

Colorado's Program to Integrate Care for Medicare-Medicaid Enrollees (MMEs)

Making Medicare & Medicaid
work together for Coloradans



Department's Mission:

Improving health care access
and outcomes for the **people**
we serve while demonstrating sound
stewardship of financial **resources**



Why You're Here Today

- Medicare-Medicaid general overview
- Program Overview
- How the Program helps clients
- Where clients can get help



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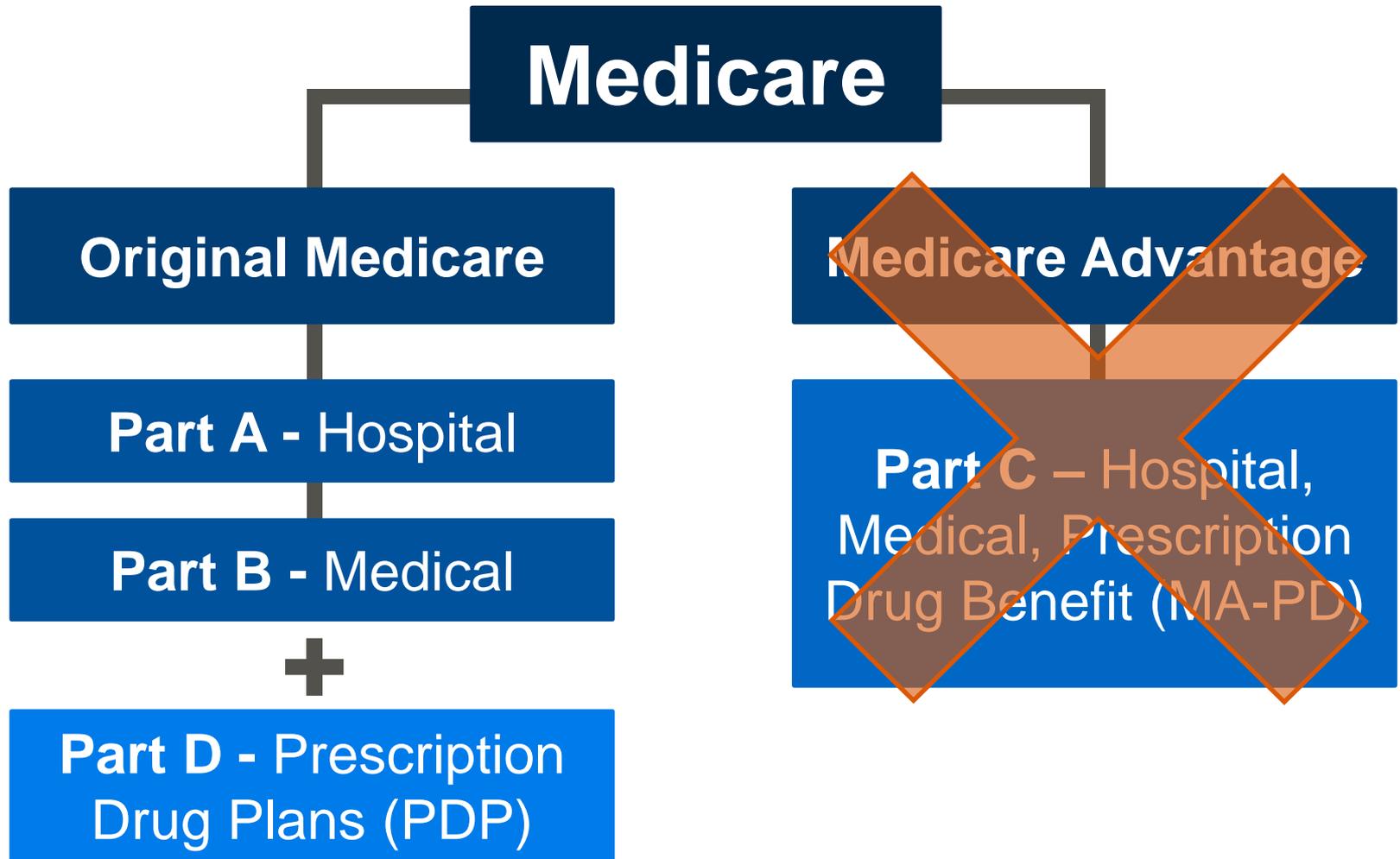


Medicare-Medicaid Enrollees

- Rely almost entirely on government programs
- Have low-incomes & are disproportionately vulnerable
- Suffer from:
 - Multiple, chronic conditions
 - Cognitive impairments
 - Low literacy
 - Housing isolation
- **Needs** are great; **resources** are few



Parts of Medicare



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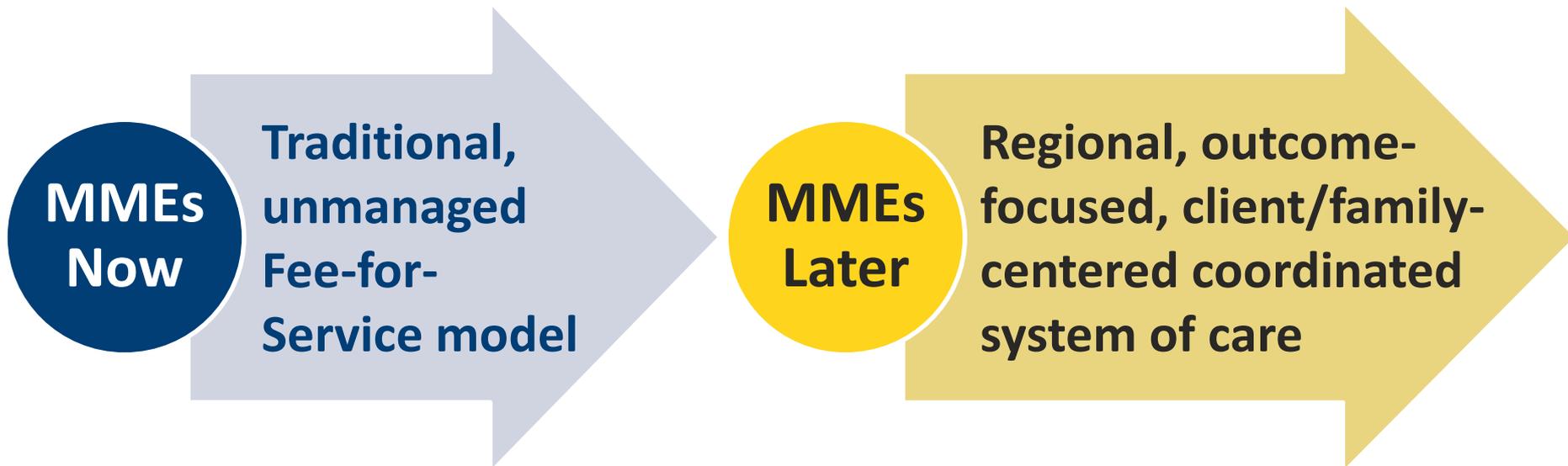


Program 's Goals

- Improve health outcomes
- Decrease unnecessary & duplicative services
- Promote person-centered planning
- Improve client experience through enhanced coordination & quality of care



Program Vision



Program Eligibility

Beneficiary must:

- Be enrolled in Medicare Parts A and B, and eligible for Part D;
- Receive full Medicaid benefits under FFS;
- Have no other private/public health insurance; and
- Be a Colorado resident



Program Eligibility

Ineligible beneficiaries include:

- Individuals enrolled in
 - Medicare Advantage
 - Program of All-inclusive Care for the Elderly (PACE)
 - Denver Health Medicaid Choice
 - Rocky Mountain Health plans
- Residents of Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID)



Program Enrollment

- State passively enrolls MMEs based on RCCO geographic area & existing beneficiary-provider relationships
- Department using 7 month phase-in for enrollment
 - Allows existing infrastructure optimization
 - Monthly categorization of potential enrollees in RCCO/county/delivery system/provider-type matrix
 - Phasing-in based on level of need
 - Approximately 7,500 beneficiaries enrolled per month

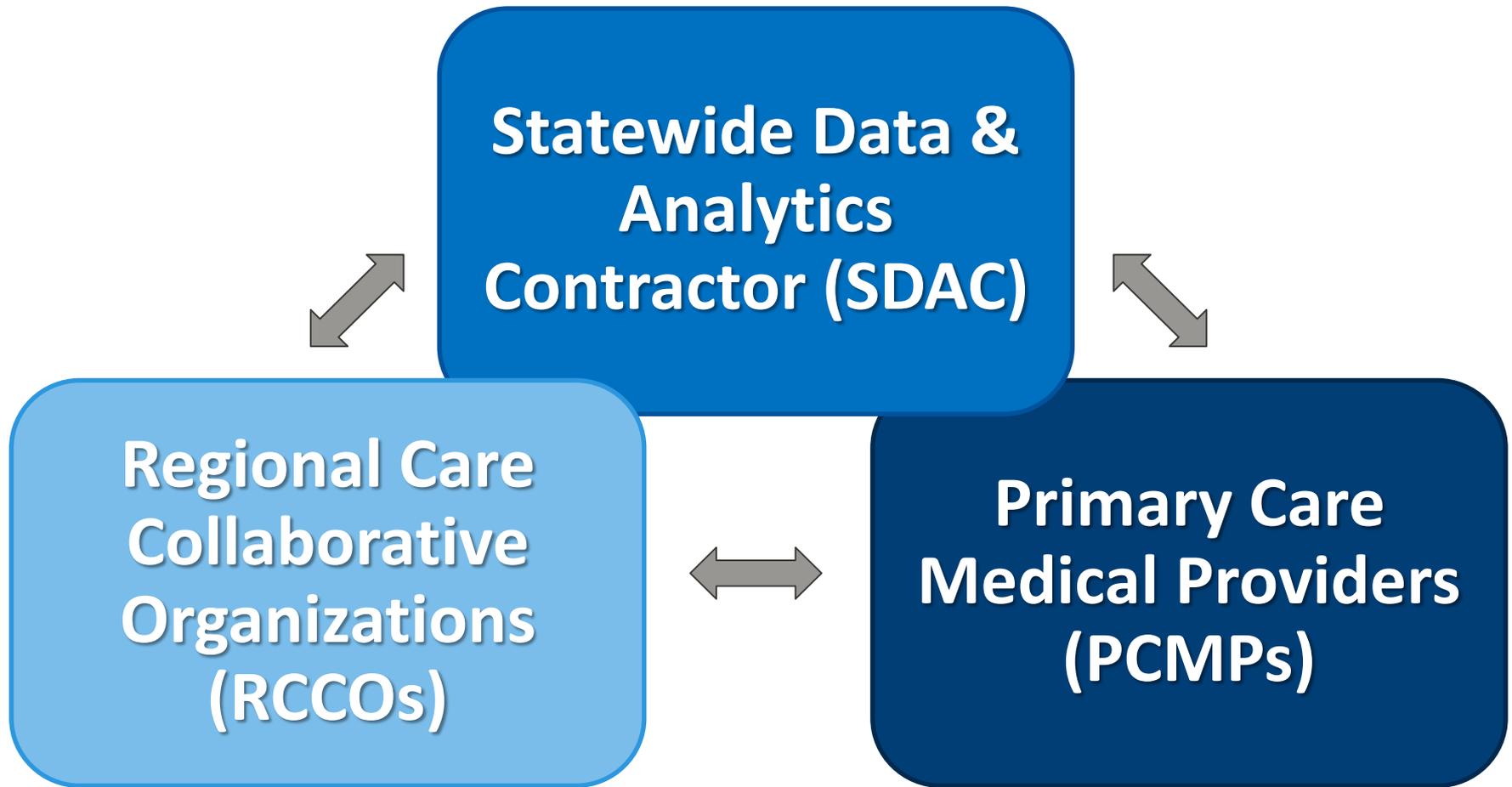


How the Program Helps

- Coordinates Medicare/Medicaid services
- Cost savings through:
 - Improvements in quality of care
 - Reductions in unnecessary expenditures
- Builds on infrastructure, resources and provider network found in Accountable Care Collaborative (ACC)



ACC Components



Component 1: RCCOs

- Achieves financial & health outcomes
- Ensures medical home enrollment for client
- Manages PCMP provider network



Component 2: PCMPs

- Serves as client medical home
- Coordinates client care across providers
- Provides culturally & linguistically sensitive care



Component 3: SDAC

- Launches population & patient-level analytics
- Offers reporting tools for PCMPs & RCCOs
- Reports performance on SDAC Dashboard
- Controls web portal & access
 - **Beneficiaries identified via web portal**



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Helping Clients Through the Program

Part 1: Service Coordination Plan (SCP)

Part 2: Protocols

Part 3: Disability Competent Care



Helping Clients Through the Program

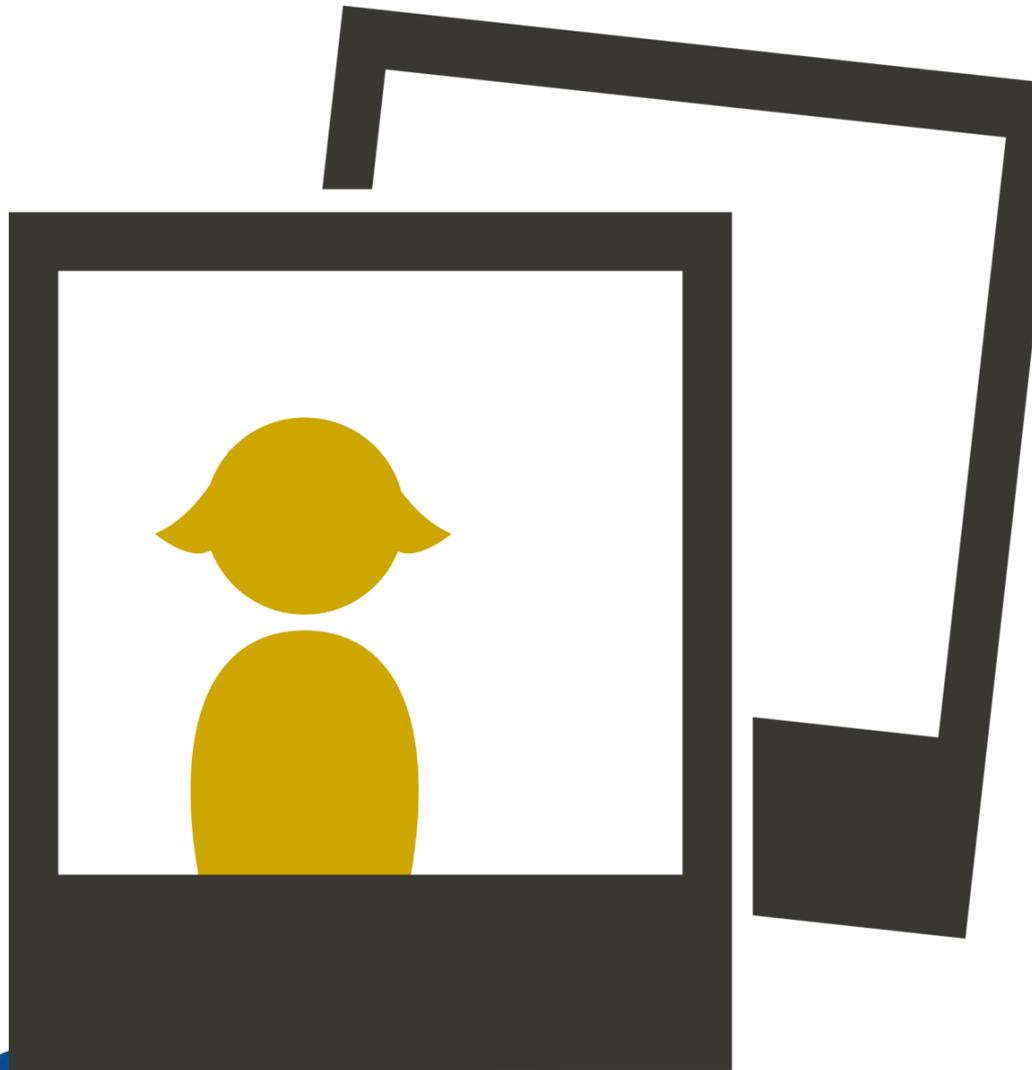
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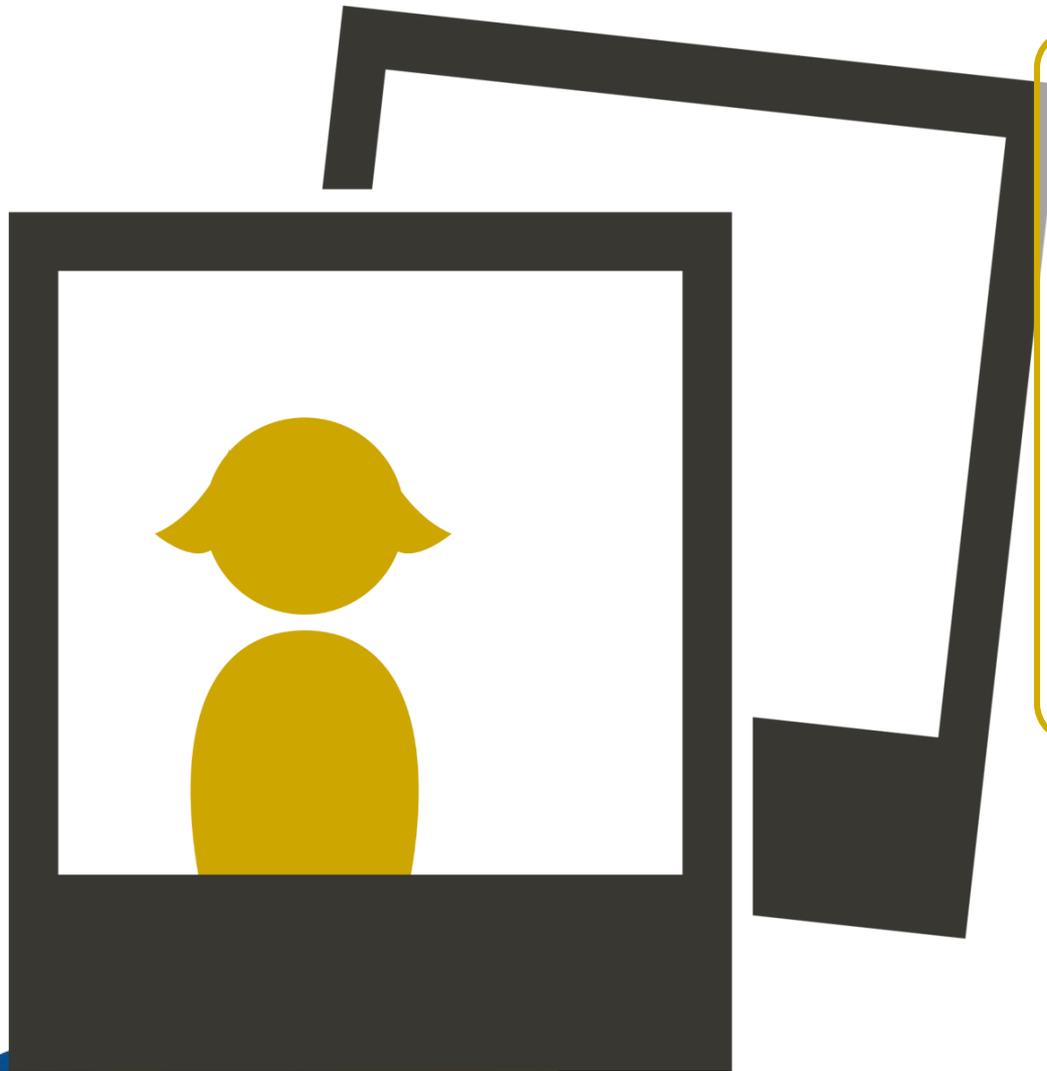
Service Coordination Plan



- Tool for coordinating client care
- Provides complete view of elements needed to synchronize physical, behavioral & social health care, services & supports
- Includes client's short- & long-term goals



Service Coordination Plan



- Where clients may have care plans through SEPs, CCBs, BHOs, or other Medicaid providers, the SCP is meant to *complement* the existing care plans done for clients

Service Coordination Plan



- Organizes care **between all providers** seen by client
- Completed by care coordinator **with client** to capture client's wants & needs

Service Coordination Plan



- Reviewed & revised by care coordinator **every 6 months, or as needed**, to ensure client is:
 - **On track with plan**
 - **Receiving all care & services needed to attain their health goals**
- RCCO does initial SCP assessment then works with client & PCMP on future SCPs

Helping Clients Through the Program

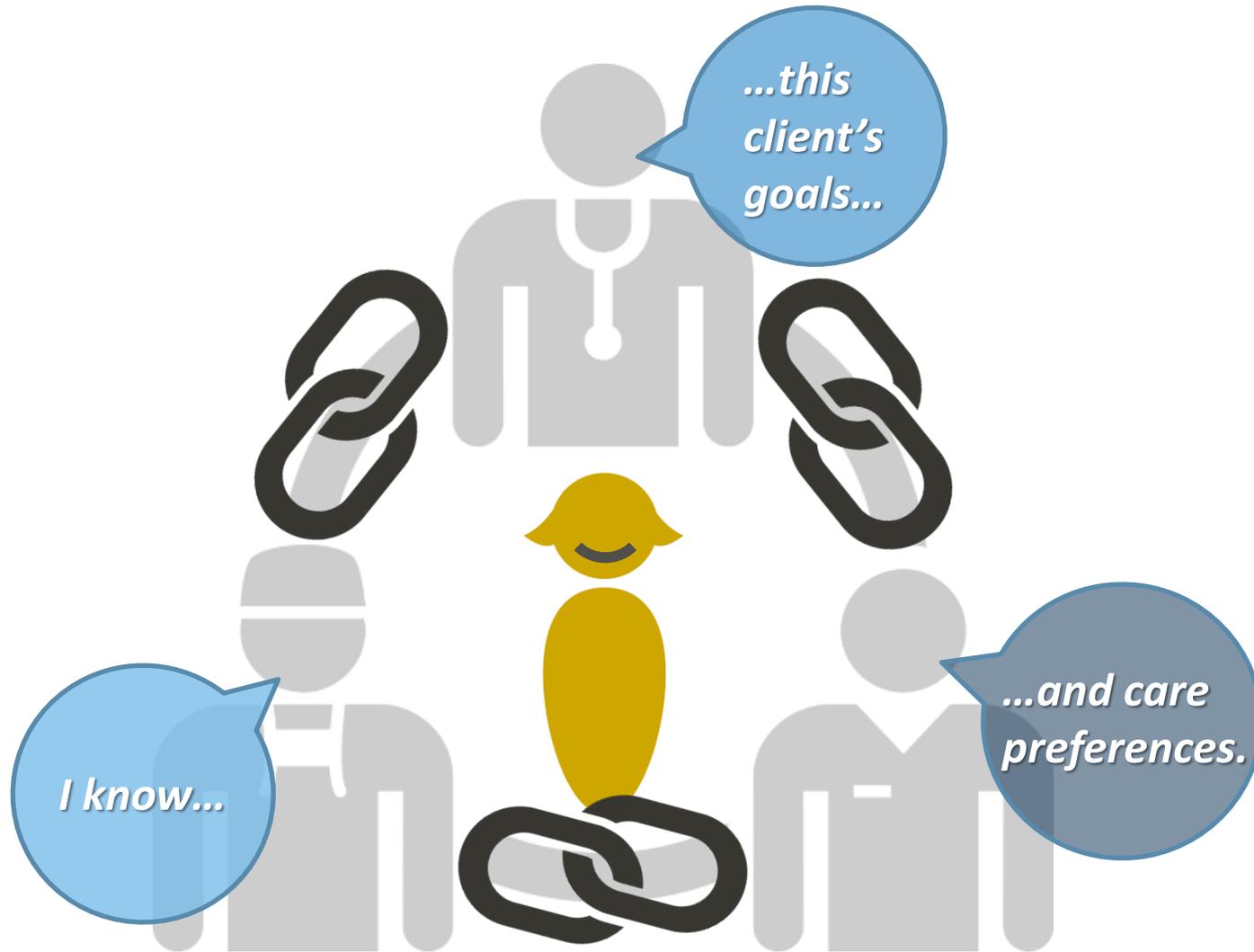
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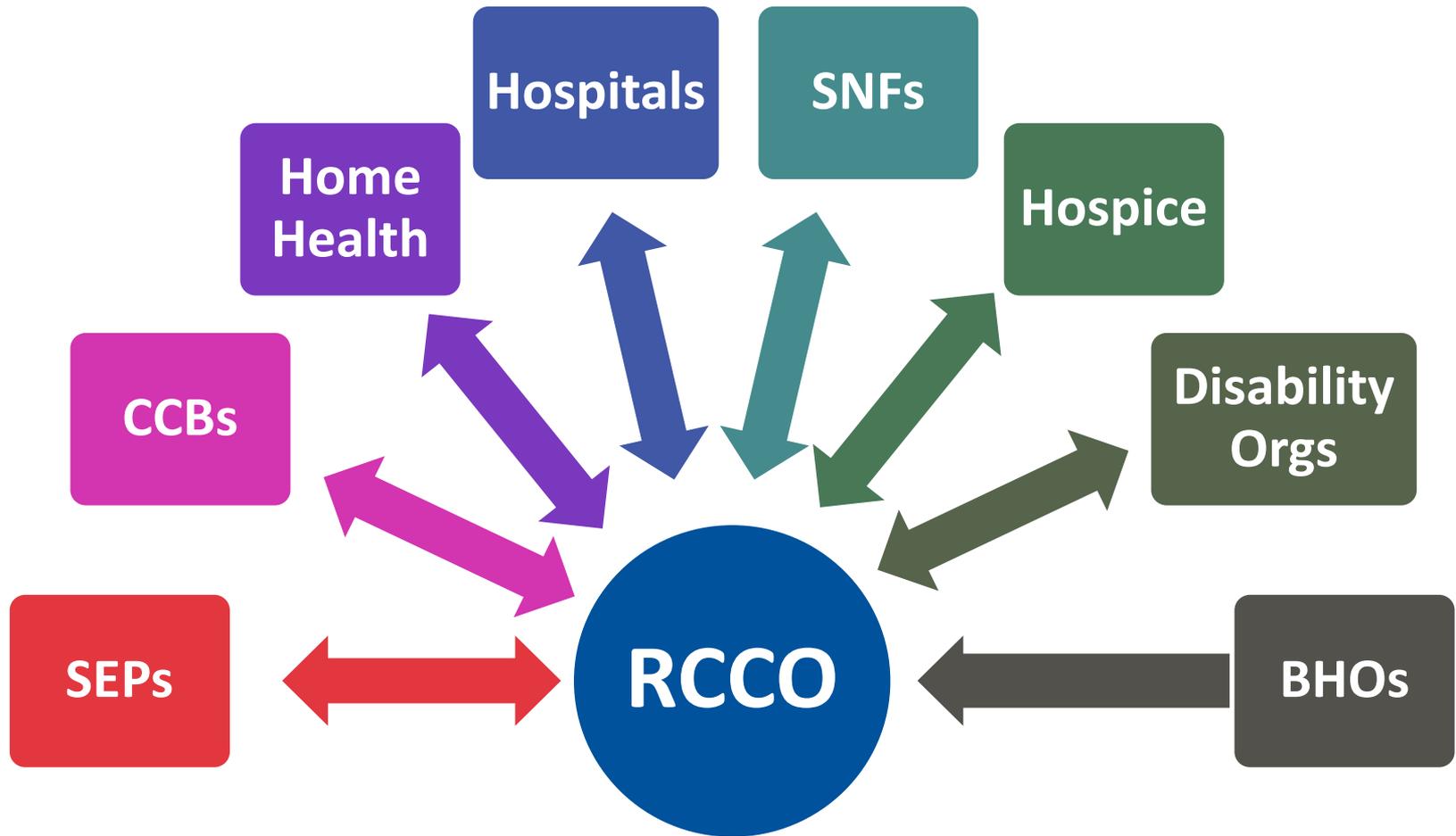
Part 3: Disability Competent Care



Communication Protocols



Protocol Network



General Protocol Requirements

1. Continuously improving
2. Bi-directional & collaborative
3. Identification & prioritization of shared clients
4. Understanding coordination activities
5. Regular contact & communication
6. Mutually agreed upon support function



Helping Clients Through the Program

Part 1: Service Coordination Plan (SCP)

Part 2: Protocols

Part 3: Disability Competent Care



Disability Competent Care

Rather than focusing on a diagnosis, disability-competent care focuses on providing care and supports for maximum function and addressing the barriers to integrated, accessible care.



Ensuring Disability Competent Care

- Assessment Tool
- Inventory for clients
 - On HCPF website
- Ongoing training with PCMPs
 - Webinars & other communications



How Are We Measuring Success?

- ✓ Independent evaluator(s)
- ✓ Quality performance monitoring
- ✓ 16 total Program quality measures
 - Clients placed in most appropriate setting
 - Quality of Service Coordination Plans
 - Disability Competent Care trainings provided
- ✓ Rapid-cycle evaluation/feedback
- ✓ Spending expenditure calculations
- ✓ Retrospective performance payment to State



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Appeals & Grievances

- Beneficiary Rights & Protections Alliance
 - Members include Medicare & Medicaid ombudsman & advocates
 - Assists Department with development of outreach materials for Program beneficiaries
 - Supports seamless access to services provided by Alliance members
 - Meets regularly to evaluate impact of Program on clients



Appeals & Grievances



Questions?

Contact Information

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Thank you!

