Dual Integration Demonstration Project in Virginia
WHAT DOES DUAL ELIGIBLE MEAN?

“Dual eligibles” receive coverage from Medicare and Medicaid. They make up about 15 percent of Medicaid enrollment but consume nearly 39 percent of program spending.

Medicare
- Elderly and/or Disabled
- 46 million people
- Total spending: $424 billion
- Administered and financed by federal government alone

Medicaid
- Low-Income
- 60 million people
- Total Spending: $330 billion
- Administered and financed by state and federal governments

Dual Eligibles
- Low-Income and Elderly/Disabled
- 9 million people
- $261 Billion ($132 B Medicare, $129 B Medicaid)

SOURCE: Kaiser Family Foundation, “Medicare’s Role for Dual Eligible Beneficiaries” and “Medicaid’s Role for Dual Eligible Beneficiaries.” All figures are for federal fiscal year 2008 and are rounded.
COMPARISON OF DUAL ELIGIBLES AND OTHER MEDICARE BENEFICIARIES, 2006

- **Cognitive/Mental Impairment**: 61% Dual Eligible Beneficiaries (9.0 million), 27% Other Medicare Beneficiaries (34.9 million)
- **3 or more Chronic Conditions**: 54% Dual Eligible Beneficiaries, 43% Other Medicare Beneficiaries
- **Fair/Poor Health**: 51% Dual Eligible Beneficiaries, 23% Other Medicare Beneficiaries
- **Under Age 65 (Disabled)**: 38% Dual Eligible Beneficiaries, 10% Other Medicare Beneficiaries
- **Long-Term Care Facility Resident**: 16% Dual Eligible Beneficiaries, 2% Other Medicare Beneficiaries

**NOTES:** Total number of dual eligibles includes beneficiaries eligible for full Medicaid benefits, along with other low-income beneficiaries eligible for assistance with Medicare premiums and cost-sharing requirements (the Medicare Savings Programs). 
**SOURCE:** Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.
HIGH COST OF MEDICAID/MEDICARE CLIENTS

- Dual eligible (DE) individuals have some of the most complex medical and/or behavioral health and developmental needs of all the individuals who receive Medicaid and Medicare benefits.

- Current Medicaid & Medicare systems are not at all integrated nor is health information shared.

- DE individuals often receive medical and/or behavioral health/developmental services from two completely different service systems. Providers rarely, if ever, collaborate with other.

- Lack of coordinated/integrated care often compromises the effectiveness of the medical and/or behavioral health services.

- The cost of treating DE individuals has continued to escalate over the past 10 years, resulting in large hospitalization and re-hospitalization costs billed to Medicare.
The Department of Medical Assistance Services Goals

- The goal of the Demonstration Project is to address the DE individual’s full range of health and functional needs under one integrated service delivery system.

- Managed Care Organizations (MCO’s) will insure that services are delivered by an interdisciplinary care team that will operate within an integrated care management structure.

Within this Integrated Model of Care, participating plans will have significant flexibility to:

✓ use innovative care delivery models
✓ provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services.
The target population for the Dual Demonstration Project will be those individuals 21 and over who are currently:
* enrolled in Medicare Parts A, B, and D, and
* are also currently enrolled in the full-benefit Medicaid Program (not those individuals who have only Medicaid QMB coverage).

The Demonstration Project includes:
- DE individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) home-and-community-based services waiver
- Those residing in nursing facilities (NFs).
- Those with ID/DD on the EDCD Waiver and who may be on ID/DD Wait lists.
- The project excludes any individuals who have ID or DD Waiver slots.
The Dual Integration Demonstration Project will be implemented in:

* Central Virginia,
* Northern Virginia,
* Roanoke,
* Tidewater, and
* Western/Charlottesville  (see Appendix A for Demonstration Regions and Localities)

- Managed Care Organizations (MCO’s) may apply to serve one or more of the Demonstration Project regions. DMAS anticipates contracting with three MCOs in each region. Please note: We have received preliminary information from Virginia Premiere, Human (Beacon) and Anthem regarding their participation in the project. Contracts have not be finalized.

- Each MCO selected will enter into a three-way contract with DMAS and CMS.
The Managed Care Organizations will be reviewing services based on **Measurable Goals** which could include the following:

- Improved access to essential services,
- Improved service coordination through identified point of contact,
- Improved seamless transitions,
- Improved access to preventive services,
- Improved overall health outcomes.
In Calendar Year 2012:
- There were 3857 dual eligible (Medicaid/Medicare individuals in Region V that were served by the Community Services Boards or Behavioral Health Authorities
- An average number of 25 visits or services was provided to each individual at each of the boards (this would include statistics for the day programs if the client was enrolled)
- The average age of these individuals was 49
- Approximately 56% receive primary care from a Primary Care Provider as well as our behavioral health services
Virginia Beach currently has 326 Medicaid/Medicare Clients Potentially Eligible for the Project:

Out of the 326 there are:
- 232 MH clients
- 91 DS clients
- 3 SA clients

Primary Single Accountable Individual (Care Coordinator) Locations:
- 108 MHCM
- 63 DSCM
- 82 RN
- 13 Beach House
- Other areas reflect much smaller numbers

269 of the clients have a SMI Priority 1 Diagnosis:
- 58% Psychotic Disorders
- 13% Depressive Disorders
- 11% Bipolar Disorders
Top Medical Conditions (In order of greatest frequency):
- Hypertension
- Diabetes
- Hyperlipidemia
- Gastro-esophageal Reflux
- Obesity
- Hypothyroidism
- Asthma

Medical Comorbidity: The Single Accountable Individuals (Care Coordinators) were asked to update information in our files via a survey.
WHAT WE KNOW

• Community Services Boards or Behavioral Health Authorities will continue as the providers of Targeted Case Management.

• CSB/BHAs will need to continually interact with the Managed Care Organizations to effectively coordinate their services.

• Multiple MCO’s per region may want to negotiate with individual CSB/BHAs. DMAS will select approximately 3 MCOs per region.
NEXT STEPS:

- The Dual Integration Project is slated to save dollars on Emergency Room visits, hospitalizations, and re-admissions, both psychiatric and medical.

- CSB/BHAs have and use the tools and practices to achieve these savings as extended to physical healthcare. Our service array, monitoring and strong community partnerships are going to be the key to being successful as far as facilitating improvements in the overall health of the clients.
A VBCSB Steering Committee has been implemented:

- We have an internal steering committee that is working on the many aspects of this project with the staff members:

  - **GOALS FOR THE STEERING COMMITTEE:**
  - Goal 1: Define DHS dual eligible (DE) population
  - Goal 2: Review the current Targeted CM Services Model
  - Goal 3: Facilitate and complete contract negotiations
  - Goal 4: Implement services for the defined group of clients
  - Goal 5: Improve health outcomes for clients served
  - Goal 6: Continue to establish partnerships in the community
Questions?