THE SCAN FOUNDATION

Milbank Memorial Fund
Reforming States Group
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Medicare-Medicaid Integration: A Work in Progress

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Framing the Problem: Life Expectancy has Changed Dramatically

1910

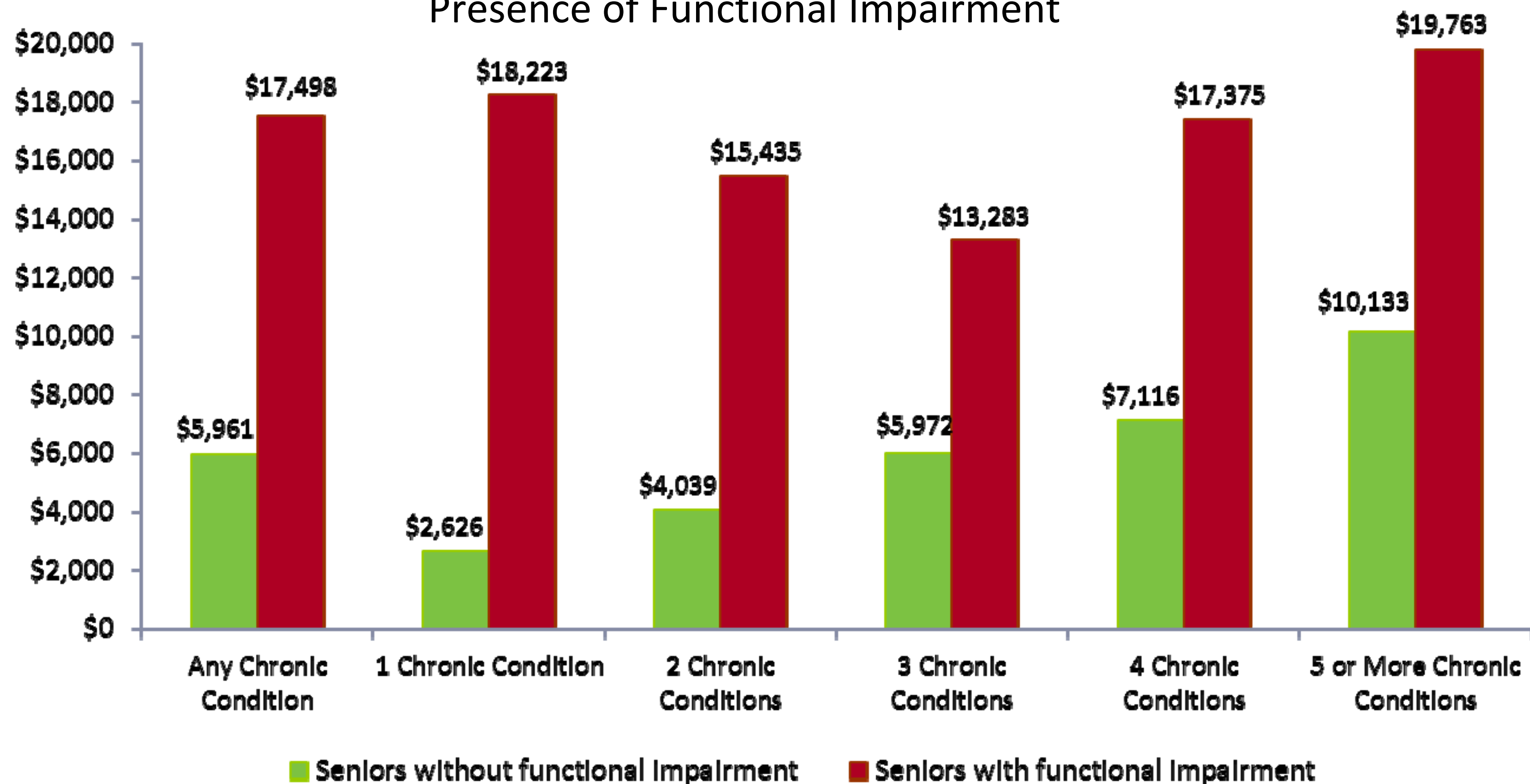
1. Heart disease
2. Influenza & pneumonia
3. Tuberculosis
4. Diarrhea/intestinal diseases
5. Stroke
6. Nephritis
7. Accidents (ex. motor vehicle)
8. Cancer
9. Premature birth
10. Senility

2010

1. Heart disease
2. Cancer
3. Chronic lung diseases
4. Stroke
5. Accidents
6. Alzheimer's disease
7. Diabetes
8. Nephritis
9. Influenza & pneumonia
10. Suicide

Acute / Chronic

Hidden Costs of Chronic Conditions & Functional Impairment



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A Risk We All Face

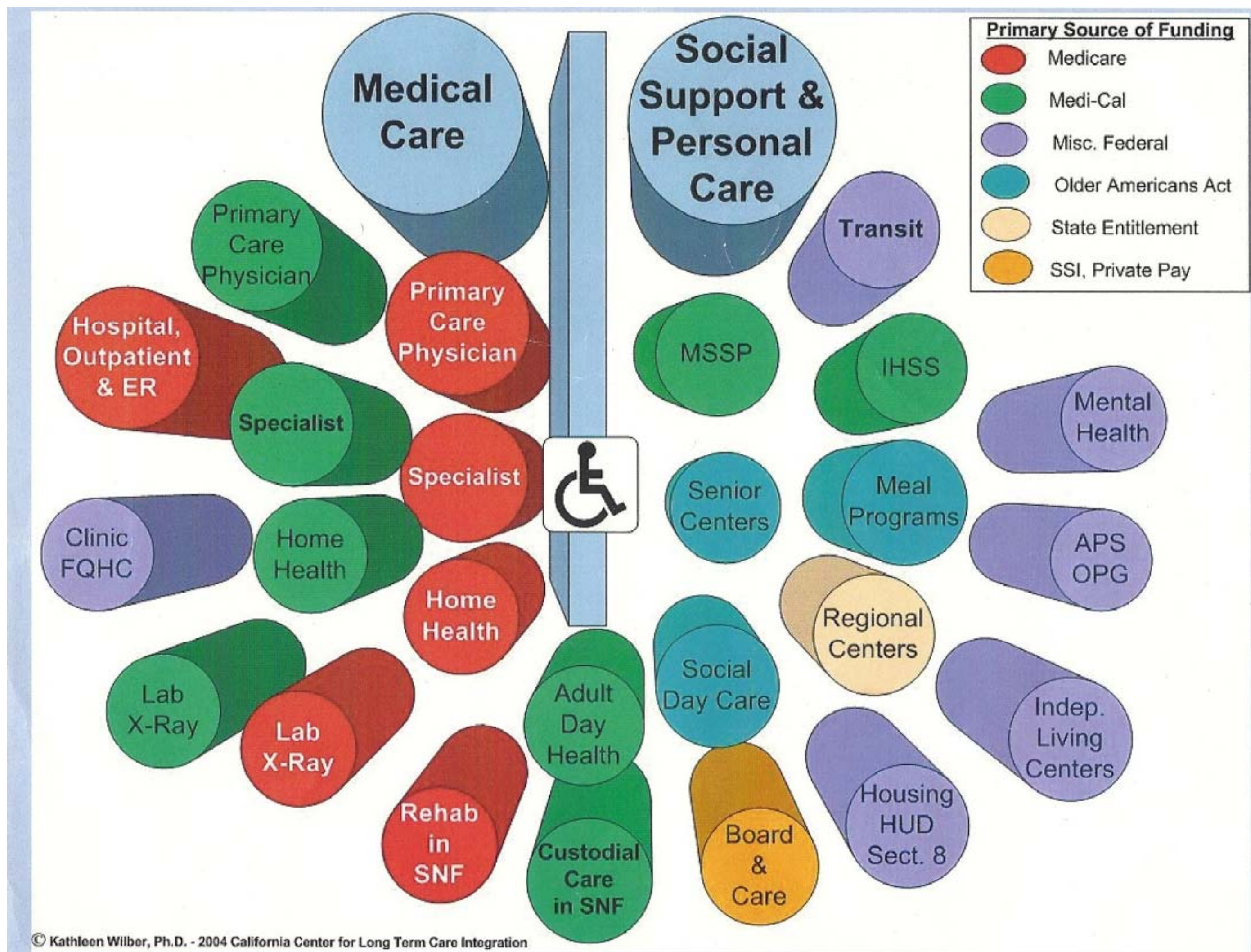
Half of Adults Age 65+ Will Need a High Level of Care at Some Point

Favreault & Dey (2015), Table 1

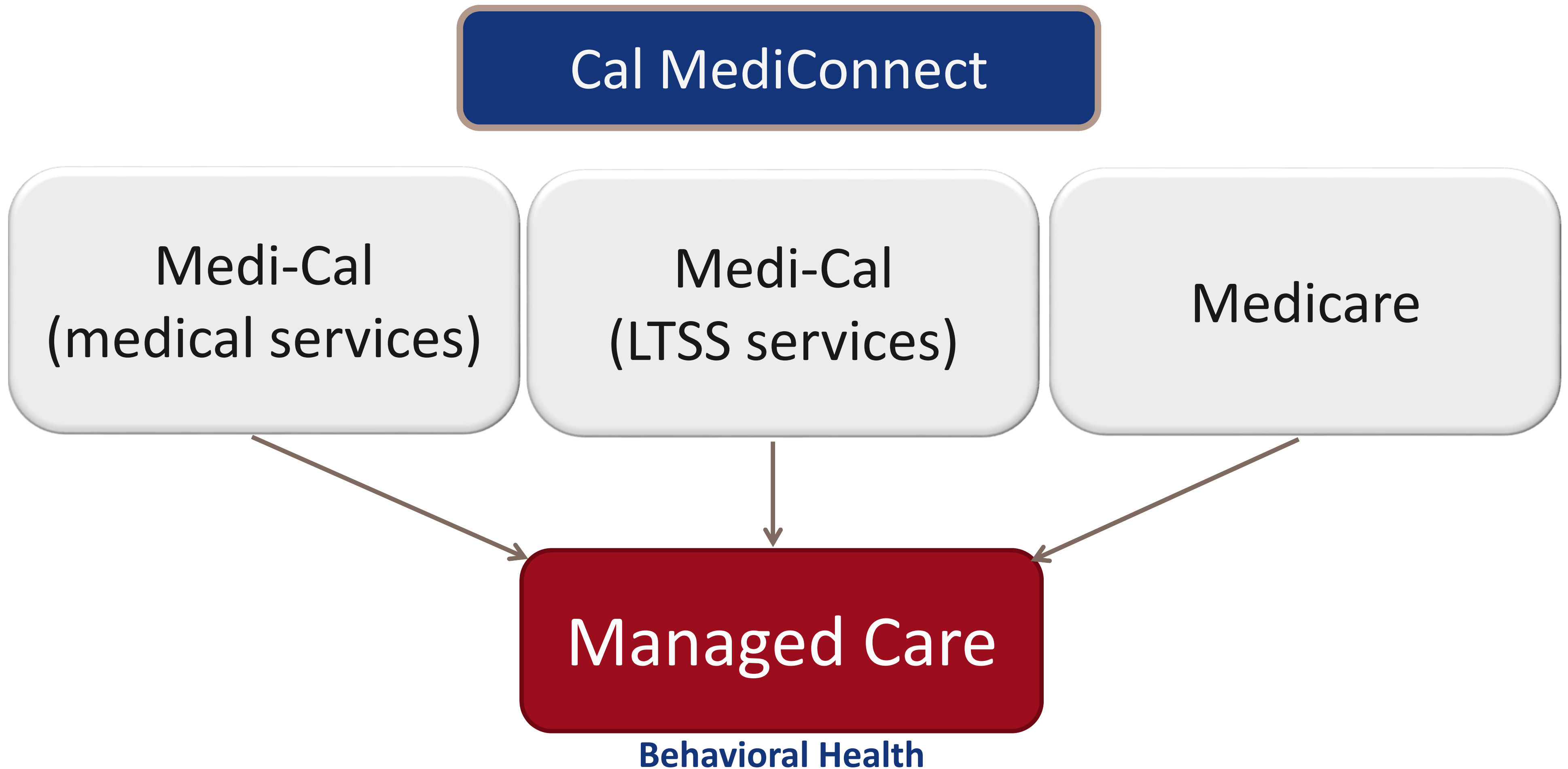
Medicare: The Challenges

- Purpose built for a different time & place
- Misaligned with Medicaid
- Lack of functional data & data integration
- Provider frustrations

State Innovation
California: System Fragmentation



Cal MediConnect: Integrates Medicare/Medi-Cal



California
Defining & Achieving Success…?

CMC Enrollee Confidence & Satisfaction

	% satisfied		
	W1	W2	W3
Amount of time doctor/other staff spends w/them	83%	85%	87%
Information health plan gives explaining benefits	76%	73%	84%
Choice of doctors	77%	78%	83%
Choice of hospitals	76%	77%	81%
Way different health providers work together	77%	78%	82%
How long to wait to see a doctor when needed	73%	76%	77%

CMC Beneficiaries' Satisfaction

N=2,139	CMC	Opt-Out	Non-CCI
Very or somewhat satisfied with health insurance benefits?	89%	89%	88%
Overall quality of care rated "excellent" or "good"	83%	83%	86%
Since switching to CCI, quality of care is "better." **	36%	21%	N/A
Provider's understanding of condition or disability is "excellent" or "good"	81%	84%	84%
Have NOT filed a grievance or complaint in the last 6 months	96%	97%	97%

**indicates statistical significance, p-value <.05

CMC Increased Access to Care Coordination

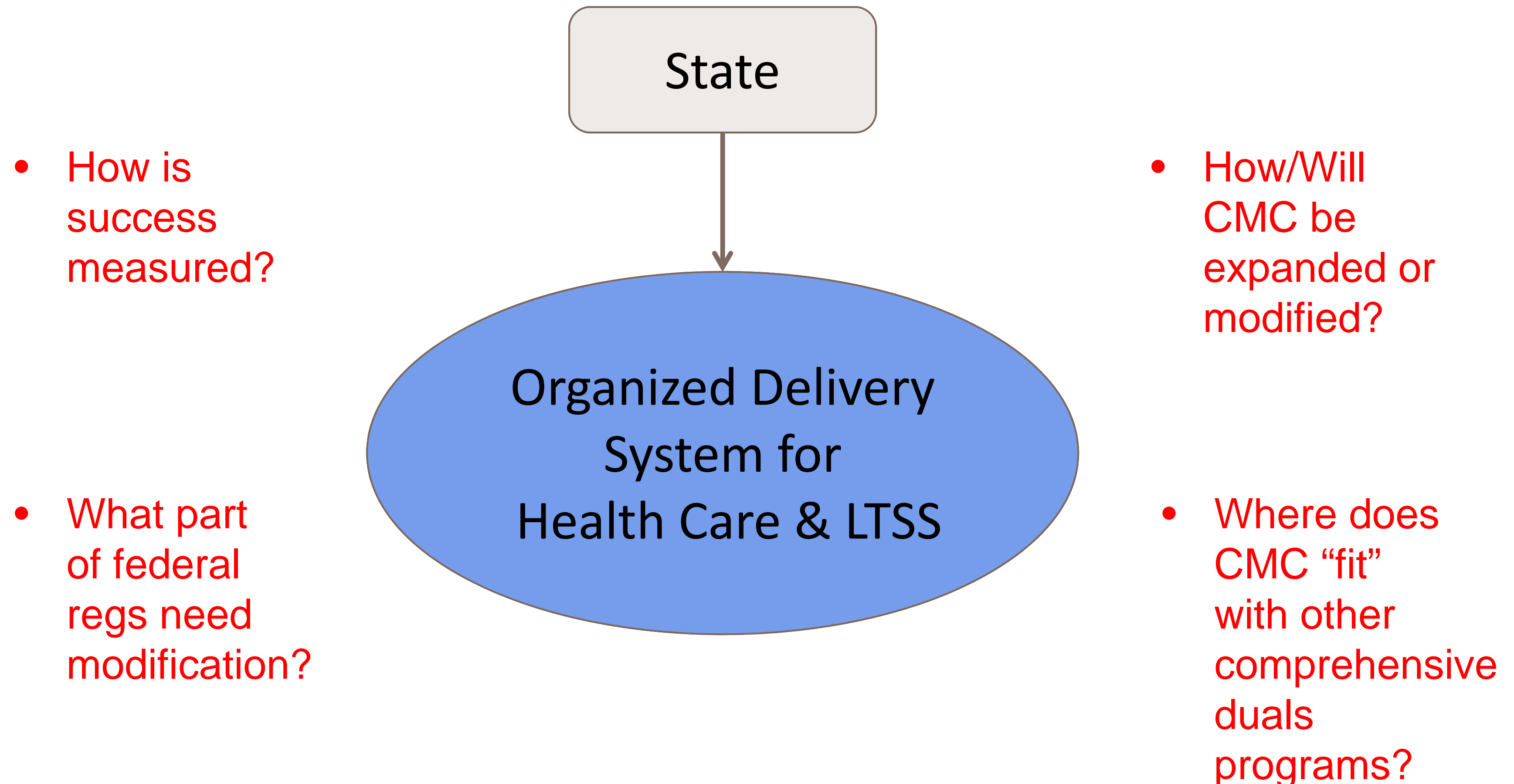
N=2,139	CMC	Opt-out	Non CCI
I have someone coordinating my care… **	35%	20%	18%
Care is being coordinated by CMC or other health plan **	68%	20%	28%
Care is being coordinated by providers office or other community agency **	13%	45%	51%
I could use more help with care coordination	22%	23%	31%

**Indicates statistically significant difference, p-value < .05

Care Coordination Improves Experiences with CMC

N= 744 in CMC	Had a CC	No CC
Very satisfied with CMC benefits	72%	50%
Plan has done something to make it safer or easier to live in my own home	31%	18%
More aware of CMC benefits like transportation	66%	41%
Experienced a disruption after transition	17%	20%
Any disruption after transition was resolved	63%	29%

Where California Is Going?



- How is success measured?
- What part of federal regs need modification?
- How/Will CMC be expanded or modified?
- Where does CMC "fit" with other comprehensive duals programs?

Lessons Learned: Foundations

- Ask the right questions
- Critical role in creating common narrative
- Creating actionable formative data: Rapid cycle quality improvement
- Support comprehensive evaluation
- Represent the voice of the beneficiary

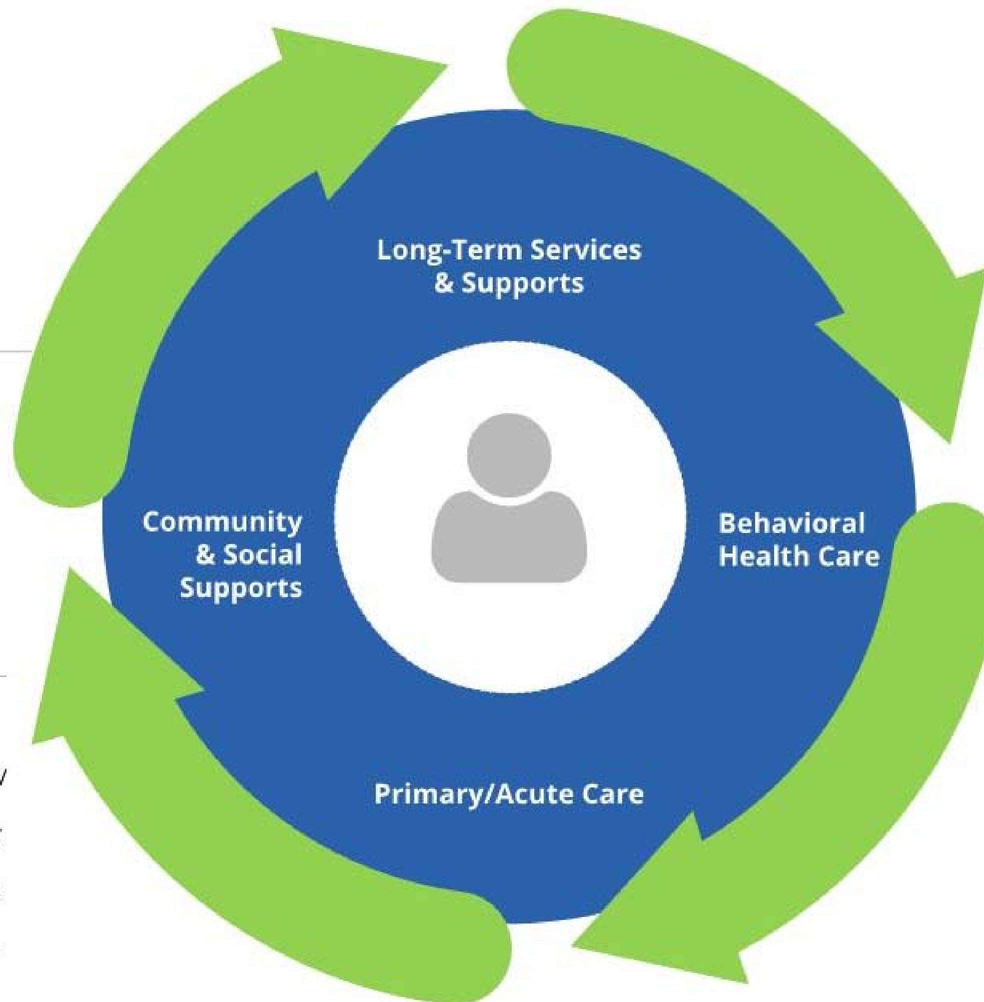
Lessons Learned: States

- Set a clear "North-Star"
- Be an active participant
- Engage beneficiaries and providers at the beginning
- Need for uniform assessment and functional data
- Plan your own evaluation
- Regular oversight of policy and budget committees in state legislature

Health Care Payment Tied to Performance as Defined by Consumers

Attribute 1:
Each individual's range of needs and goals, both medical and non-medical, as well as for family/caregivers, are identified and re-evaluated on an ongoing basis to drive care plans.

Attribute 2:
Each individual's needs are addressed in a compassionate, meaningful, and person-focused way and incorporated into a care plan that is tailored, safe, and timely.



Attribute 4:
Individuals and their family/caregivers continually inform the way the delivery system is structured to ensure that it is addressing their needs and providing resources tailored to them.

Attribute 3:
Individuals have a cohesive, easily navigable delivery system so that they can get the services and information they want by themselves or with support when needed, and avoid the services they do not need or want.

Our Vision:

A society where older adults can access health and supportive services of their choosing to meet their needs.

Our Mission:

To advance a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence.

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Medicare-Medicaid Integration Case Study - Background

- Mattie is a 72 year old Medicare-Medicaid enrollee who:
  - » Is in the hospital after suffering a stroke
  - » Has acute care, behavioral health and LTSS needs
  - » Wants to return home
- Mattie is enrolled in a Medicaid MLTSS plan and FFS Medicare
- Mattie's MLTSS care manager wants to work with several people to develop Mattie's new care plan:
  - » Mattie;
  - » The hospital discharge planner;
  - » Mattie's primary care physician; and
  - » Rebecca, Mattie's daughter.

Medicare-Medicaid Integration Case Study - Activity

- Divide into small groups of five to discuss Mattie's care plan
- Each group member assumes one of the following roles: Mattie; the care manager; Mattie's primary care physician; the discharge planner; or Rebecca.
- Discuss the following questions from your assigned perspective:
  1. What are the most important services Mattie needs? Where should Mattie go after discharge?
  2. What clinical, functional and personal concerns do you have about Mattie's transition?
  3. Which providers and other stakeholders must be involved and what information must be shared across providers? What are barriers to coordinating services across Medicare and Medicaid and potential solutions?
  4. Who should have the final say about Mattie's transition and plan of care? Why?