Medicaid for nursing home care or home and community based waiver services (HCBS) and Medicare for inpatient and physician services. Further increasing the complexity of the system, dual eligibles now receive their prescription drugs from a Medicare plans with the advent of Part D. The fragmentation of Medicaid and Medicare create incentives for cost-shifting between programs and discourages effective coordination of services for the consumer.

Integrated acute and long-term care programs have the potential to improve the long-term care system for consumers and families, providers and for the Commonwealth.

### 1. Advantages for Consumers

*Consumer-Centered Care Coordination:* Integrated ALTC programs provide comprehensive care coordination to all individuals who require LTC services or have multiple chronic illnesses. Care coordinators work with consumers, families, the primary care physician and other providers involved in the individual's care to develop an individualized care plan that addresses the consumer's full range of medical, functional, social and environmental needs.

*Enhanced Access to Home and Community-Based LTC Services:* Through the care plan development process, the consumer can access the full range of LTC services from personal care to nursing facility care that is appropriate to meet their functional needs. With an Integrated LTC Program, access to HCBS is no longer artificially limited to individuals who are in a 1915(c) waiver "slot". Consumers who can be appropriately served in a community setting can choose those services. The Texas STAR+PLUS program generated a 31% increase in the use of personal care, and a 38% increase in use of adult day care[1], when all consumers who could benefit from HCBS were able to receive it through the program.

*Flexibility and Consumer-Direction:* Because the consumer's needs and preferences for their care drive the individualized care planning process, integrated ALTC programs have the flexibility to provide very different services for individuals with diverse needs. ALTC programs do not rely on a "medical" or "social" model of care coordination, but a holistic approach that will emphasize medical management for a nursing home resident with multiple chronic illnesses and consumer-directed personal care and social support services for consumers with disabilities.

*Improved Clinical Outcomes:* Through individualized care coordination, integrated ALTC programs have improved clinical outcomes for dual eligibles and individuals who require LTC services. Examples of clinical improvements achieved by other State ALTC programs include:

- Texas STAR+PLUS achieved a 22% reduction in unnecessary hospitalizations and 38% reduction in ER visits[2]
- Florida Nursing Home Diversion clients had 12% probability of entering a nursing home compared to 26% of clients in the FFS HCBS waiver program and;
- Florida Nursing Home Diversion clients' nursing home stays were shorter, averaging 43 days, than the baseline group which stayed in nursing homes an average of 132 days[3].

*High Customer Satisfaction:* – for members and for their family members

- In Arizona, 93% of consumers and families surveyed were satisfied with their care coordinator. 90% of those surveyed felt they were involved in decision-making regarding their care[4].
- In Minnesota, 94% of those surveyed would recommend their care coordinator to others, 96% would recommend their health plan to others[5].

**2. Advantages for LTC Providers**

*Partnership with Providers through Care Coordination:* Care coordinators in ALTC programs work closely with providers to support delivery of care. Additional clinical support from care coordinators supplements efforts of LTC providers and physicians. For community-based consumers with multiple chronic conditions, care coordinators attend physician appointments with the enrollee so that the PCP can address the full range of needs in the enrollee's care plan. Evercare has been serving nursing facility residents since 1989, using specialized nurse practitioners working closely with physicians and nursing home staff focused on preventing unnecessary hospitalizations and providing more care on-site.

*Support Improving Quality of LTC Services:* Care coordinators also provide LTC providers with additional support in meeting quality standards. For personal care providers, care coordinators will arrange for appropriate training, and monitor to assure the service is delivered in a timely and appropriate way. In the nursing facility setting, a nurse care coordinator provides on-site primary care, increases communication with the PCP and family, supplementing facility staffing.

**3. Advantages for the Commonwealth**

*Gradual "Rebalancing" of the Medicaid LTC System:* Integrated ALTC programs slow the rate of growth in Medicaid LTC spending by more effectively supporting individuals in community-based settings and delaying need for nursing facility care. States that have implemented ALTC programs have gradually increased the percentage of the total LTC population served in community settings, reducing growth in Medicaid LTC spending.

*Integrated Financing with Medicare Advantage:* Integrated ALTC programs allow health plans to use a single care coordinator to support dual eligible consumers in accessing all Medicare and Medicaid services. In addition to improving support consumers receive, Medicare/Medicaid integration allows the State opportunities to optimize its investment in Medicaid services for dual eligibles.

*Capitated Model:* Capitated financing provides incentives to manage chronic illness and invest in good health outcomes.

## Policy Options for Integrated Acute and Long-Term Care in Virginia

At September 26th ALTC Meeting, DMAS outlined three major policy decisions regarding the design of an ALTC program for Virginia: 1) Populations Covered; 2) Benefits Covered; and 3) Enrollment options. Evercare has had extensive expertise operating ALTC programs in six states. Below is our perspective on what is most effective in our experience on these three policy decisions.

- **Populations Eligible for the ALTC Program**

We recommend that the ALTC Program include the following groups:

1. Dual Eligibles
2. Seniors and individuals with physical disabilities who require nursing facility level of care
3. Medicaid-only ABD population not already enrolled in managed care

These three groups include nursing facility residents and HCBS waivers serving seniors, groups that will benefit greatly from comprehensive care coordination. These groups also include "well" duals and ABD consumers with chronic illnesses so that the ALTC program can facilitate early access to HCBS supports to prevent need for hospitalizations and nursing home care.

We would suggest that DMAS may want to consider excluding the MR/DD population and children with special needs ages 0-21. Both these groups require a wide range of very specialized services and have very different clinical and social needs than the rest of the ABD population. Although individuals with DD would benefit from enhanced care coordination and integration of services, no state has included the DD population in an integrated LTC program due to the clinical and political challenges in serving this group. Arizona has been most progressive with their DD delivery system; individuals with DD in Arizona are served by health plans that provide care coordination and are at risk for acute care services only. All DD long-term care services (institutional and community-based) are provided on a fee-for-service basis. Both the DD and special needs children may be opportunities for expansion of the ALTC program in the future after initial implementation for the recommended groups above.

Another key policy issue is including the serious and persistently mentally ill population. States have varied in their approach to serving the SPMI population through ALTC programs. If DMAS considers a carve-out on mental health, we would recommend a carve-out for the SPMI ***population*** rather than a carve-out of mental health ***services*** from the entire ALTC program. Seniors in LTC settings very frequently have unmet mental health and cognitive needs and it is critical to ensure that coordination of mental health for the LTC population is preserved within the ALTC model.

- **Benefits Covered by the ALTC Program**

Consumers who are dually eligible or who require LTC services access a broad package of benefits that include Medicaid acute services, nursing home care and home and full range of HCBS including but personal care, alternative residential settings (e.g. assisted living facilities, adult residential care homes). Our experience is that programs with very comprehensive benefit packages including all the services above is the most effective design for an ALTC program. Including all benefits allows empowers the consumer working with their care coordinator the greatest potential to coordinate all services to achieve the consumer's goals. Carving out key benefits not only creates gaps in

coordination and communication, but creates incentives to "cost shift" to the benefit that is carved out of the program.

- **Enrollment Options**

Evercare operates ALTC programs in States with mandatory and voluntary enrollment models. Although the voluntary programs we participate in bring great benefit to enrollees, States with mandatory programs have made greater progress rebalancing their LTC systems and have achieved greater improvements in clinical outcomes and consumer satisfaction. Mandatory enrollment also allows for a more streamlined, non-fragmented system that provides the following benefits:

- Provides the opportunity for prevention, education, and early intervention to improve outcomes and maintain wellness;
- Provides administrative efficiencies and cost savings at the state and local level which leaves more money for direct client services
- Provides enhanced continuity of care due to ability to manage care over time in a single system, rather than creating the potential for intermittent eligibility due to changes in functional status; and
- Reduces costs of "marketing" the ALTC program required in a voluntary model, resources which can be instead directed to benefits for enrollees.

**Sources:**

[1] Sema K. Aydede, PhD, "The Impact of Care Coordination on the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Patients", Institute for Child Health Policy, September 2003.

[2] Ibid.

[3] Florida Office of Program and Policy Analysis & Government Accountability, "The Nursing Home Diversion Program Has Successfully Delayed Nursing Home Entry", May 2006

[4] "Long-Term Care 2002: Now and the Next Generation". Arizona Health Care Cost Containment System (AHCCCS) and Health Services Advisory Group, 2002.

[5] "2002 Consumer Assessment of Health Care: MSHO Nursing Home Population". Minnesota Health Data Institute, August 2002

**Acute and long term care integration in Medicaid - Comments from the Virginia Association of Area Agencies on Aging**

Thank you for the opportunity to comment on this most important undertaking. Integrating and coordinating care and services are approaches that have been central to the work of the Area Agencies on Aging since our inception. I am Grace Starbird, the President of the Association of Virginia's Area Agencies on Aging, V4A. The holistic approach to care is a much more efficient, effective and person-centered care model than a fragmented series of care providers. It is patient-centered and quality-driven…a model for healthcare that puts patients at the focus of efforts. And a model that stretches healthcare and human service dollars to better support the needs of patients.

As you look at community-based integrated care, V4A asks that you have as a tenet of the model the utilization of community-based organizations with proven track records working with the various populations. Whether seniors or individuals with disabilities or chronic disease, these are our residents and clients today…they are constituents with whom the local area agencies on aging are working and with whom we have trusted relationships. We would ask also that the support services such as personal care and homemaker services which enable better health to be integral to the models developed. We all know that nutrition is vital to any healthy regimen, especially for the populations being discussed. Patient empowerment through choices is an important reassurance to individuals and to their families.

We would ask that you not restrict too severely the benefits or financial incentives if you proceed with enhanced benefit account plans. It is vital that individuals have supporting services (nutrition, in-home services, transportation to healthcare, emergency access through a telephone, etc.). Therefore, we would ask that these tools and services be considered and included for patients enrolled in any integrated care and flexible plans.

If the direction undertaken is to look toward Special Need Populations with chronic conditions and integrated plans for these patients, we would ask that all due diligence be given to the integration of support services as well as utilization of community-based providers who work with these same patients and individuals today. Virginia has the benefit of a strong network of such service providers in the AAAs …neighbors who work with neighbors to make their lives work better each day. These are services that are vital to health status. AAAs are providers who know well that communities' resources are varied and patients' needs are unique. We have been practicing for decades to coordinate for both. Community-based coordination needs to be considered for plan requirements.

Again, thank you for this opportunity to be part of this undertaking which will impact so many vulnerable Virginians…V4A is a strong proponent of care coordination. It has been our model for service delivery for our seniors for years. Integrating healthcare and support services makes sense for improving the lives of some of our most vulnerable Virginians.

## Comments of the Virginia Health Care Association

***Development of a Blue Print for the Integration of Acute and Long Term Care***
**Virginia Department of Medical Assistance Services**

October 11, 2006

On behalf of our 233 nursing facility members, the Virginia Health Care Association (VHCA) appreciates the opportunity to comment on efforts now underway by the Department of Medical Assistance Services (DMAS) to respond to a directive from Governor Kaine to develop a plan to serve as a blueprint for moving towards an integrated, acute and long term care delivery system.

We applaud the desire on the part of advocates, providers and state policymakers to explore options for the development of a system of long term care delivery which spans a continuum of coordinated services that does not exist today. We are all aware that unless changed, the model for today's long term care delivery which focuses primarily on facility-based care and care provided under a variety of home and community waiver programs will likely falter as baby boomers age and begin to require long term care services. We support efforts to develop new programs and alternatives that will delay the need for seniors to utilize the costly services which comprise the majority of today's care options.

While we support and encourage the exploration of new options and alternatives for the delivery of long term care services, we also caution policymakers against pursuing "knee-jerk" and over-simplified strategies for addressing Virginia's Medicaid-funded long term care needs. A viewpoint expressed by many today is that aggressive expansion of home and community-based long term care services should serve as the foundation for a new model for more compassionate and less costly care.

It is hard to imagine individuals in need of long term care who would not desire to be taken care of in their own home – and this option should be the preferred care setting when appropriate. But defining "appropriate" is not an easy task. Issues including beneficiary health status, the existence of quality of care oversight, the availability of both paid as well as unpaid or informal caregivers, and the coordination of services in a cost-effective approach must all be considered before making decisions regarding appropriate care settings.

VHCA suggests that all groups including advocates, payors and providers need to do a better job of identifying and documenting what works and what does not work within the existing models of providing long term care services. The availability of unpaid informal caregivers necessary for the successful care of nursing facility eligible individuals within home and community-based care programs is in short supply. Today's dual wage earner economic environment represents a dramatic departure from family structures of just 20-30 years ago where there was often a daughter, son, or grandchild available to assist someone in the home with his or her long term care needs. Additionally, health care providers across the spectrum compete for qualified nursing staff – a problem likely to grow as baby boomers age and start to access long term care services.

**Comments of the Virginia Health Care Association**

Despite efforts by some to negatively characterize the care provided in nursing facilities, Virginia's nursing homes provide high-quality, cost-effective care to nearly 18,000 Medicaid residents each and every day. This care is delivered around the clock by dedicated caregivers in an environment designed to ensure the safety and satisfaction of both residents and staff. Indeed, a 2005 survey of 111 Virginia nursing homes conducted by an independent research and quality improvement organization found that 80% of more than 3,600 family members surveyed gave their facility either an excellent or good rating, and indicated they would recommend it to others as a place for a loved one to receive care.

In an effort to better understand the potential for and cost of transitioning Virginia nursing facility residents to home and community-based care services, VHCA commissioned an independent study to answer the question, "Could a significant number of Virginia Medicaid nursing facility residents be cared for at an equal or reduced expense to the state in their home or other community-based care option?"

To answer the question, the study which was recently completed and will be made available prior to October 31st, reviewed the Minimum Data Set (MDS) records of over 73,000 unique Virginia nursing facility residents during 2005. The study focused on almost 18,000 Medicaid nursing facility residents that had a full MDS assessment conducted in 2005. The study compares real costs in various settings and determines the number of current nursing facility residents that might be taken care of in a home or community-based setting.

Major findings of the study include: (1) only about 1.3% of all nursing facility residents have over a 50% likelihood of discharge from a nursing facility due to their need for intensive health care and available assistance at home or in the community; (2) the availability of an informal caregiver is the single most important factor in determining the probability for discharge back to the community; (3) home and community-based services for nearly 99% of 2005 Virginia Medicaid nursing facility residents would be two to three times more expensive than nursing home care; and (4) home and community-based services are less costly than facility-based care *only* when the state is not paying for bed and board *and* when informal/family caregiver support exists for individuals with generally less severe physical and cognitive conditions.

The study also reveals the actual cost of care for Medicaid long term care to the Commonwealth of Virginia's General Fund to be only $50 per day for the average nursing home, $33 per day for the average Assisted Living Auxiliary Grant recipient and $40 per day for participants in the existing pre-PACE program. Other community programs varied greatly in their costs. These amounts take into consideration the impact of "patient pay" offsets which serve to lower the actual state support expenditure by requiring that Medicaid beneficiaries assign income from sources such as social security to cover the cost of their care and the fact that 50% of Medicaid outlays in Virginia come from Federal sources.

**Comments of the Virginia Health Care Association**

Key findings and observations of the study are:

- There were more than 330,000 MDS assessments for over 73,000 unique Virginia nursing facility residents during 2005. There were approximately 18,000 unique Medicaid residents that had a full MDS assessment conducted. Other residents were primarily private pay or short-term Medicare funded residents.

- Of these 18,000 unique Medicaid residents, 915 were discharged back to a home setting or assisted living facility in 2005. The study found that the 915 discharged residents were generally younger, had shorter stays, had significantly fewer physical and mental problems, and generally had someone in the community to assist in their care.

- Based on a statistical analysis of these 915 Medicaid NF residents, only about 214 or 1.3 percent of the remaining 17,000 Medicaid NF residents, could expect to be discharged to a community-based setting at an equivalent or lower cost.

- The study found that while a number of factors are important to discharge status – including activities of daily living (ADL) status, cognitive acuity, and the use of therapy – the availability of an informal unpaid caregiver is the single most important factor in determining the probability for discharge back to the community. In other words, discharge is highly correlated with informal caregiver availability and less acute diagnosis.

- Using the MDS database, the study constructed eight hypothetical individual profiles for purposes of comparing the specific costs of community-based care with the costs of providing facility-based care. The eight profiles were composed of four with a high probability (greater than 50%) for discharge (1.3% of all residents) and four with a low probability for discharge (or those 98.7% of all residents with a less than 50% probability for discharge).

- The study found that the cost of home and community-based services for almost 99% of the 2005 Virginia Medicaid nursing facility residents would be two to three times more expensive than nursing home care. These findings support the argument that Virginia nursing facilities are the care centers of last resort, and are being appropriately utilized to provide high-quality, cost effective long term care nursing services to Medicaid recipients with serious medical or cognitive health conditions.

- The study indicates that home and community-based services are less costly to Virginia than facility-based care ***only*** when bed and board are self-provided ***and*** when informal/family caregiver support exists for individuals with generally less severe physical and cognitive conditions.

**Comments of the Virginia Health Care Association**

We recognize that the Olmstead decision, federal initiatives such as "Money Follows the Person" and "Real Choice Systems Change Grants" demonstrate a desire for people needing Medicaid long term care services to be given the option of Medicaid sponsored care in community settings. **If additional Medicaid long term care funds are to be allocated to home and community-based care, it should be done to expand options for Medicaid recipients and not as a cost saving strategy for Medicaid.** Given the strict Medicaid nursing home admission criteria in place in Virginia, the study confirms the fact that few nursing home eligible Medicaid recipients can be cared for more effectively, efficiently or inexpensively in other settings.

As the baby boomers age, the number of people needing long term care services will dictate an increase in the overall costs to society. All levels of long term care will be necessary to keep up with the demand for services. Innovative policies will be needed to care for the frail and elderly in the most efficient and cost-effective setting. The Virginia Health Care Association stands committed to work with other providers of long term care services and with DMAS to provide the most appropriate care for Virginia's frail elderly and disabled citizens.

Continuum Development Services

October 19, 2006

**VIA Electronic Mail**

Ms. Cynthia Jones
Chief Deputy Director
Virginia Department of Medical Assistance Services
600 E. Broad Street
Suite 1300
Richmond, Virginia 23219

**RE: BLUE PRINT FOR AGING COMMENTS**

Dear Ms. Jones:

Riverside Health System (RHS) engaged my organization to assist them in the development of the Program for All-inclusive Care of the Elderly (PACE) on the Peninsula and in Richmond. RHS and Anthem have already initiated discussions regarding potentially coordinating efforts to develop PACE and Special Needs Plans (SNP). I attended the first Town Hall meeting and wanted to provide written comments to Blue Print for Aging regarding two areas, which are:

1. The integration of PACE and SNP; and
2. PACE rate setting and participant's share of cost (Patient Pay)

**PACE AND SNP INTEGRATION**

A key decision in the development of a coordinated managed long-term care program is if the providers would be capitated for nursing home care. A number of state waiver programs capitates providers for waiver services but the state then assumes payment for services when the Medicaid recipient transfers to a nursing home. A review of Michigan's Medicaid Waiver Program in Muskegon and Ottawa Counties shows that PACE could clearly demonstrate cost neutrality to the state for the first year of operations if 50% of the Waiver Participants who were going to be permanently placed in the nursing home were enrolled in PACE. Attached is the letter showing cost neutrality.

1501 Greer Lane ▪ Signal Mountain, TN 37377
423.517.0567 ▪ 423.517.0568 Fax
dan.gray@consulting-cds.com

PACE is designed to be capitated for nursing home care because of the comprehensive coordination of all services delivered to the participant. I strongly urge the Commonwealth's consideration of capitalizing on its commitment to PACE development by designing coordination with Special Needs Plans or Medicaid Waiver Programs.

## PACE Rate Setting and Participant Share of Cost (Patient Pay)

DMAS has set the stage for developing successful PACE programs across the state. The only issues, which I believe could affect the success of PACE in Virginia, are the rate setting methodology and the patient pay payments currently being made by some participants at the pre-PACE program operated by Sentara.

### Rate Setting

Earlier this year, a letter was sent to Bill Lessard commenting on draft rates for the different regions of Virginia (attached). This letter outlines CDS' arguments for setting rates based on average statewide utilization and adjusting regional rates for cost factors such as labor, hospital charges, and nursing home rates. The initial work by the actuaries had the lowest rate in the rural regions differing from northern Virginia by slightly over $1,000 per member per month. I believe these proposed rates will make it difficult to develop PACE in rural areas and probably over-pay in northern Virginia.

### Patient Pay

Sentara's Senior Care (pre-PACE: Medicaid Only) currently collects a "Patient Pay" payment from a number of participants who are above 100% of the poverty level but below 300%. In most states, which have developed PACE, participants are eligible for PACE if their income is under 300% of the poverty level and do not have to pay anything to the program unless permanently placed in a nursing home.

PACE does not pay for housing or living expenses for the participants. It is very difficult for residents to pay these expenses (food, housing, utilities) from their own resources, in addition to monthly payments from $50 to $300+ to the PACE program. A number of potential PACE participants could go directly to a nursing home on Medicaid and not have to pay this amount in addition to the costs of living in their home. My review indicates that eligibility for PACE can be at the 300% of poverty level and I strongly urge the Commonwealth to take whatever action necessary to avoid any PACE participants being subject to Patient Pay. Otherwise, a significant number of potential PACE participants will be forced to go directly to the nursing home costing the state more money.

DMAS should be commended for its thoughtful approach to developing a long-term care plan and PACE. If I can answer any questions regarding my comments, please do not hesitate to call.

Sincerely,

Dan Gray
President

Public Comments to the Development of a Blue Print for Integration of Acute and Long Term Care Services
October 18, 2006

Good morning and thank you for the opportunity to address the development of a blueprint for the integration of acute and long-term services. I am Keren Ellis a Regional Administrator for Professional Healthcare Resources, a Medicaid and Medicare home health and personal care provider here in Richmond and the Vice President of the Virginia Assocation for Home Care and Hospice, chair of the legislative committee, and a registered nurse.

As an organization we recognize that there is tremendous pressure on both our Medicare and Medicaid systems to constrain the cost of the programs. As providers we also recognize that those cost restraints can have an adverse impact on our industry. These two factors are compounded by the fact that Virginia's Medicaid program is one of the most conservative programs from both a beneficiary and provider perspective leaving little room for cost savings or budget trimming.

VAHC recognizes that our system is in need of reform but not at the cost of patient care. Without a strong home health care industry in Virginia patients cannot receive the quality of care that they deserve. Any type of integrated acute and long-term care must be based on uniform quality standards and not solely on the construct of saving program dollars.

I want to tell you a little bit about our transition to Medicare managed care from a home health perspective in the hopes that there can be some lessons learned. Prior to this past year there was little to no Medicare managed care in Virginia. Wholesale reforms created by the Medicare Modernization Act created a paradigm shift in our Medicare system, which was based on managed care. The transition took place in concert with the new prescription drug benefit and resulted in a significant passive enrollment. Medicare beneficiaries thought they were in traditional Medicare and they were not. They had unknowingly been enrolled in a managed care plan. Many of their home health benefits had changed, in some cases significantly. From a provider perspective, we received no training from the wide array of new Medicare managed care plans on preauthorizations or billing procedures. Providers carried large receivables for many months not knowing when, or even if, they would be paid for services that had already been delivered. Cash flow is a vital component of the home health business model.

Systems were not in place nor do they adequately exist 12 months later. Managed care organizations did not, and still do not, understand the home health model. How we deliver services, our patients, or our systems and there has been little to no effort on their part to gain this knowledge. We as providers continue to struggle in the Medicare managed care environment with only six percent of beneficiaries enrolled in managed care.

Medicaid rates for home health are low. Medicaid rates for personal care are 40% below national averages. Any attempts to down-stream risk will result in a failed program. Providers can not absorb any additional cost

cutting schemes as they apply to either Medicare or Medicaid. Data from 2004 indicates that one-third of Virginia's Medicare home health care agencies have margins of less than 0. The balance between Medicare and Medicaid is in poor health itself. Any system transformation must be taken slowly to minimize any potential negative outcomes.

Home health and personal care services are one of the few bridges between hospitalization and independence. A recent study published in the Journal of American Geriatrics Society concluded that older adults who do not have help with activities of daily living, such as dressing and bathing are much more likely to be hospitalized for acute illness than adults who receive the personal care help that they need. Evidence exists of those older adults who qualify for nursing home care due to disabilities in activities of daily living can continue to live in their homes provided they receive personal care assistance. Thus home health and personal care services can serve as the bridge between the acute care and long-term care models of care. According to the June 2006 MedPac Report to Congress, integrating the use of nurse care managers and information technology in the clinical care of patients with high-cost, complex needs has the potential to improve quality and reduce costs in our health care system. The report also notes increased hospitalization is attributed to poor monitoring of treatment between physician visits and the lack of communications among providers.

Home health offers a great degree of care coordination and nursing interventions coupled with new technology. This is a great opportunity to

create additional efficiencies in our health care system as it pertains to both our aging and disabled populations.

CHCS

Center for
Health Care Strategies, Inc.

Resource Paper

# *Disability Care Coordination Organizations – The Experience of Medicaid Managed Care Programs for People with Disabilities*

Susan E. Palsbo
Center for Health & Disability Research
National Rehabilitation Hospital* (now at the College of Health & Human Services, George Mason University)

Margaret F. Mastal
Delmarva Foundation for Medical Care

*Funded by the Center for Health Care Strategies, Inc. under the Robert Wood Johnson Foundation's Medicaid Managed Care Program.*

*April 2006*

*281*

# I. Executive Summary

One of the greatest challenges facing every state Medicaid program is devising an appropriate and effective delivery system for its most resource-intensive beneficiaries. Children and adults with disabilities consume a disproportionately high quantity of Medicaid services, and their annual costs are increasing at the highest rate of all beneficiary groups.

One way for states to make their Medicaid expenses more predictable is capitation. Most states have turned to fully or partially capitated arrangements for Medicaid beneficiaries, and today, approximately 80 percent of beneficiaries are in capitated programs. Disabled beneficiaries are usually exempted from capitation and managed care because of fears of under-treatment, restricted access to services and providers, and poor quality.

Bucking this trend are several pilot programs. Most of them have strong roots in working with people with disabilities. The programs are taking the best attributes of managed care and reconfiguring them to improve the lives of Medicaid beneficiaries with disabilities. We visited seven pilot programs during 2004. This paper synthesizes the programs' key components and describes the challenges they face in documenting their effectiveness to advocates and regulatory agencies. A companion paper presents a strategy to report comparative measures of program outcomes.

## Findings

Following are our key findings:

**Findings on Mission**

- The primary mission of each program is to coordinate publicly funded medical and social services. They blend attributes of social services agencies and health care agencies. We refer to these new entities as: Disability Care Coordination Organizations (DCCOs).

**Findings on Scope of Coordinated Services**

- Medicaid beneficiaries in DCCOs have most or all of their benefits coordinated by the DCCO.
- DCCOs targeting people with physical disabilities coordinate DME, transportation, and personal care assistance; they may also provide non-Medicaid supplements to these services (e.g., in-home wheelchair repair).
- Capitated DCCOs offer supplemental benefits, funded out of cost savings.
- PCCM and fee-for-service models are unable to offer supplemental benefits.

**Findings on Care Coordination Process and Key Functions**

- Engage participants in writing a self-directed, patient-centered plan of care.
- Collaborate with other agencies, providers, and vendors to meet participants' needs.
- Organize and disseminate information across all agencies and providers.

- Communicate proactively with each participant on a regular basis, timed to meet participants' needs.
- Attend clinical visits when needed.
- Available to participants 24/7.

**Findings on Organizational Structure**

- Organizational structures range from being a specialty service provider to a full-fledged HMO.
- The DCCO is a flexible, robust approach to support independent living in the community, and person-centered and consumer-directed care, across a variety of disabling conditions.
- Care coordination models reflect the community environment and populace they serve.
- Three "core competencies" are: service coordination, patient education, and quality improvement.

**Findings on Staffing Configuration**

- Caseloads range from 20-75 participants per care coordinator.
- Some DCCOs stratify their participants by resource need to distribute the coordination burden equitably across the coordinator structure.
- Most DCCOs invest significant time and resources to develop productive teams and interdisciplinary cognizance between nurses and social workers.
- DCCOs using combined nurse-social worker teams house the teams at the corporate office, providing dedicated physical space for each team.
- DCCOs embedding nurse coordinators in physician offices link them with the expertise of social workers.
- DCCOs in states with advanced practice nurses are evolving models that best utilize their education and training in the comprehensive care coordination process.
- DCCOs targeting persons with physical disabilities must address mental health issues and develop expertise among care coordinators for dealing with these concerns.

**Findings on Information Systems**

- DCCOs are internally developing separate and distinct information management systems for the care coordination of their complex populations.
- Extensive relational databases are needed for effective care coordination of complex populations.

**Findings on Quality Management**

- There are few shared measures across DCCOs, partly because they target different types of disability clusters.
- The sophistication of quality measurement and reporting (number of measures, process to select measures, input of data to create measures) varies widely across sites.

**Findings on Financing of Care Coordination Processes**

- Capitated entities have the most freedom to allocate resources to provide person-centered health care.
- DCCOs that charge fee-for-service for coordination services may eventually become self-sustaining businesses rather than relying on grants.
- Blended financing models (some services capitated, some fee-for-service) are common.

**Findings on Origins/Catalysts**

- DCCO established effective partnerships between two or more sectors (state Medicaid program, community development agency, providers, or consumer advocates).
- Involving Centers for Independent Living (CILs) is an efficient strategy to obtain organized consumer input into the design and start-up of DCCOs, even though they may play a smaller role once the program is launched.

## Outcomes

- Preliminary evidence indicates care coordination reduces hospitalizations and emergency room use, and improves access to primary, preventive, and specialty care.
- Quality of life improves for participants according to self-reported data.
- Satisfaction with Medicaid is increased for participants, providers, and coordinators over fee-for-service Medicaid.
- Internal DCCO data on clinical outcomes show they are improving the quality of life and health of many participants.

## Recommendations for States

States designing and implementing managed care programs for adults with disabilities should consider the following:

1. Ensure that DCCOs are grounded in the infrastructure of the community served.
2. Develop mechanisms for formal input by beneficiaries into governance.
3. Fully capitate, if possible; if not, they should at least partially capitate and ensure that DCCOs can financially benefit from care coordination savings.
4. Allow DCCOs to compile all data on carved-out services, such as mental health or pharmacy expenditures.
5. Ensure that DCCOs have a sophisticated management information system.
6. Track quality of life outcomes, in addition to satisfaction, clinical, utilization, and financial outcomes.
7. Track utilization and pay for care coordination services.

Appendix C
Part II

# Comments Received
# Regarding the Draft Blueprint for the Integration of Long Term and Acute Care Services

1. **Jean Kane**

2. **Stuart Yael Gordon, Director, Policies and Programs, National Association of Chain Drug Stores (NACDS)**

3. **Craig Connors, Executive Director, PACE, Riverside Health System**

4. **Virginia Association of Community Service Boards (VACSB)**

5. **Virginia Health Care Association (VHCA)**

6. **Virginia Network of Private Providers**

**Jean King**
**Received via email on December 4, 2006**

My comments below deal with minor details rather than being substantive. Unfortunately, the timeline for returning comments (<72 hours, mostly over a weekend) precluded anything else.

1) Throughout this draft, there is an indication that the phrase "community-based" is being deleted from references to home and community-based services or references to institutional and community-based services. Is this deletion really intended, and if so, is it appropriate? Much of the blueprint seems to be about expanding community-based services, so that referencing them seems to me to be essential.

2) On page 7, next to last sentence of first paragraph: Should that read "$1.5 million in start-up funds for six..." (rather than ...in star funds...)?

3) On page 9, I believe you mean $923 million in Medicaid funded institutional care (the word million is presently missing).

4) Also p. 9 and p. 33: You state that fewer than 70,000 people nationwide receive LTC through managed care, and that 40,748 people in Virginia receive LTC, through Medicaid. It would be nice to know what percentage of Virginia's LTC clients are in managed care.

5) p. 13, Figure 2. It would be very interesting to know how this would change under several different scenarios: e.g., if eligibility in Virginia matched median for the nation rather than being among the most stringent, or if reimbursement rates more nearly matched actual costs, which apparently is not the case, and has precipitated an exodus of practitioners in some areas of medicine.

6) p. 16. How has the number of patients in nursing homes remained constant over five years, given the overall population increase during that period and the additional increase in the aging population? And also, if the number of people served has held constant, why the increase in costs that significantly exceeds inflation over the period? May I assume it is because we have begun to address the excessively low reimbursement rates? If yes, that should impact costs for a capitated system as well.

7) Page 17, figure 5. What year is this data for? The PACE data for 2005 on the next page suggests that care for the elderly is much higher than for the EDCD segment of those under waivers. How different are the two populations, and if they are similar, why the cost differentials?

Several of these comments ask questions, based on my own limited background in the details being discussed. If this blueprint is just for internal use by DMAS staff, readers may be able to "fill in the blanks" quite easily. But for any external audience, this document assumes background knowledge that too few will actually have.

I am sure that as the work of the LTC Workgroup proceeds, I will have many more questions about details that are beyond my present knowledge base. I look forward to learning as I contribute to this effort.

Jean Kane

**National Association of Chain Drug Stores**

December 4, 2006

Mr. Patrick W. Finnerty
Director
Department of Medical Assistance Services
600 East Broad Street
7th Floor
Richmond, VA 23219

**RE: Comments on *Blueprint for the Integration of Acute and Long-Term Care***

Dear Director Finnerty:

The National Association of Chain Drug Stores (NACDS) has reviewed the draft *Blueprint for the Integration of Acute and Long-Term Care*, and while we note that the report contains many important insights, we are concerned that it fails to discuss the advisability of carving out the prescription drug benefit under the managed care integration models reviewed.

Specifically, we are concerned that the report fails to address whether to carve out prescription drugs from managed care coverage. We believe a failure to carve out the drug benefit could leave the Department of Medical Assistance Services (DMAS) with a loss of control over which necessary drug treatments beneficiaries can receive and how they receive those treatments, as MCOs restrict services to remain solvent under captitated reimbursement. MCO management of prescription drugs also would strip the state of its ability to ensure a uniform approach to the effective utilization of prescribed drugs and to the availability of medication therapy management. Finally, a failure to carve out prescription drugs would create unnecessary administrative burdens and costs for the state in coordinating prescription drug benefits for dual enrollees receiving drug benefits under Medicare Part D.

NACDS represents the nation's leading retail chain pharmacies and suppliers, helping them better meet the changing needs of their patients and customers. Chain pharmacies operate more than 37,000 pharmacies, employ 114,000 pharmacists, fill more than 2.3 billion prescriptions yearly, and have annual sales of nearly $700 billion. In Virginia, there are about 1,275 pharmacies in Virginia, of which about 965 are chain pharmacies. Those chain companies employ 64,050 Virginia residents, including over 2,930 pharmacists, and pay over $961.27 million in taxes to the state annually.

**Report Fails to Review the Question of Managed Care Pharmacy Carve-Outs**

The overview of other state efforts to integrate care on page 25 of the draft report notes only in passing that some state programs include pharmacy benefit carve-outs. However, with the prescription drug benefit constituting 11 percent of Virginia Medicaid costs, we believe it is important that this issue be discussed in greater detail.

Access to effective prescription drug treatments can provide savings in other aspects of the Medicaid program. Effective prescription drug treatments avoid and reduce hospital stays and delay the need for institutionalized skilled nursing care. It is only through access to effective prescription drug

treatments in mid- and late-life, that community-based care can become a real alternative to far more costly institutionalized care.

However, an MCO looking for ways to operate within the limits of capitated payments will be forced to choose among services delivered and methods for delivering those services. It may choose not to deliver an optional Medicaid service, such as prescription drugs, at all. Or it may choose to deliver that service in a less costly, but far less effective manner, such as by delivering prescription drugs through a mail order approach that deprives beneficiaries of the every-day patient counseling now available to them in neighborhood pharmacies. MCOs now operating in Virginia are delivering Medicaid therapy management services over the phone, using nurses, rather than through face-to-face interaction with the patient's neighborhood pharmacist and doctor, and this is under a far less extensive managed care model.

In addition, of course, an MCO may choose to nominally provide a service while reimbursing network providers at a rate that is so unfavorable – due to limits imposed by capitation – as to effectively deny its enrolled beneficiaries access to those services.

**Loss of Control Over Utilization Measures**

Virginia Medicaid has spent a great deal of time and effort over the last few years in developing approaches to focusing utilization, such as through mandatory generic substitution and preferred drug lists. Those approaches have controlled costs while ensuring that enrollees continue to receive necessary medications. There is no guarantee that an MCO managing prescription drug costs for an integrated care beneficiary would chose to adopt the same well-conceived approaches. Nor are there any guarantees that an MCO – a step removed from consumer pressures and public transparency – would have the same public policy concerns in mind while fashioning its own approach to managing costs that were at the forefront of prescription drug discussions in the legislature and before the Department.

**Coordination of Drug Coverage Under Part D Rules**

Finally the rules for Medicare Part D coverage and treatment of beneficiary true out-of-pocket expenses are complex and difficult. However, they would be far easier to address, and less costly and administratively burdensome for DMAS, if coverage and management of prescription drugs not covered by Part D were to remain in the purview of the Virginia Medicaid program rather than being transferred to one or more MCO administrators. It also would be easier for DMAS to continue to ensure that elderly and disabled beneficiaries are receiving the maximum drug benefit available.

**Conclusion**

NACDS believes that any integrated care model must carve out the Medicaid pharmacy benefit in order to ensure that Virginia's Medicaid enrollees continue to receive effective and cost-effective prescription drug treatment that ensures that they remain healthy and out of institutionalized care as long as possible, in the manner most appropriate to the public welfare.

Thank you for the opportunity to offer this very important concern for consideration

Sincerely,

Stuart Yael Gordon
Director, Policies and Programs

**Received Via Email: November 28, 2006**
**Riverside Health System**

**From:** Connors, Craig [mailto:Craig.Connors@rivhs.com]
**Sent:** Tuesday, November 28, 2006 10:15 AM
**To:** ALTC
**Subject:** Question on Blueprint

First, I think the document is very well done and I commend DMAS for the process used to develop the Blueprint.

I have one question regarding enrollment: in Phase II of the regional model participants will be able to opt out of managed care after being passively enrolled. Will the opt out apply only to the long-term care portion of the benefit (keeping the acute-care portion mandatory as long as there are 2 MCOs) or will it apply to all acute and LTC benefits?

Sincerely,
**Craig Connors**
Executive Director, PACE
Riverside Health System

**Comments of the Virginia Association of Community Services Boards (VACSB) Regarding the Draft Blueprint for the Integration of Long Term and Acute Care**

Thank you for the opportunity to respond to the Draft document. The VACSB and its member CSB/BHAs appreciate the ability to make our comments.

The VACSB congratulates DMAS on the open and informative process during the development of the Draft Blueprint. At every step in the process, comments and questions were welcomed and heard.

We appreciate the efforts by DMAS to hear and address the concerns of the VACSB and other advocates regarding the specialized needs of individuals who have disabilities, especially those of a cognitive nature. Retaining long term care services in the fee-for-service arena helps demonstrate that current services, which are working well for Medicaid recipients with mental retardation, should not be disrupted. Thank you for attending to the message of *Do No Harm* message.

Additionally, the concept of **coordinated** care rather than **integrated** care for individuals receiving services through the Mental Retardation Waivers will assure that the social and rehabilitation model that assists individuals to live in their communities will retain utmost importance.

Finally, the concept of a true pilot to assess the viability and benefits of a coordinated system for individuals with mental retardation is a reasonable one. The VACSB and its member look forward to working closely with DMAS in the details of pilot planning and implementation.

As with any change, the VACSB, member CSBs, and families of individuals with mental retardation have concerns that must be addressed during the process of piloting and evaluating. Among the concerns:

- We are unaware of any experience managed care organizations have with serving individuals with mental retardation, especially given the need to coordinate closely with families, primary caregivers, CSB case managers, and/or those who are substitute decision-makers. If there are organizations with a demonstrated track record of quality primary managed care coordinated with long term care for people with MR and consumer satisfaction results, it would be beneficial to receive detailed information.
- Local relationships with primary healthcare providers and pharmacies have been developed over the years and should be maintained.
- Primary caregivers, including providers of residential services, should be able to access medical services for the individuals in their care without delaying assessment strategies that, for individuals with mental retardation who may be unable to verbalize problems, can create adverse health conditions.
- CSBs and private providers of MR Waivers services must follow DMHMRSAS Licensure and Human Rights Regulation for all licensed services. We are unsure if managed care organizations recognize the health and safety issues, including speedy access to medical services when needed, dictated by such regulations.

- Families of individuals with mental retardation may have serious concerns unless there are clear, guaranteed and added health benefits, such as dental care, for example.
- Are there data to support the premise that those individuals with mental retardation whose current healthcare needs are managed receive quality care and are satisfied with that care?
- The Individualized Service Plan (ISP) of each person in the MR Waivers should be the primary plan for treatment and supports since the plan represents what is needed so that the individual can live in the community. The CSB case manager, who is monitoring the ISP, can better coordinate with the primary care plan regarding the medical needs. While medical care management may be deemed necessary, the CSB case manager has the responsibility of assuring the ISP is followed.
- Honor a system of services that has been carefully and painstakingly developed over many years and scrutinized closely by decision-makers in Virginia.

**December 4, 2006**
**Virginia Hospital and Health Care Association**

On behalf of our 233 nursing facility members, the Virginia Health Care Association (VHCA) appreciates the opportunity to comment on the draft report entitled *Blueprint for the Integration of Acute and Long-Term Care* (the report) developed by the Department of Medical Assistance Services (DMAS) to respond to a directive from Governor Kaine to develop a plan to serve as a blueprint for moving Virginia towards an integrated, acute and long term care delivery system.

We applaud the desire on the part of advocates, providers and state policymakers to explore options for the development of a system of long term care delivery which spans a continuum of coordinated services that does not exist today. We are all aware that unless changed, the model for today's long term care delivery which focuses primarily on facility-based care and care provided under a variety of home and community waiver programs will likely falter as baby boomers age and begin to require long term care services. We support efforts to develop new programs and alternatives that will delay the need for seniors to utilize the services which comprise the majority of today's care options. At the same time, the Virginia Health Care Association firmly supports the concept that Medicaid beneficiaries should reside and receive care in the most cost effective setting able to meet the health care and social needs of the recipient.

The Commonwealth has seen rapid growth in the care provided under home and community-based Medicaid waiver programs. As shown in Figure 3 of the draft report, expenditures for Medicaid home and community-based care have increased in excess of 50% for the most recent five-year period. For those advocating for greater Medicaid long term care waiver service options, this rate of increase compares favorably to the overall rate of increase for nursing facilities of less than 35%. This growth clearly indicates that alternatives to facility-based care exist for those in need of long term care services.

While we support and encourage the exploration of new options and alternatives for the delivery of long term care services, we also caution planners and policymakers against pursuing "knee-jerk" and over-simplified strategies for addressing Virginia's Medicaid-funded long term care needs. The report endorses a very limited set of options for meeting this goal without strong evidence demonstrating that the endorsed approach has considered Virginia's long term care population or that the option is the best for Medicaid long term care residents. The report does not clearly identify the problem that needs to be fixed.

Virginia, with a Medicaid program for nursing facility care which combines provider payment rates that fall well below national averages, residents with documented medical acuity that historically is among the highest in the country and high average facility occupancy rates of approximately 90%, appears to be in a position to be envied by the vast majority of other states. Given these attributes, we question the validity of many of the touted benefits for the Commonwealth that managed long term care promises. The Blueprint draft appears to be more of a national perspective "solution" looking for a problem to solve. The reality is that many, if not most, of the benefits being sought by states considering managed Medicaid long term care programs are already being realized in Virginia. Managed care organization can only make

money by limiting access even more than the current system or by reducing payments to some or all providers. In a "lean" Medicaid program such as Virginia's both options are very limited and could negatively affect consumers and providers.

Nationally, administrative costs incurred by states for operating their Medicaid programs typically range between 4% and 6% of total expenditures. For 2005, DMAS reported administrative expenses of 1.8% of total program expenditures. All other expenditures go to pay for medical care. According to a recent Wall Street Journal article, administrative costs for Medicaid managed care organizations generally range from 15% to 20%. Historically, Virginia has taken a certain pride in running a lean and efficient Medicaid program. We have significant doubts about the Department's contemplation of an unproven approach that is all but certain to move dollars away from beneficiary care.

For most of the more than 250 Medicaid-certified nursing facilities in Virginia, Medicaid residents comprise a majority of their overall patient population. This distinguishing feature alone defines a provider community that is vastly different than exists for services provided through the Commonwealth's existing managed care system for non-elderly and disabled Medicaid beneficiaries. We believe that there are serious and significant risks associated with inviting managed care organizations into the existing Virginia nursing home provider community environment characterized by relative stability and relatively weak financial performance.

While Medicaid represents, on average, a moderate component of services provided by physicians and hospitals, it represents nearly two-thirds of all nursing facility residents. Managed care organizations have an established track record of ignoring the operational and financial health of the providers with whom they contract. The relative stability that Medicaid residents, the providers that provide their care and the Department enjoy today could decline dramatically if the plan outlined in the Blueprint report is implemented.

We are disappointed in the Department's decision to include content in the report which demonstrates a lack of in-depth study and analysis of this vitally important topic. Perhaps the single biggest offender is the table reproduced as Figure 8 on Page 23 of the draft. We do not believe that the conclusions reached in the table are accurate and encourage the Department to take a close look at this table and the remainder of the draft in an effort to create a final report which is factual, balanced and unbiased.

It is hard to imagine individuals in need of long term care who would not desire to be taken care of in their own home – and this option should be the preferred care setting when appropriate. But defining "appropriate" is not an easy task. Issues including beneficiary health status, the existence of quality of care oversight, the availability of both paid as well as unpaid or informal caregivers, and the coordination of services in a cost-effective approach must all be considered before making decisions regarding appropriate care settings.

Despite efforts by some to negatively characterize the care provided in nursing facilities, Virginia's nursing homes provide high-quality, cost-effective care to nearly 18,000 Medicaid residents each and every day. This care is delivered around the clock by dedicated caregivers in an environment designed to ensure the safety and satisfaction of both residents and staff. Indeed,

a 2005 survey of 111 Virginia nursing homes conducted by an independent research and quality improvement organization found that 84% of more than 3,600 family members surveyed gave their facility either an excellent or good rating, and indicated they would recommend it to others as a place for a loved one to receive care.

In an effort to better understand the potential for and cost of transitioning Virginia nursing facility residents to home and community-based care services, VHCA commissioned an independent study to answer the question, "Could a significant number of Virginia Medicaid nursing facility residents be cared for at an equal or reduced expense to the state in their home or other community-based care option?"

To answer the question, the recent study titled *Comparing Long Term Care Settings – The Potential for and Cost of Discharging Nursing Facility Residents to Home and Community-Based Care* reviewed the Minimum Data Set (MDS) records of over 73,000 unique Virginia nursing facility residents during 2005. The study focused on almost 18,000 Medicaid nursing facility residents that had a full MDS assessment conducted in 2005. The study compares real costs in various settings and determines the number of current nursing facility residents that might be taken care of in a home or community-based setting.

Major findings of the study include: (1) only about 1.3% of all nursing facility residents have over a 50% likelihood of discharge from a nursing facility due to their need for intensive health care and available assistance at home or in the community; (2) the availability of an informal caregiver is the single most important factor in determining the probability for discharge back to the community; (3) home and community-based services for nearly 99% of 2005 Virginia Medicaid nursing facility residents would be two to three times more expensive than nursing home care; and (4) home and community-based services are less costly than facility-based care *only* when the state is not paying for bed and board *and* when informal/family caregiver support exists for individuals with generally less severe physical and cognitive conditions.

As indicated above, the *Comparing Long Term Care Settings* report documents that only about 1.3% of Virginia nursing home residents are clinically able to be cared for at home. Even if a managed care organization defers nursing home admission, many of these beneficiaries will eventually need nursing home care. Thus the savings can only be obtained by the managed care organization in the initial delay. We believe that other, more cost effective, options should be explored for identifying care resources to be pursued in advance of nursing facility placement.

We believe the Department's blueprint fails to address many key issues that require in-depth consideration before announcing plans to move forward. For nursing facilities, among these key issues are:

- Will the new model include minimum hold-harmless provisions designed to protect the nursing facility community from financial failure?

- How will Medicare and Medicaid funding sources be blended?

- Will multiple managed care organizations be mandated for each unique geographic region to insure a minimal level of competition?

- How will patient care liability risks be allocated between nursing facilities and the managed care organizations with which they contract? Will managed care organizations indemnify providers should professional liability limits be lowered in response to new operating models and lower payment levels?

- What role will managed care organizations play in addressing the physical plant reinvestment requirements that facilities must address? What recognition will managed care give to the need for funding additional technology investments within nursing homes?

- What changes will be made within the state/federal survey process to reflect the new reality that facilities will likely be caring for even sicker residents with fewer financial resources?

The Commonwealth is uniquely positioned to adopt a limited wait and see approach to Medicaid managed long term care. At the same time that DMAS, the Administration and the General Assembly take advantage of the favorable environment created by a combination of relatively low nursing facility payment rates coupled with controlled utilization resulting from stringent nursing home admission criteria, planners and policy makers can use the next three to five years to monitor Medicaid managed long term care efforts around the country to see what programs work and which ones do not. Absent this strategy, Virginia could wind up with the worst of all worlds – limited state dollars intended to fund care instead being siphoned off to managed care organizations whose objectives, lower payment and lower utilization, have already been accomplished.

VHCA suggests that all groups including advocates, payors and providers need to do a better job of identifying and documenting what works and what does not work within the existing models of providing long term care services. The availability of unpaid informal caregivers necessary for the successful care of nursing facility eligible individuals within home and community-based care programs is in short supply. Health care providers across the spectrum compete for qualified nursing staff – a problem likely to grow as baby boomers age and start to access long term care services.

As baby boomers age, the number of people needing long term care services will dictate an increase in the overall costs to society. All levels of long term care will be necessary to keep up with the demand for services. Innovative policies will be needed to care for the frail and elderly in the most efficient and cost-effective setting. The Virginia Health Care Association stands committed to work with other providers of long term care services and with DMAS to provide the most appropriate care for Virginia's frail elderly and disabled citizens.

**Virginia Network of Private Providers**

Let me express our concerns about the proposed Blueprint for the Integration of Acute and Long-Term Care in three parts with specific focus on the potential impact on MR Waiver residential clients and providers:

**Part I – Services Included**

- The report asserts that "Including these clients [in the MR, Day Support, IFDDS or Technology Assisted Waivers] in managed care for their health care needs is a major step forward to ensuring that these long-term clients benefit from … disease management programs." ***Prior to accepting this assertion, we should examine the utilization and effectiveness of the disease management program currently available to clients in the MR Waiver; we should also assess whether a "new" disease management program through an MCO will be more or less effective for the individuals in the MR Waiver who have opted in to the current program.***

- The report also states that when a client with mental retardation is "fortunate to receive a Mental Retardation waiver slot; then these clients are thrown back into the fee for service delivery" for acute care. ***A simple examination of a sample of 67 MR Waiver Residential clients comparing the date of admission with the advent of Managed Care services in various regions of Virginia shows that 76% of these individuals were never in Managed Care so for them, and for all the other current MR Waiver clients, a switch to an MCO will (or may) be disruptive to the relationships they currently have.***

- The report describes the current system as illogical, lacking in the provision of a "consistent health care delivery system that is responsive to their needs and not the funding or long-term care services utilized." ***We need to examine the data in a more formal way as it relates to this specific population. For the most part providers and families work very hard to build a network of health care providers who are both capable and willing to provide health care to this most challenging population. Any disruption could have very negative implications.***

**Part II – Impact of Phasing on Residential Providers**

- It is difficult to conceive of any way to make the delivery of services to a very fragile population more challenging than to force a residential provider to employ two entirely different methods for acute care within a single program. ***The proposal would have Medicaid-only clients be included in Managed Care in the next biennium, but those who are, or who become, dual-eligible not be included until the following biennium. In the same sample of 67 clients listed above 37 are dual-eligible (including 2 who are not receiving Medicaid funded LTC) & 30 Medicaid only – only two of the twenty-two residential sites have a single type.***

- One particular concern is the risk of losing the ability to contract with a single LTC pharmacy to provide medication, medication administration records and Order sheets. ***If pharmacy services are included in the Managed Care Service, the ability of the provider to ensure that only one LTC pharmacy is providing medication and forms to the entire program will be difficult.***

**Part III – Regulatory Demands**

- Regulatory demands, liability concerns and, most importantly, client care issues often require that Emergency Room visits or physician consultation occur over and above what would be expected in a "non-disabled" population. When a client begins to vomit at 2:00 am it is generally not acceptable to wait until the following morning to assess the problem or seek medical attention. Cognitively impaired clients can not always "tell you where it hurts!" ***As residential providers we will, and should, err on the side of caution – not necessarily a practice which fits comfortably with a managed care program.***

As the Blueprint unfolds and we move toward implementation, I would propose the following:

- We carefully examine the data that will show cost differences between managed care and FFS for the individuals in the target group who have been served in both systems; and examine the reasons for any differences which may be evidenced by the data.

- Survey the current population who are on the MR and DD Waiver Waiting List who are receiving acute care services through a Medicaid Managed Care entity to assess the satisfaction, successes and/or failures of their care. **We can not assume that the current MCOs are meeting the needs of this complex population to consumer satisfaction.**

- Consider "carving out" **at least** the population in MR Waiver residential – most of the concerns above apply to that group or at least are magnified with that group. We would consider working with DMAS staff to develop a pilot with persons who are not in residential services.

- Consider expanding the role/use of the Skilled Nursing service in the MR Waiver to put more emphasis on having nursing expertise available to residential providers to ensure the coordination and appropriateness of acute care services.

As the proposal to implement managed care for acute care services proceeds, the details of both the process and the requirements of the managed care entity need careful consideration and review by the providers charged with the responsibility of ensuring the quality of care.

# Appendix D
# Services Provided through Virginia's Home and Community-based Waiver Programs

**•Elderly or Disabled with Consumer Direction (EDCD)**
–Personal care, adult day health care, respite, and personal emergency response systems (PERS); consumer direction

**•Mental Retardation (MR)**
–Day support, congregate residential support, in home residential support, pre-vocational services, respite care, supported employment, therapeutic consultation, personal care, assistive technology, environmental modifications, skilled nursing, crisis stabilization, companion care, crisis supervision, and PERS; consumer direction

**•Day Support (DS)**
–Day support and prevocational services

**•Individual and Family Development Disabilities Support (DD)**
–Day support, supported employment, in-home residential support, therapeutic consultation, personal care services, respite care, skilled nursing services, attendant services, family and caregiver training, crisis stabilization, environmental modifications, assistive technology, PERS, and support coordination; consumer direction

**•HIV/AIDS waiver (AIDS)**
–Case management, nutritional supplements, private duty nursing, personal care, and respite; consumer direction

**•Technology Assisted Waiver (TECH)**
–Personal Care, private duty nursing, respite care, environmental modifications, and assistive technology

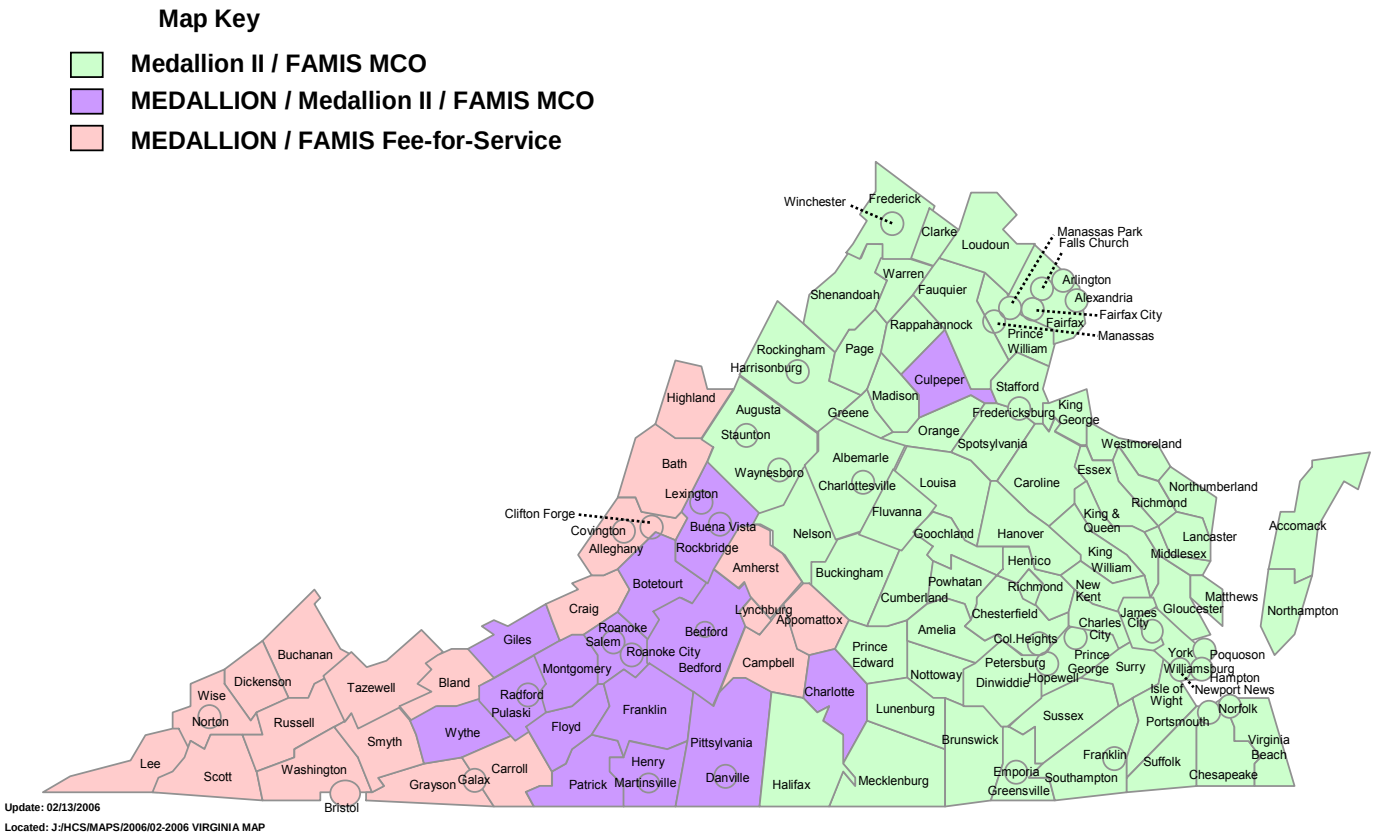
**•Alzheimer's Assisted Living Waiver (AAL)—Newest Waiver**
–Individuals who have a diagnosis of Alzheimer's or related dementia and meet nursing facility criteria
–Are at least 55 years in age (regulations under revision)
–Are receiving an Auxiliary Grant
–Reside in an assisted living facility
–200 slots

# Appendix E
# Medicaid Long-term Care Expenditure Data

## SUMMARY OF MEDICAID LONG-TERM CARE EXPENDITURE DATA

| HCFA/CMS Category/Object Code | | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|---|
| | **Nursing Facility** | **519,117,960** | **539,268,035** | **582,787,275** | **623,759,304** | **646,557,497** | **697,984,269** |
| 123450 | Nurses Aides | 211,864 | 652,063 | 246,956 | 190,076 | 52,668 | 210,730 |
| 123501 | Skilled Nursing Facilities | 518,906,096 | 538,615,973 | 582,540,319 | 623,569,228 | 646,504,829 | 697,773,539 |
| 123503 | Intermediate Care Facility | 0 | 0 | 0 | 0 | 0 | 0 |
| | **ICF/MR/Public Facilities** | **160,871,232** | **192,727,929** | **157,953,140** | **172,036,545** | **179,385,336** | **184,427,438** |
| 123507 | ICF - MR State | 160,871,232 | 192,727,929 | 157,953,140 | 172,036,545 | 179,385,336 | 184,427,438 |
| | **ICF/MR/Private Facilities** | **19,292,971** | **18,299,608** | **21,127,148** | **25,460,429** | **34,036,235** | **40,532,655** |
| 123508 | ICF - MR Community | 19,292,971 | 18,299,608 | 21,127,148 | 25,460,429 | 34,036,235 | 40,532,655 |
| | **Total Institutional LTC Services** | **699,282,163** | **750,295,573** | **761,867,563** | **821,256,278** | **859,979,068** | **922,944,362** |
| | **Home Health** | **5,211,239** | **5,002,691** | **4,411,341** | **3,052,856** | **4,555,784** | **5,018,912** |
| 123402 | Home Health | 5,211,239 | 5,002,691 | 4,411,341 | 3,052,856 | 4,555,784 | 5,018,912 |
| | **Home/CBC Waivers** | **287,562,995** | **318,007,100** | **352,596,635** | **401,788,210** | **446,366,665** | **517,902,524** |
| 123412 | Community MR Services Waiver | 174,353,926 | 201,908,132 | 226,224,384 | 254,831,687 | 281,251,878 | 309,272,373 |
| 123414 | ACR Intensive Assisted Living | 1,720,219 | 756,307 | 563,148 | (537,620) | (319,378) | 135,752 |
| 123418 | DD Waiver | (13,268) | 1,050,553 | 3,695,356 | 2,575,810 | 2,952,803 | 6,593,115 |
| 123505 | Personal Care | 87,350,210 | 86,918,319 | 92,985,419 | 109,613,510 | 120,882,811 | 143,796,227 |
| 123509 | Private Duty Nursing | 19,892,429 | 18,774,626 | 20,264,966 | 20,568,248 | 22,629,761 | 28,494,974 |
| 123510 | Adult Day Care | 2,621,886 | 5,507,295 | 2,898,596 | 3,374,955 | 3,196,245 | 3,405,299 |
| 123513 | Respite Care | 1,637,593 | 3,091,869 | 5,964,766 | 11,361,620 | 15,772,545 | 23,076,959 |
| 123515 | Companion Care* | | | | | | 107,448 |
| 123517 | CD Facilitator Services* | | | | | | 869,177 |
| 123801 | Day Support Waiver | | | | | | 1,578,852 |
| 123864 | Waivered DME* | | | | | | 572,348 |
| | **Total Community LTC Services** | **292,774,234** | **323,009,791** | **357,007,976** | **404,841,066** | **450,922,449** | **522,921,436** |
| **Total LTC Service Expenditures** | | **992,056,397** | **1,073,305,365** | **1,118,875,539** | **1,226,097,344** | **1,310,901,517** | **1,445,865,798** |
| **Community LTC %** | | **29.5%** | **30.1%** | **31.9%** | **33.0%** | **34.4%** | **36.2%** |

# Appendix F
# Virginia Medicaid Managed Care Geographic Coverage



# Appendix G
# Medicaid/Medicare Service Comparison Chart

| Type of Service | Coverage Under Medicare | Coverage under Medicaid (see note below) |
|---|---|---|
| Inpatient and outpatient hospital | Covered with limitations on the duration of inpatient hospital stays. | Mandatory. Some states limit the duration of inpatient hospital stays, and/or the number of outpatient visits. |
| Mental health facilities | Coverage is limited to 190 days per lifetime in a mental hospital. Also covers partial hospitalization services. | Optional. Covered by 49 states and D.C. Does not cover services for adults between ages 22 and 64 who reside in an institution for mental disease. |
| Nursing facility | Covered for post-hospital stays, with limitations on the duration (up to 100 days per benefit period). | Mandatory. Generally, states do not limit the duration of coverage. |
| Physician | Covered. | Mandatory. States may limit the number of visits per year. |
| Other licensed practitioners (e.g., chiropractors, psychologists) | Covered for certain types of practitioners (e.g., physician assistants, clinical social workers). Coverage may be restricted to certain types of services. | Optional. Covered by 50 states and D.C., though not all states or D.C. cover all types of practitioners. |

| Type of Service | Coverage Under Medicare | Coverage under Medicaid (see note below) |
|---|---|---|
| Home health | Covered for persons who need skilled nursing care on an intermittent basis or physical, speech, and occupational therapy. In addition, the individual must be homebound. | Certain home health services are mandatory for some individuals (e.g., nursing services); others are optional (e.g., therapy). States may limit the number of visits per month, or per year. |
| Rehabilitation | Covered for inpatient rehabilitation facilities subject to limitations on the duration, and for comprehensive outpatient rehabilitation facilities. | Optional. Covered by 50 states and D.C. Many states use this service category to cover mental health and substance abuse services. |
| Therapies (physical, occupational, speech/language) | Covered, subject to limitations in the total expenditures covered in certain settings. | Optional. Covered by 39 states and D.C. Not all states may cover all types of therapies. |
| Hospice | Covered for individuals who are considered terminally ill (a life expectancy of six months or less). | Optional. Covered by 47 states and D.C. |
| Transportation | Covers ambulance services when necessary (and other transportation is not available). | Mandatory. Coverage is provided for medical appointments. |
| Clinic | Covers some laboratory and screening services. Medicare also covers services provided by federally qualified health centers, rural health centers, and freestanding ambulatory surgical centers. | Optional. Covered by 48 states and D.C. States often cover freestanding ambulatory surgical centers, as well as mental health clinics under this category. |
| Prescription drugs | Covered by private prescription drug plans. | Optional. Covered by all states and D.C. For dual eligibles, states may not cover drugs in those drug categories that are covered by Medicare Part D. |
| Dental | Not covered (with a few exceptions). | Optional. Covered by 43 states and D.C. Some states may limit services to emergency dental services; others may also provide preventive services. |
| Intermediate care facility for persons with mental retardation | Not covered. | Optional. Covered by all states and D.C. Generally, states do not limit the duration of coverage. |
| Personal care | Not covered. | Optional. Covered by 35 states and D.C. |
| Private duty nursing | Not covered. | Optional. Covered by 26 states and D.C. States may limit the duration of services covered. |

| Type of Service | Coverage Under Medicare | Coverage under Medicaid (see note below) |
|---|---|---|
| Home and community-based waiver services under Section 1915(c) of the Social Security Act | Not covered. | Optional. As of July 2003, there were 275 waivers operating in 49 states and D.C. These waivers provide a broad range of home and community-based long-term care services. |

**Source:** CRS analysis of Medicare & You 2006 Handbook; Medicaid At-A-Glance, 2005; unpublished Medicaid waiver data, FY2003; and CRS Report RL30526, *Medicare Payment Policy*, by Sybil Tilson et al.

# Appendix H:
# Managed Care Integration: Summary of State Integrated Care Programs

| | Arizona Long Term Care System (ALTCS) | Florida Diversion Program | Massachusetts Senior Care Options (SCO) | Minnesota Senior Health Options (MSHO) | New York Managed Long-Term Care (MLTC) | Texas STAR+PLUS | Wisconsin Family Care | Wisconsin Partnership Program |
|---|---|---|---|---|---|---|---|---|
| Implementation Date | 1989 | 1998 | 2004 | 1997 | 1997 | 1998 | 2000 | 1995 |
| **Estimated Enrollment in Integrated Programs** | 23,427[1] | 2,800[1] | 6,000 | 35,000 | 7,078[1] | 10,671[1] | 10,003 (as of 10/2006) | 2,854 (as of 10/2006) |
| **Type of Integration**[1] | Type 2 (Medicaid Acute and Long-term Care) | Type 2 (Medicaid Acute and Long-term Care) | Type 3 (Medicare & Medicaid/ Acute and Long-term Care) | Type 3 (Medicare & Medicaid/ Acute and Long-term Care) | Type 1 (Medicaid Long-term Care Only) | Type 2 (Medicaid Acute and Long-term Care) | Type 1 (Medicaid Long-term Care Only) (Acute Care through Fee-for-service | Type 3 (Medicare & Medicaid/ Acute and Long-term Care) |
| **Targeted Population Group** | Aged and Disabled; Nursing Facility (NF) eligible | Aged Only; NF eligible | Aged Only; Any or no LTC needs | Aged Only: Any or no LTC needs | Aged Only (majority); NF eligible | Aged and Disabled; Any or no LTC needs | Aged and Disabled; NF eligible | Aged and Disabled; NF eligible |
| **Program Enrollment Choice** | Mandatory | Voluntary | Voluntary | Voluntary (Mandatory for Part D) | Voluntary | Mandatory | Mandatory | Voluntary |
| **Geographical Coverage** | Statewide | 25 urban and contiguous counties | Nearly statewide (urban and rural) | Statewide | Multiple counties (mostly urban) | 1 urban county; statewide urban expansion proposed | 5 counties (rural and urban) | 6 counties (rural and urban) |
| **Percent Dually Eligible for Medicare and Medicaid** | 75% | 100% | 90% | 100% | n/a | 50% | 88% | 89% |
| **Managed Care Funding** | Capitated | Capitated | Fully Capitated Medicare and Medicaid | Fully Capitated Medicare and Medicaid | Not Capitated | Capitated | Capitated for LTC only | Fully Capitated Medicare and Medicaid |
| **Federal Authority** | §1115 | §1915(c) | §1915(a) (shifting SNP status) and Medicare 222 (phasing out to end 2007) | §1915(a)/(c) (shifting to SNP status) | §1915(a) | §1915(b)/(c) | §1915(b)/(c) | §1115 §1115 authority expiring at the end of 2007 |

[1] Major types of Managed Long-Term Care: **Type 1** – Medicaid LTC only (HCBS and Nursing Home) ; **Type 2** – All Medicaid (HCBS, Nursing Home, Medicaid Primary, Medicaid Acute, and Medicaid Pharmacy); **Type 3** – Medicaid – Medicare (All Medicaid PLUS Medicare Acute, and Medicare Pharmacy).