



Amerigroup Corporation



Dual RFI Response Summary

*Improving Care through Integrated Medicare
and Medi-Cal Delivery Models*

Stakeholder Meeting
August 30, 2011

Organization Background

- Amerigroup founded in 1994
- Provides health coverage to about 2 million members in government health programs through:
 - Medicaid, CHIP and LTC plans in 11 states
 - Medicare dual eligible special needs plans (SNPs) and MA-PD plans in seven states
- Powered by 4,700 associates, including about 1,000 clinicians

Existing Problems this Proposal Addresses

- Amerigroup responded to RFI to provide DHCS with its views on key features of an integrated program
 - Aligned enrollment model
 - Integrated care management model
 - Scope of contracted benefits and services
 - Transparency in the member experience – materials, member service, communications
 - Desirable characteristics and abilities of potential contractors

Key Points: Proposed Integrated Care Model

- Program benefits include acute care, behavioral health, pharmacy, LTC/LTSS – no carve-outs
- MCO has full responsibility for:
 - Managing all aspects of the member's care and full spectrum of covered services
 - Medical, behavioral, social, LTSS services
- Comprehensive initial and periodic assessments; results implemented through case management and comprehensive, person-centered service plans
- Care model emphasizes:
 - Connecting members with needed services
 - Management of care transitions – locations or levels of care

Specific Care Integration Challenges

- **Mental & Behavioral Health Care**
 - Day-to-day care management should integrate physical and behavioral health
 - In-house behavioral health expertise
 - Physical/mental/behavioral health co-rounding
- **Long Term Care**
 - Maintain LTSS provider reimbursements for transition period
 - Develop/reinforce channels of communication between LTSS providers and MCOs
 - Align definition and reimbursement of “crossover” services covered by both Medicare and Medi-Cal

Measures for Success

- Consumer satisfaction and retention
- Access to care
- Rates of acute & SNF care discharges to community vs. institutional settings
- Maintenance of members in community setting
- Operational measures of integration – integrated call center, appeals process, member materials
- Quality measures and cost savings compared with FFS/ historical levels
- Measurements in 18-24 month time frame

Information Needed from CMS and the State

- Confirm enrollment model – mandatory, passive enrollment with opt out, voluntary?
- Confirm target populations and service areas
- Assumptions used in rate setting, structure of blended payments
- Data tracking and reporting requirements
- Confirm implementation timeframes and milestones
- Medi-Cal vs. mixed Medi-Cal/Medicare regulatory framework