



Department of Medical Assistance Services



Stakeholder Advisory Committee: Commonwealth Coordinated Care and Managed Long-term Supports and Services

November 18, 2015



Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

November 18, 2015 from 1:00 to 3:00 pm

Conference Room 7A&B, DMAS

600 East Broad Street

Richmond, VA 23219

Meeting 10

I. Welcome	Department of Medical Assistance Services (DMAS)	1:00 pm
II. National Update	Alexandra Kruse Center for Health Care Strategies	1:05 pm
III. Virginia CCC Updates	Jason Rachel, PhD- DMAS Aubrey G. Lucy- MAXIMUS	1:15 pm
IV. CCC Focus Session: <i>CCC Evaluation Update</i>	Alison Cuellar, PhD, George Mason University	1:30 pm
V. MLTSS Welcome <i>Virginia transition to MLTSS</i>	Karen E. Kimsey, DMAS	1:45 pm
VI. MLTSS Update: <i>Managed Long-Term Supports and Services (MLTSS) Status Update</i>	Tammy Driscoll DMAS	1:50 pm
VII. MLTSS Focus Session: <i>MLTSS Model of Care</i>	Elizabeth Smith, RN DMAS	2:15 pm
VIII. Public Comment	Meeting Attendees sign up for 3 minutes of open public comment	2:25 pm
IX. Closing Remarks	DMAS	2:55 pm

CHCS Center for
Health Care Strategies, Inc.

Advancing access, quality, and cost-effectiveness in publicly financed health care



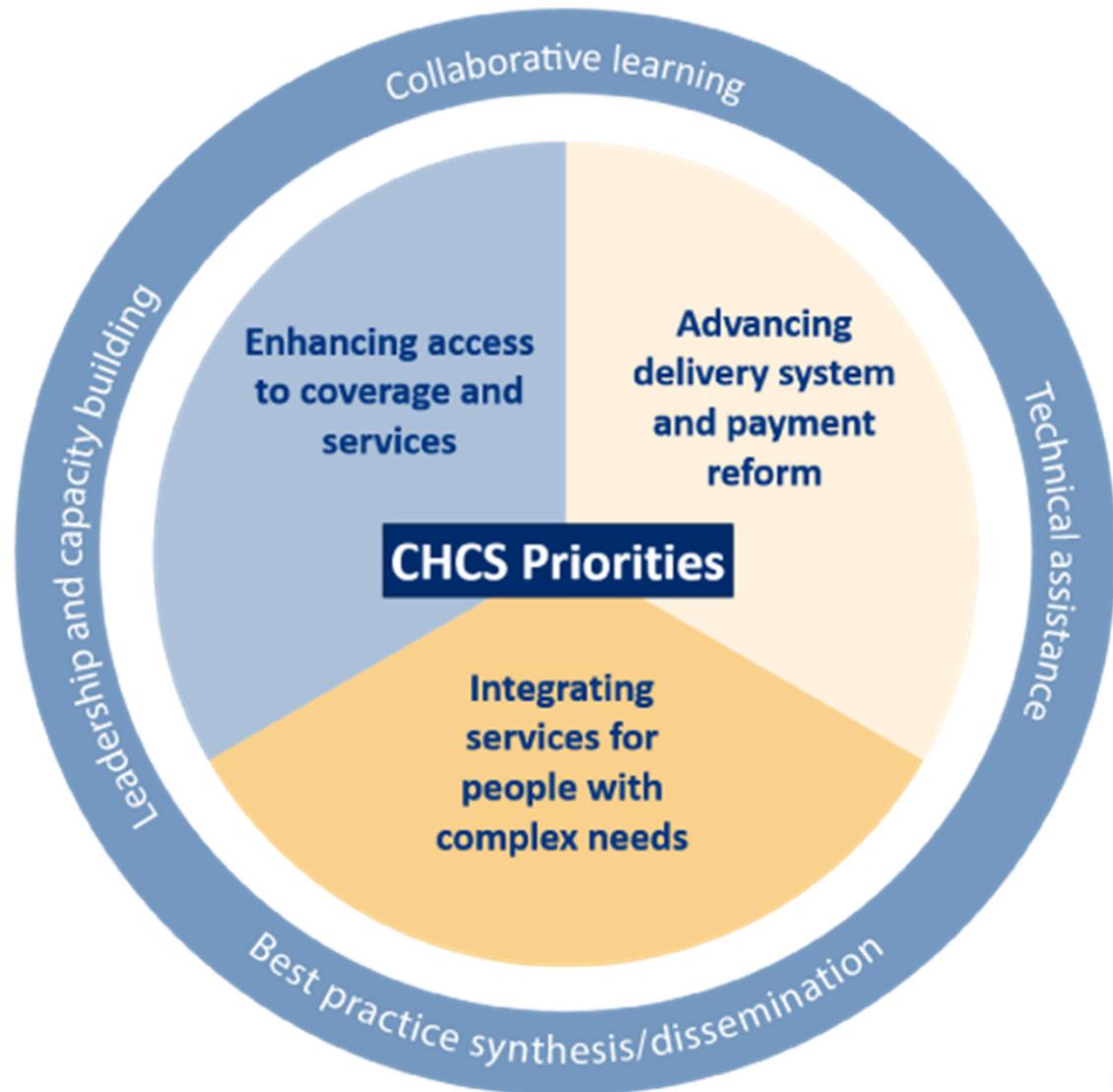
Virginia Advisory Council Meeting

November 18, 2015

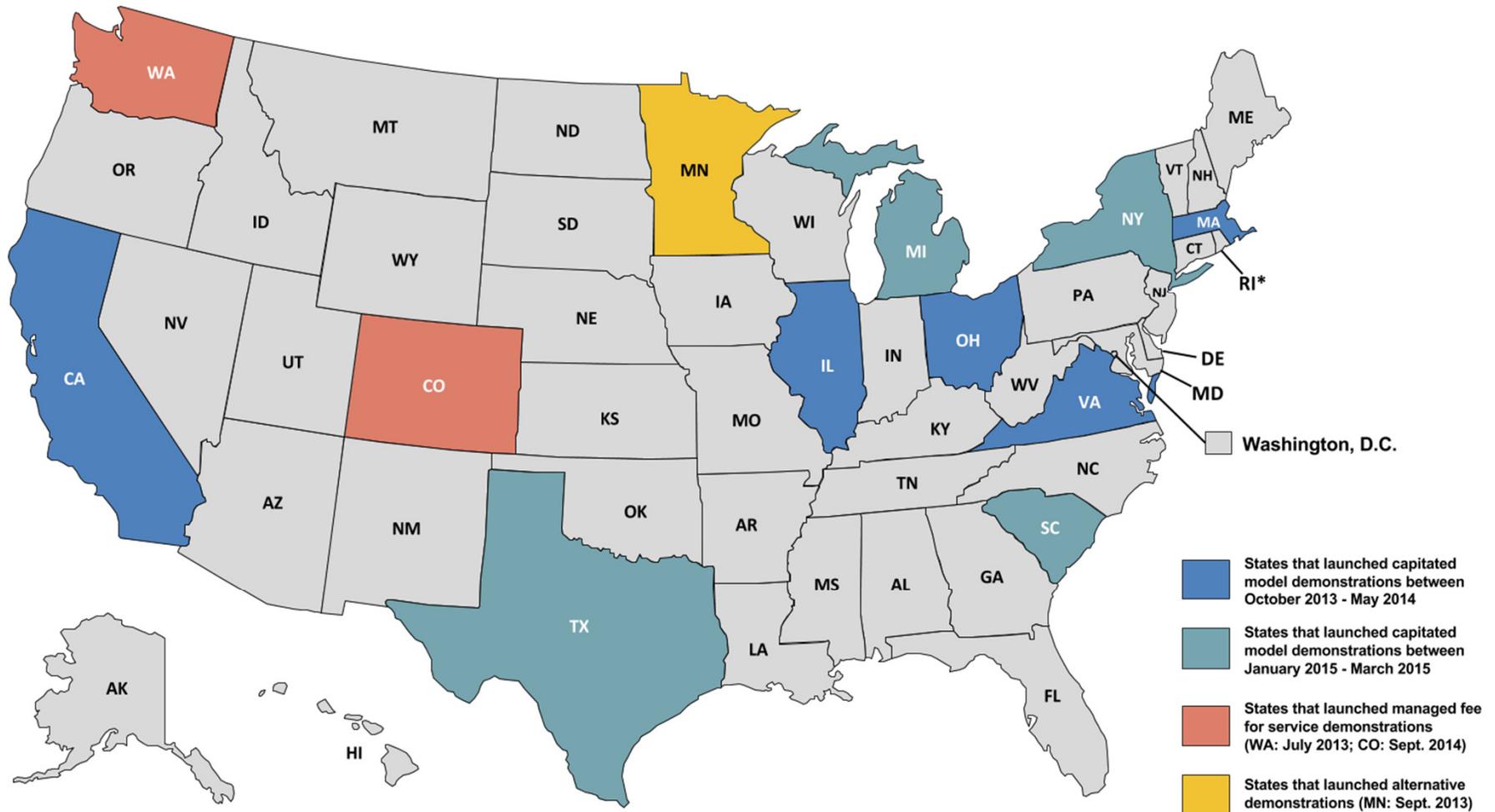
Alexandra Kruse, Senior Program Officer

About the Center for Health Care Strategies

**A non-profit health
policy center
dedicated to
improving the
health of low-
income Americans**



Financial Alignment Initiative: Implementation Snapshot



*Rhode Island's projected enrollment start date is winter 2015/2016.

INSIDE Project Overview

- Implementing New Systems of Integration for Dually Eligible Enrollees (INSIDE) brings together 14 states for collaborative learning.
 - States: AZ, CA, FL, ID, MA, MN, NJ, NY, OH, RI, SC, TX, VA, WA
 - Funders: The Commonwealth Fund and The SCAN Foundation
- Includes all-state calls, in person meetings, and affinity group work to assist states in implementing and enhancing integrated care programs.
- Priority areas for states have included: state management of new care management models, communicating results from new programs, and housing as health care.
- Informal connections are made between federal officials and health plan and provider partners as all parties work together to oversee new care management models and further alignment.

Questions?

Contact Information:

Alexandra Kruse: akruse@chcs.org

www.chcs.org



VIRGINIA UPDATE



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Jason Rachel, Ph.D

Supervisor CCC Operations

Virginia Update for CCC Advisory Committee

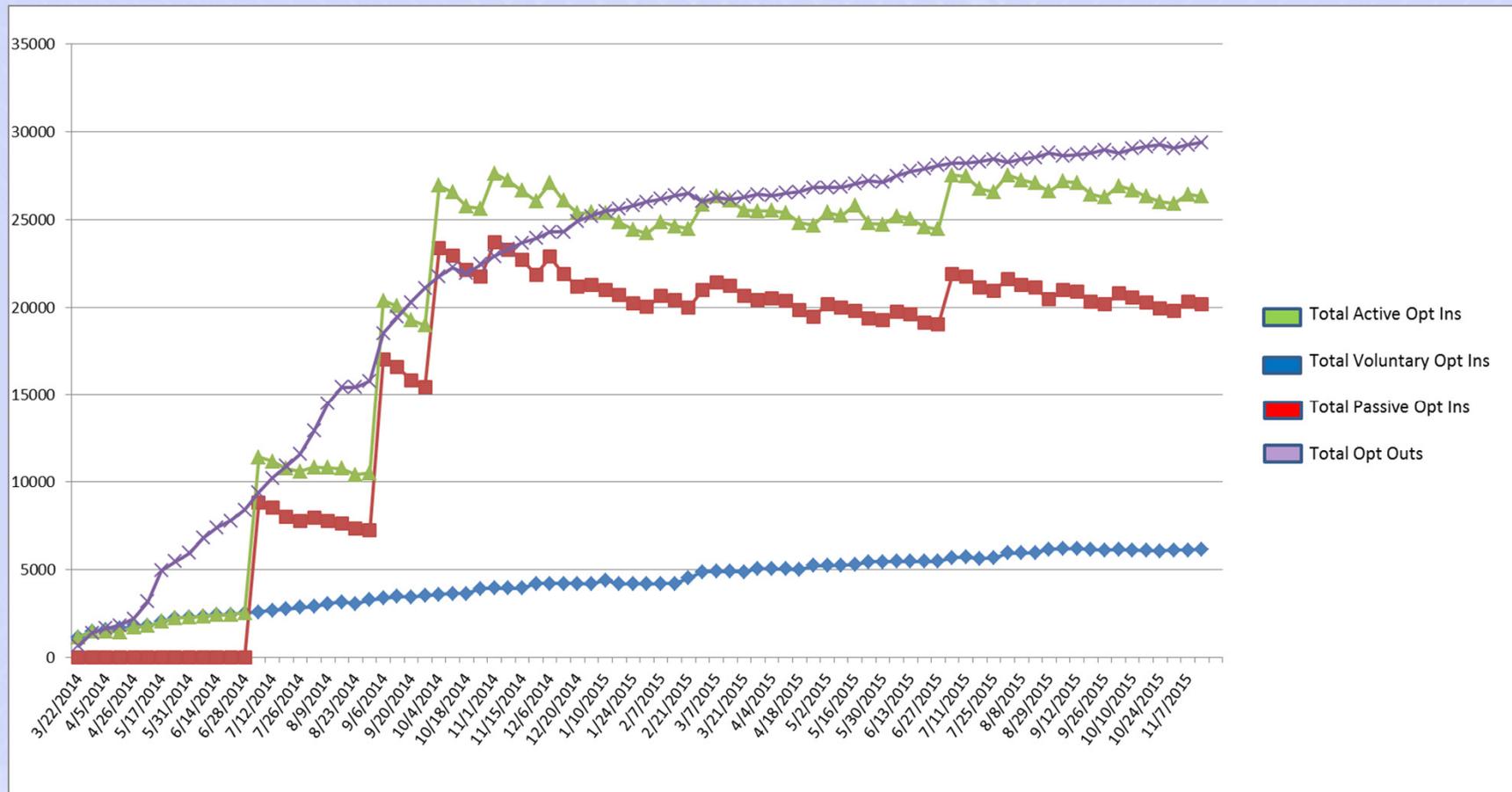
November 18, 2015

CCC Enrollment Update

- Opt-out to Opt-in ratio
 - Approximately 3 to 1
- Continuous monthly automatic assignment
 - Approximately 1500 per month

CCC Optins By Plan and Optout- Nov 14, 2015			
Optins			
MMP NAME	Active	Passive	Total
VaPremier	1095	4926	6021
HealthKeepers	2982	9137	12119
Humana	2063	8441	10504
Total Optins	6140	22504	28644
Total Optouts			29383

CCC Enrollment Trend



EQRO Onsite Compliance Review

- Review Tool
 - Combined Medicaid and Medicare requirements
- Desk Audit
 - Conducted in Summer 2016
- Onsite Compliance Review
 - Conducted in September and October 2016
- Preliminary Reports Completed
 - Sent to MMPs in November 2016

Enrollee Merged Survey

- Collaborative effort between DMAS and the MMPs to create a merged enrollee satisfaction and quality of life survey
- Each MMP used and administered the same survey the same way
- Random sample of all three subpopulations
- Mailed survey with follow-up reminder by phone
- Assistance by VICAP and LTC Ombudsman



Beneficiary Escalations Log Overview

Aubrey Lucy, Project Manager

MAXIMUS

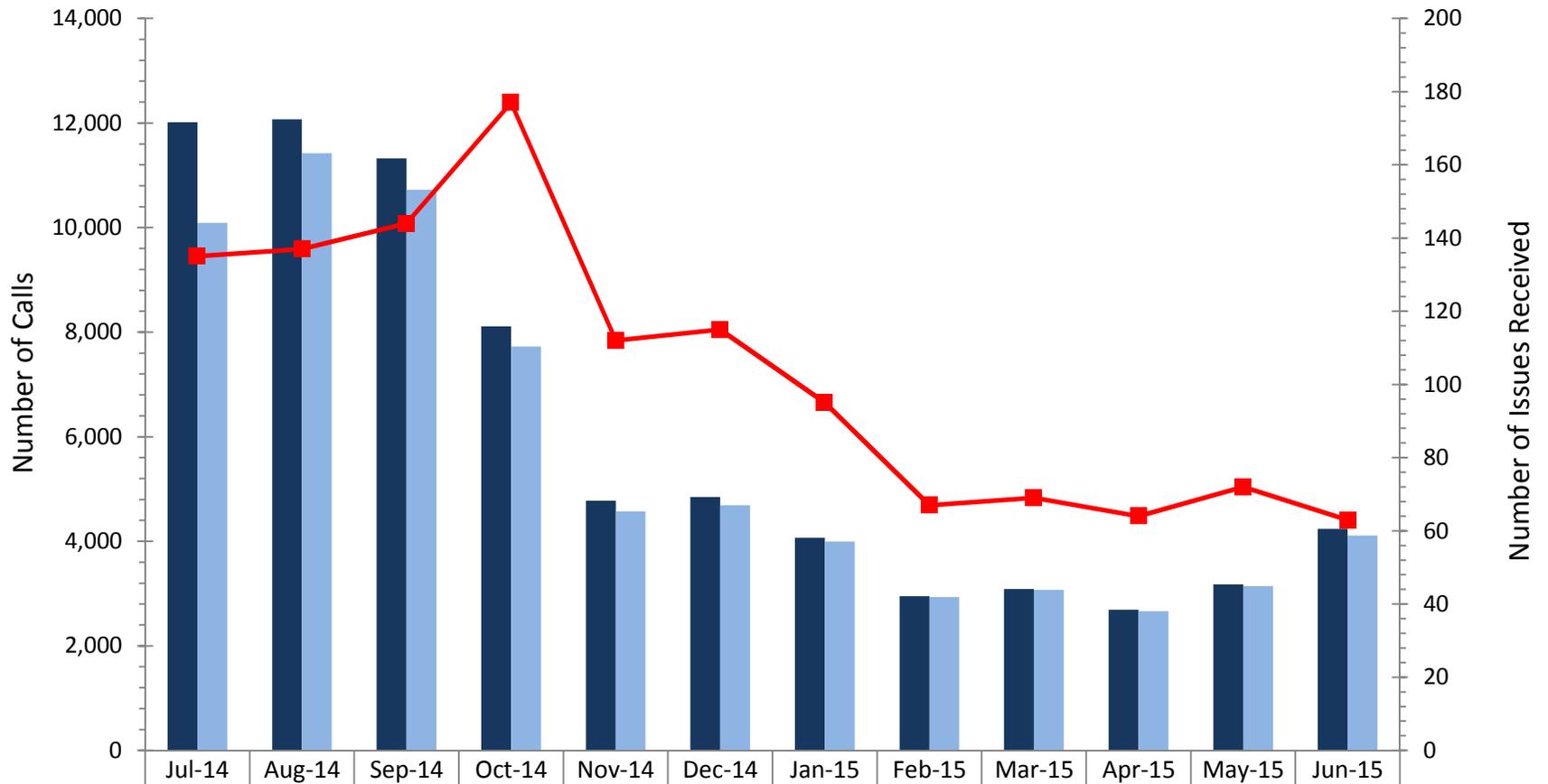
November 18th, 2015

CCC – Call Center Operations Review

- Call Volume versus Escalations Log Activity
- Top Three Beneficiary Escalations Reasons by CCC Region
- Review of Escalation Reasons

Commonwealth Coordinated Care Call Volume

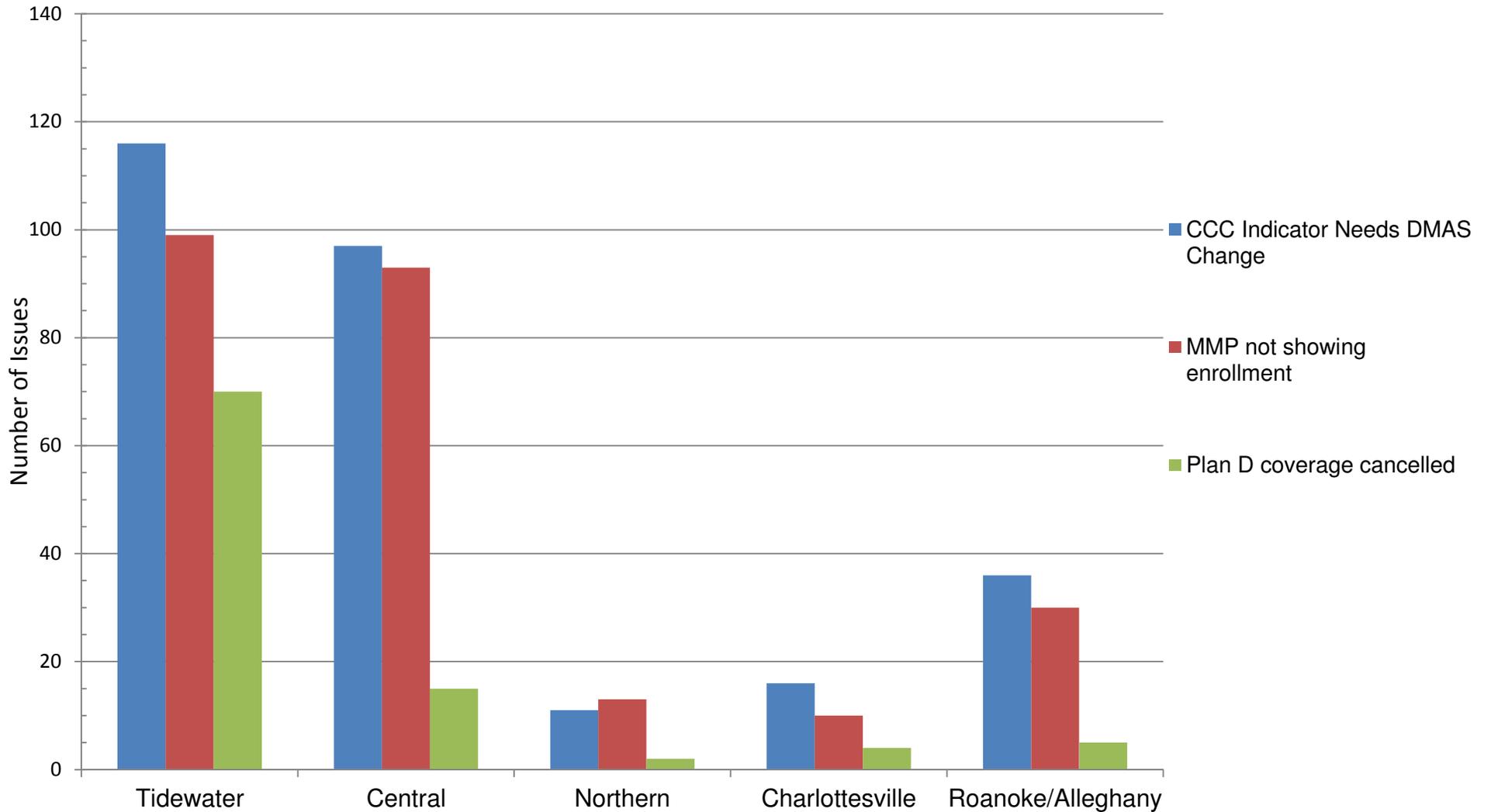
From July 2014 to June 2015



■ Calls Received	12,018	12,069	11,320	8,108	4,777	4,848	4,066	2,948	3,085	2,690	3,175	4,239
■ Calls Answered	10,089	11,420	10,723	7,726	4,570	4,689	3,994	2,932	3,070	2,663	3,144	4,110
■ Issues Received	135	137	144	177	112	115	95	67	69	64	72	63

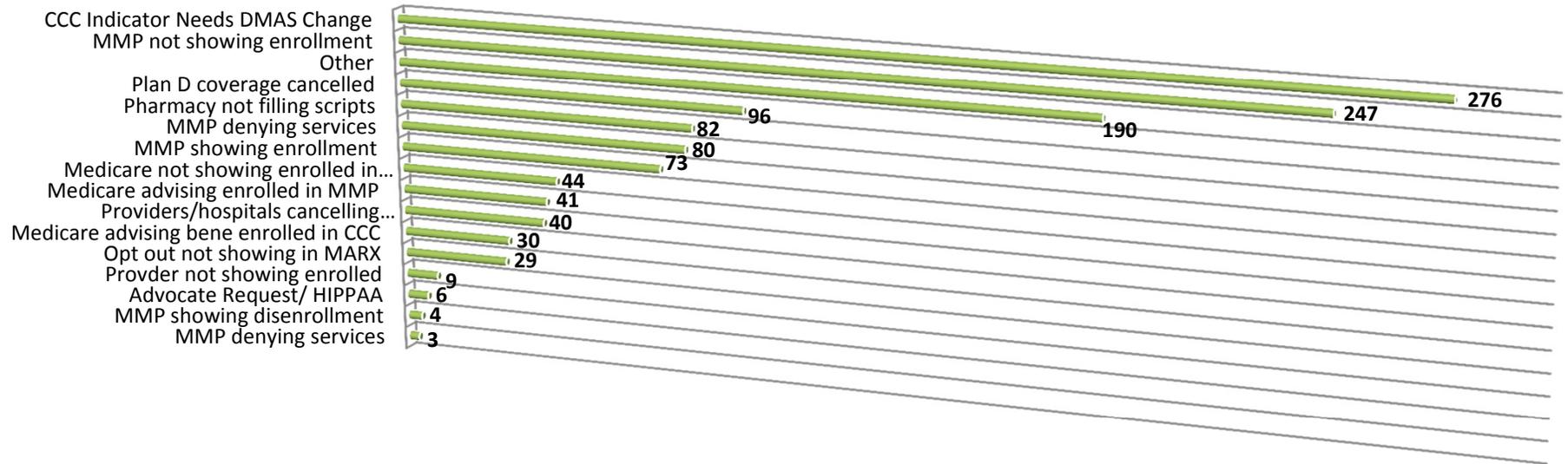
Commonwealth Coordinated Care High Frequency Issues

From July 2014 to June 2015



Commonwealth Coordinated Care Issues Summary

From July 2014 to June 2015



Most Common 'Other' Escalations

Top Ten "Other" Escalations	
Beneficiary not able to make decision/needs advocate	
VAMMIS should reflect Opt Out/match MARX	
Closure code error – need correction	
Beneficiary needs care coordinator/MMP not helpful	
R indicator issue in VAMMIS	
Enrollment needs correction due to ESRD	
MMP stating eligibility ending	
Passively enrolled with only one MMP	
Providers sending medical bills to beneficiaries	
VAMMIS assignment code correction	

**Early Survey Findings from
Dual-eligible Beneficiaries who receive EDCD waiver services
and Who Participated in the
Commonwealth Coordinated Care (CCC) Program**

Alison Cuellar, PhD, George Mason University
Gilbert Gimm, PhD, George Mason University
Carole Gresenz, PhD, RAND Corporation

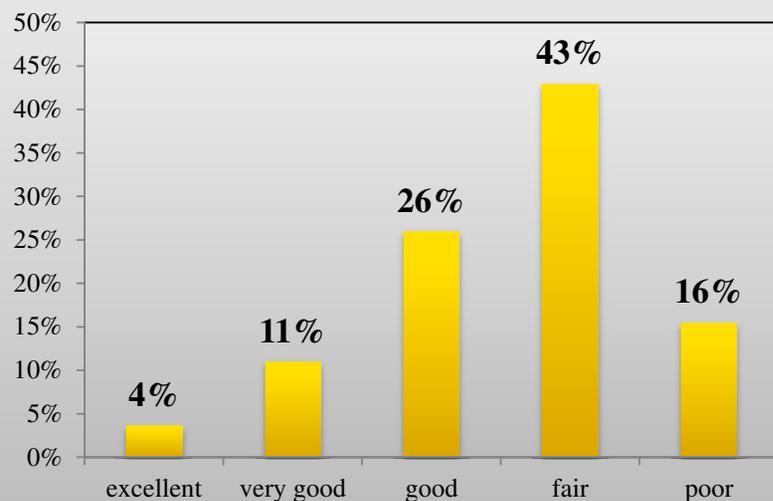
Survey Overview

- The survey content areas were primary care, specialty care, care coordination, personal attendant services, other LTSS, mental health services, health plan satisfaction and health plan enrollment and health status.
- 996 beneficiaries with working phone numbers were contacted by telephone
- 52% responded
- A mail survey has been added to reach individuals with missing phone numbers
- Survey conducted by George Mason University Center for Social Science Research

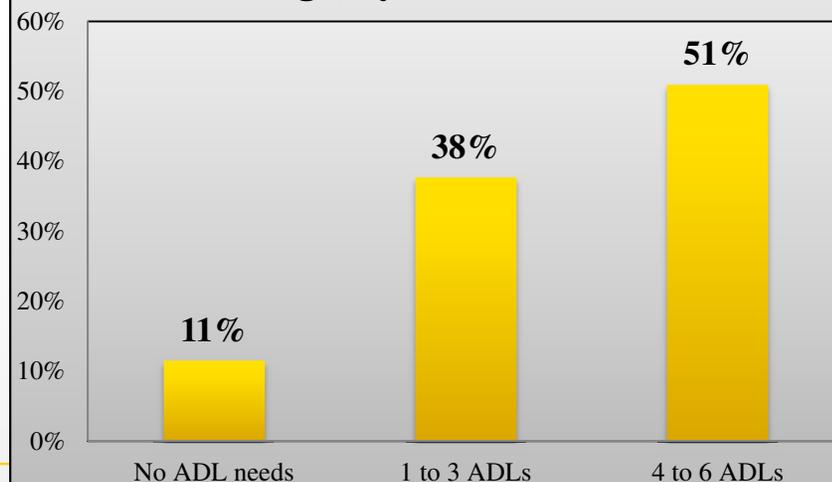
Results from Telephone Survey

- Survey confirms that dual-eligible EDCD beneficiaries are in relatively poor health and have multi-fold health and long-term services and support needs

Self-reported Health Status



Limitations in Activities of Daily Living*, by Total Number



*bathing or showering, dressing, eating, getting in and out of bed or chairs, walking, or toileting

Health Plan Satisfaction & Primary Care

Health Plan Satisfaction

- Survey respondents reported high levels of satisfaction with their health plans, including their plan's medical services and customer service (average 8.6 out of 10).

Primary Care

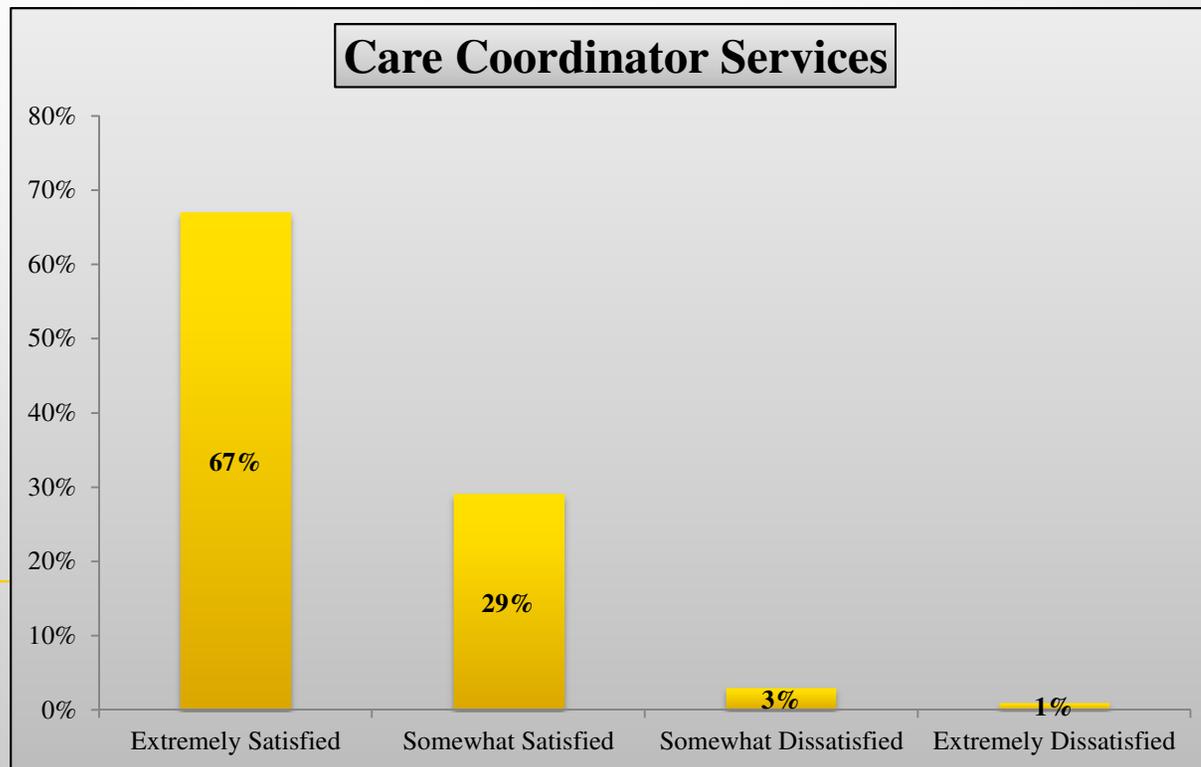
- Nearly all respondents reported having a primary care doctor who met their needs very well or somewhat well.
- **19%** reported that their needs were being met better than 6 months ago, the majority, **74%**, reported no change, and **6%** reported a worsening

Medical Specialty, Personal Attendant & Mental Health Services

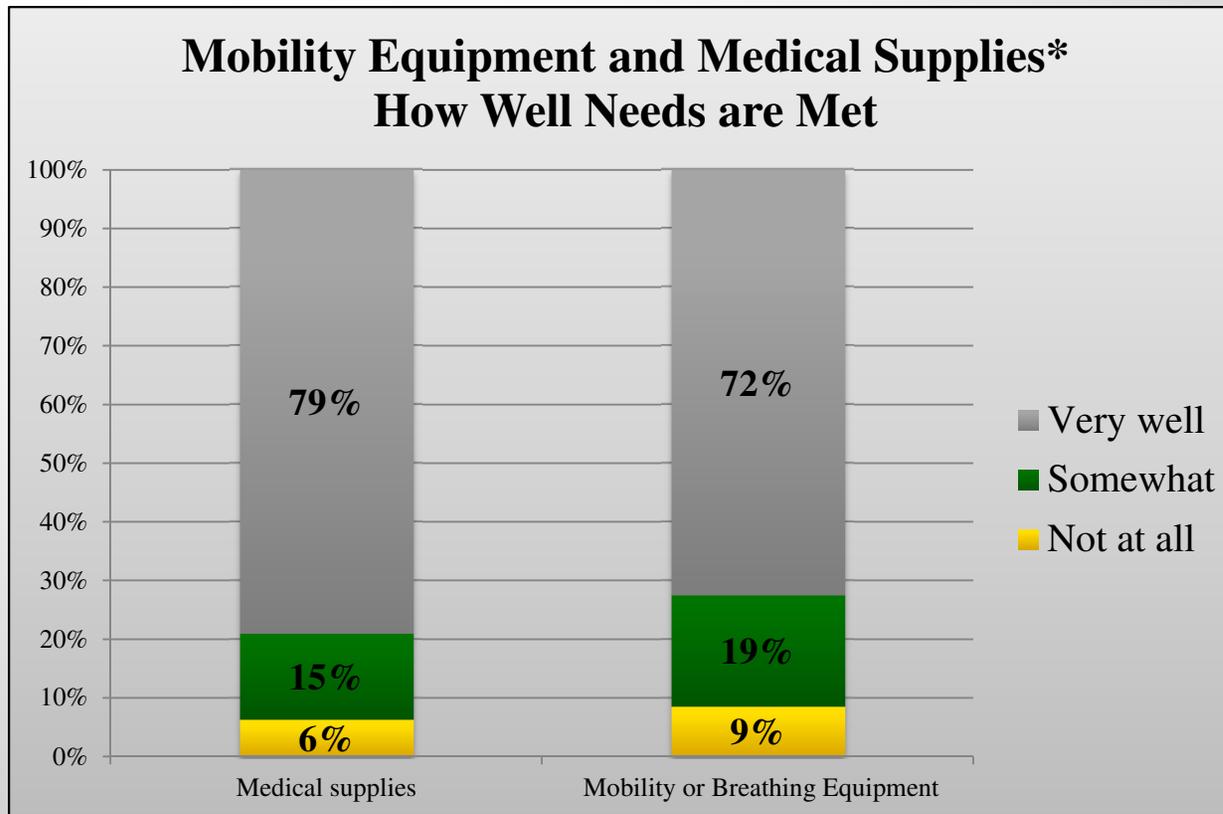
- Most experienced no change in how their needs were met for *medical specialty care* or *personal care*
- About one fifth reported improvements in medical specialty and personal attendant care, and fewer than 10% reported a worsening.
- For *mental health care* there were higher reports of a worsening in how well needs were met than for other services. Among mental health services users 16% reported a worsening.

Care Coordinators

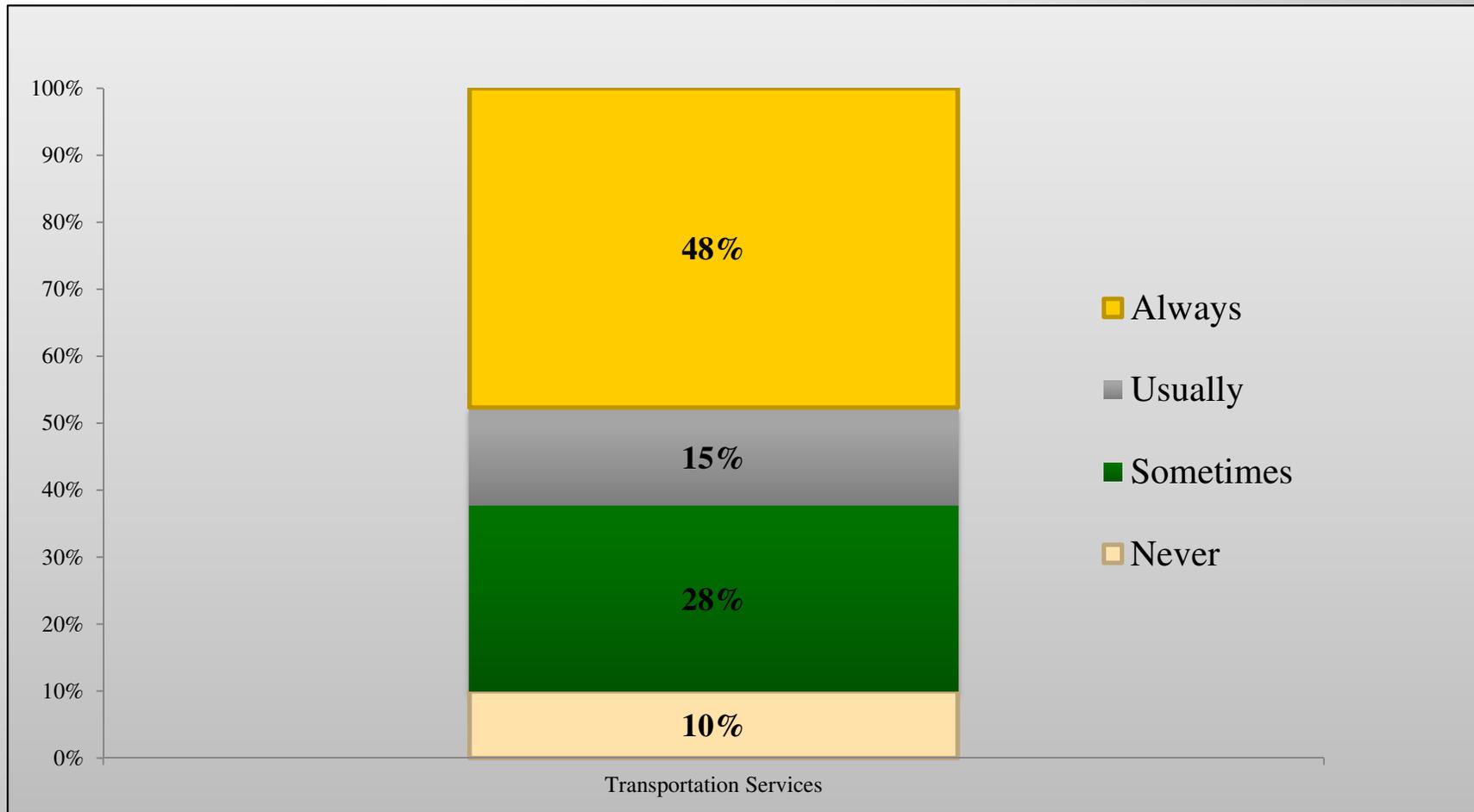
- Half of respondents recalled meeting with their care coordinator and their satisfaction was very high



Other LTSS Services



Transportation: How Well Needs are Met



Health Plan Enrollment

- 91% reported that the health plan information and enrollment process were “somewhat easy” or “very easy” to understand
- 71% reported were aware they could disenroll from their plan at any time

Summary of Early Findings

- The dual-eligible EDCD-waiver beneficiaries in CCC have complex health and LTSS needs.
- Satisfaction with CCC health plans is high.
- Care coordinators were very well regarded.
- Potential areas for further exploration: beneficiaries who do not recall meeting with a care coordinator, mental health services, and transportation
- The enrollment process appears straightforward and understandable to most.



Managed Long Term Services and Supports (MLTSS) VIRGINIA UPDATE

November 18, 2015

Revised MLTSS Plan

Managed Long Term Services and Supports



Objectives

1. Key Points From August Advisory Meeting
2. Stakeholder Input and MLTSS Strategy
3. MLTSS Implementation Strategy
 - Initial Strategy
 - Revised Strategy
 - What Will Not Change
 - Where We Are Now
4. CMS Guidance on MLTSS
 - 10 Key Elements
5. MLTSS and DSRIP
6. Next Steps

Key Points from the August 2015 Meeting

The Department's goal is to develop a managed care model that is designed to provide individuals with enhanced opportunities to improve their lives . . .



❖ *to promote long term care options in community settings*

❖ *to promote community capacity and supports designed to better enable individuals to thrive in the community*



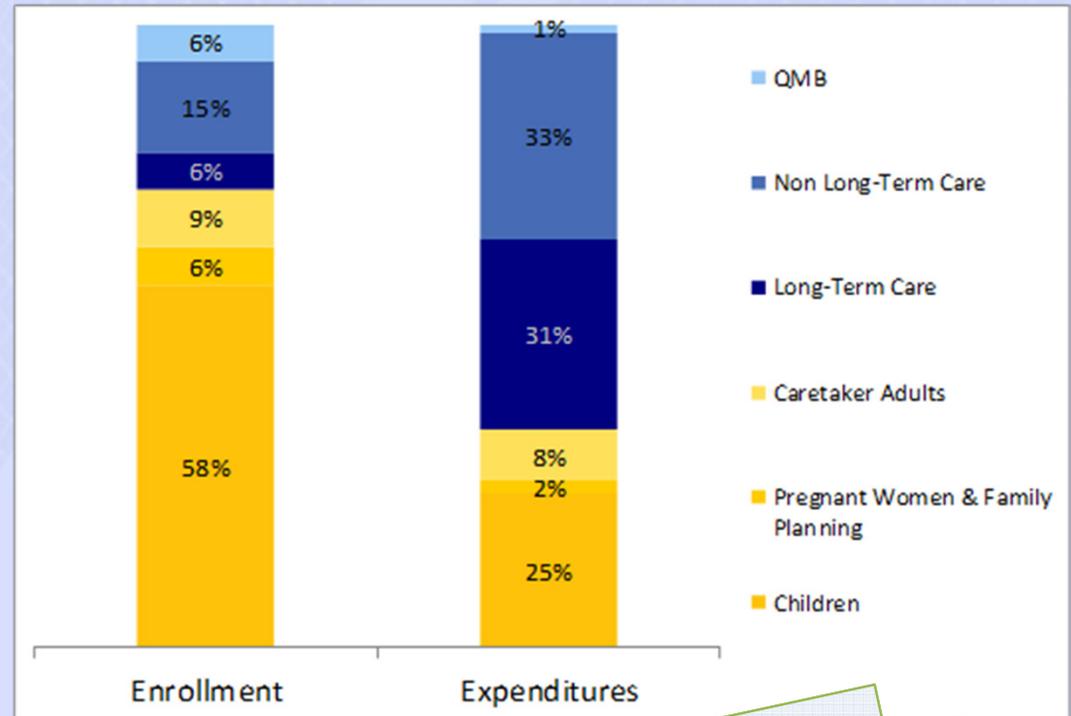
❖ *to provide flexible and innovative benefit plans to serve individuals in their setting of choice*



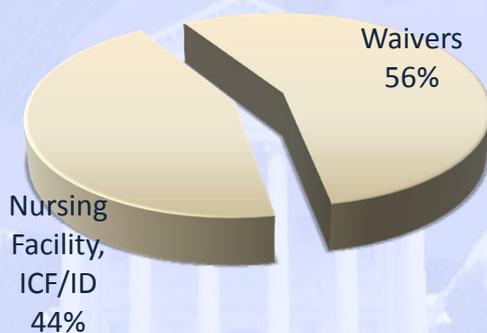
Key Points from the August 2015 Meeting

Medicaid Enrollment v. Expenditures

The current fee-for-service system lacks comprehensive care coordination, the flexibility to provide innovative benefit plans & value based payment strategies, and budget predictability



Long-Term Care Expenditures



Current LTSS spending trends are unsustainable

Key Points from the August 2015 Meeting

Consistent with Virginia General Assembly and Medicaid reform initiatives, DMAS is moving forward transitioning individuals from fee-for-service delivery models into managed care

General Assembly Directives beginning 2011 through 2015

Continue to transition fee-for-service populations into managed care

Phases 3 of Medicaid Reform

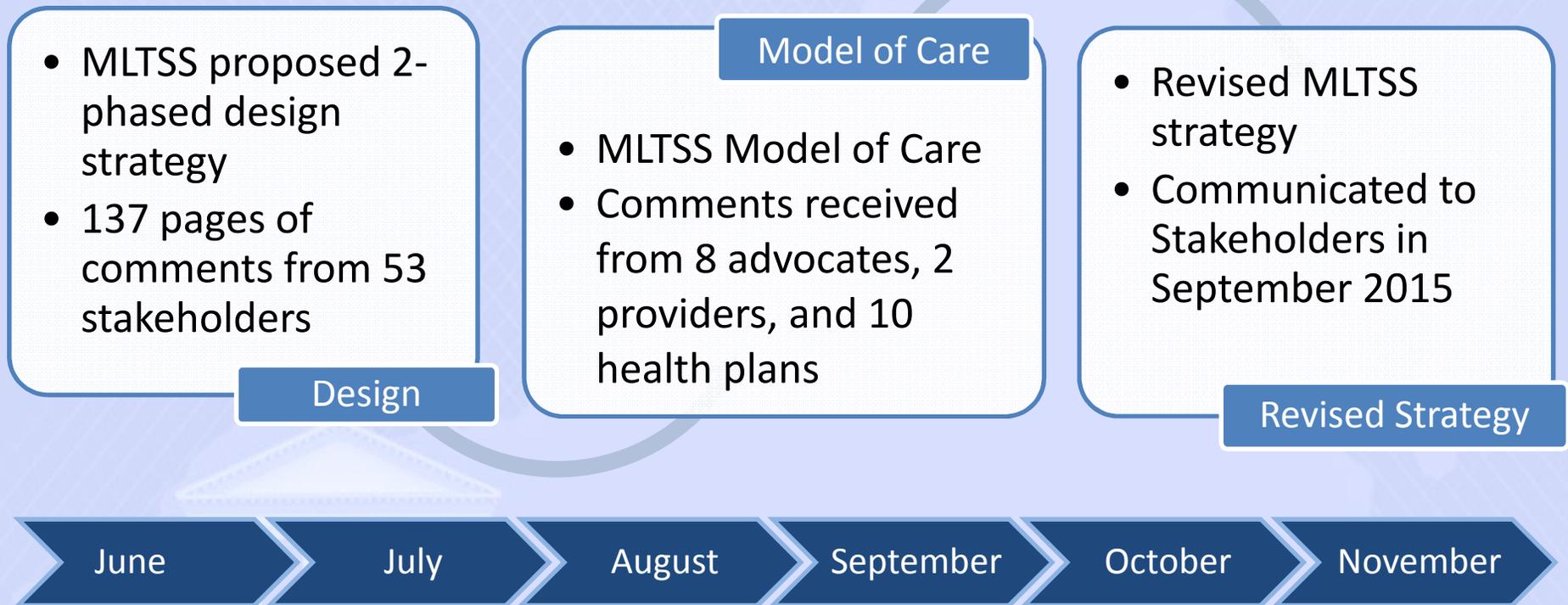
Move forward with managed long term services and supports (MLTSS) initiatives

Value of Managed Care

Timely access to appropriate, high-quality care; comprehensive care coordination; and budget predictability

Stakeholder Input & MLTSS Strategy

Stakeholder input has significantly informed the DMAS MLTSS program design and implementation strategy



Stakeholder Input for MLTSS Design

Initially DMAS proposed to operate MLTSS through two separate and distinct contractual arrangements; MLTSS-I and MLTSS-II

MLTSS-I for CCC
Eligible Individuals
Who Opt-out of CCC

- Enroll individuals who opt out of CCC with an existing CCC plan for their Medicaid coverage;
- Would operate concurrently with the CCC demonstration (same populations/services);
- Earliest start date would be July 1, 2016

MLTSS-II for Duals
and LTSS Individuals
*Who Are
Not CCC Eligible*

- Competitively procure MLTSS plans (RFP);
- Populations would be phased in regionally;
- Earliest start date would be mid-year 2017

Proposed Strategy

Stakeholder Input and MLTSS Strategy

The revised MLTSS strategy will operate under a single, comprehensive implementation design. The CCC Demonstration will continue operating as an optional program until CCC ends (December 31, 2017)

Revised Strategy

MLTSS for Duals and LTSS Individuals

- Competitively procure MLTSS plans (RFP);
- Populations would be phased in regionally;
- Earliest start date would be Spring 2017
- CCC demonstration participants will begin to transition to MLTSS when the CCC demo ends, beginning January 1, 2018. DMAS will work closely with CMS to develop a transition plan that ensures continuity of care.

**Individuals enrolled in the ID, DD, and DS Waivers will continue to receive their home and community-based LTSS through Medicaid fee-for-service until the Department of Behavioral Health and Developmental Services completes the redesign of these Waivers. Individuals residing in ICF-ID facilities will be excluded from MLTSS until after the completion of the redesign*

What Will Not Change

- DMAS remains committed to the CCC program for the duration of our contract with CMS (through December 2017)
- MLTSS will include many of the core program values from CCC (e.g., person centered, integrated care, care coordination, etc.)
- MLTSS allows us to proceed with the directives from the General Assembly to move our remaining vulnerable populations into a coordinated care delivery model
- MLTSS is being thoughtfully developed in a manner that allows sufficient time for program development, stakeholder input, and a strategic implementation
- Stakeholder input into advancing MLTSS began in May 2015 and continues

What Will Not Change

Vision and goals remain the same

Coordinated system of care that focuses on improving quality, access and efficiency

- Improves quality of care and quality of life
- Enhances community-based infrastructure and community capacity
- Promotes innovation and value based payment strategies
- Improves care coordination and reduces service gaps
- Better manages and reduces expenditures and provides for budget predictability (full-risk, capitated model)

MLTSS Strategy

- *Where we are now. . .*



MLTSS Included Populations

Duals

*who are excluded from
the CCC Demo*

- Full Medicaid and any Medicare benefits
- Nursing facility and Waiver participants
- Approximately 46,000 individuals

Non-Duals with LTSS

- Nursing facility and Waiver participants
- Waiver individuals in Medallion 3.0 (HAP)
- Approximately 18,000 individuals

CCC Demo Population

- Approximately 66,000 individuals; 28,000 enrolled and 38,000 eligible/not enrolled
- Transition from CCC to MLTSS after CCC demonstration ends; January 1, 2018

MLTSS Excluded Populations and Services

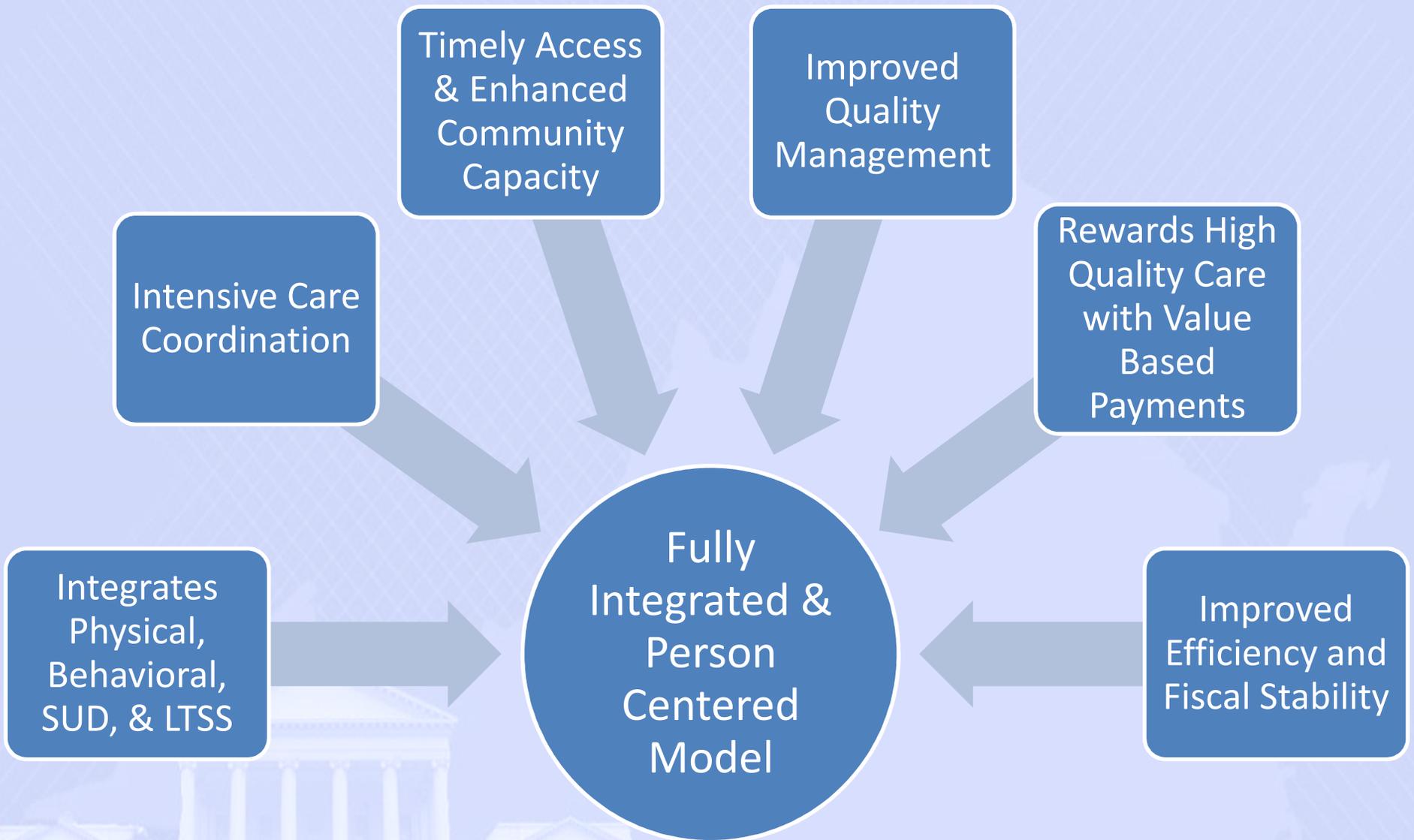
Excluded Populations

- Limited Coverage Groups (Family Planning, GAP, QMB only, HIPPA, etc.)
- Medallion 3.0 and FAMIS
- ICF-ID and MH Facilities
- Veterans Nursing Facilities
- Residential Treatment Level C
- Medicaid Works
- PACE
- Certain Out of State Placements
- Hospice and ESRD (*will remain enrolled in MLTSS if MLTSS enrolled and then subsequently enroll in Hospice or ESRD*)

Carved-Out Services

- Dental
- School Health Services
- Community Intellectual Disability Case Management
- ID, DD, and DS Waiver Services, including waiver related transportation services, until after the completion of the ID/DD redesign
- Developmental Disability Support Coordination
- Preadmission Screening
- Money Follows the Person (MFP)
 - MFP (new) enrollments end 12/31/17

MLTSS Person Centered Delivery Model



Person centered, coordinated system of care that improves community access, quality, efficiency and value

Coordination with Medicare

MEDICARE COVERS

- ▶ Hospital care
- ▶ Physician & ancillary services
- ▶ Skilled nursing facility (SNF) care
- ▶ Home health care
- ▶ Hospice care
- ▶ Prescription drugs
- ▶ Durable medical equipment

MEDICAID COVERS

- ▶ Medicare Cost Sharing
- ▶ Hospital and SNF (when Medicare *benefits are exhausted*)
- ▶ Nursing home (custodial)
- ▶ HCBS waiver services
- ▶ Community behavioral health and substance use disorder services,
- ▶ Medicare non-covered services, like OTC drugs, some DME and supplies, etc.

- ✓ MLTSS plans must operate (or obtain approval to operate) as Medicare Dual Special Needs Plans (DSNP)
- ✓ DSNPs operate under contract with Medicare and Medicaid
- ✓ Once DSNPs are operational, MLTSS individuals will have the option to choose the same plan for Medicare and Medicaid coverage
- ✓ DMAS Contracts (DSNP and MLTSS) will facilitate care coordination across the full continuum of care

MLTSS Health Plan Licensure and Certification

Dual Special Needs Plan (D-SNP)

MLTSS contracted health plans will be required to operate as a [dual special needs plan](#) (D-SNP), through the Center for Medicare and Medicaid Services (CMS) for all localities in which the plan intends to operate within two (2) years of being awarded an MLTSS contract.

Virginia State Corporation Commission's Bureau of Insurance (BOI) Licensure

MLTSS contracted health plans will need to be licensed by the Virginia State Corporation Commission's Bureau of Insurance (BOI), as set forth in the Code of Virginia §38.2-4300 through 38.2-4323, 14 VAC5-211-10 et. Seq. prior to MLTSS contract signing (if selected).

Certification of Quality Assurance of Managed Care Health Insurance Plans (MCHIP)

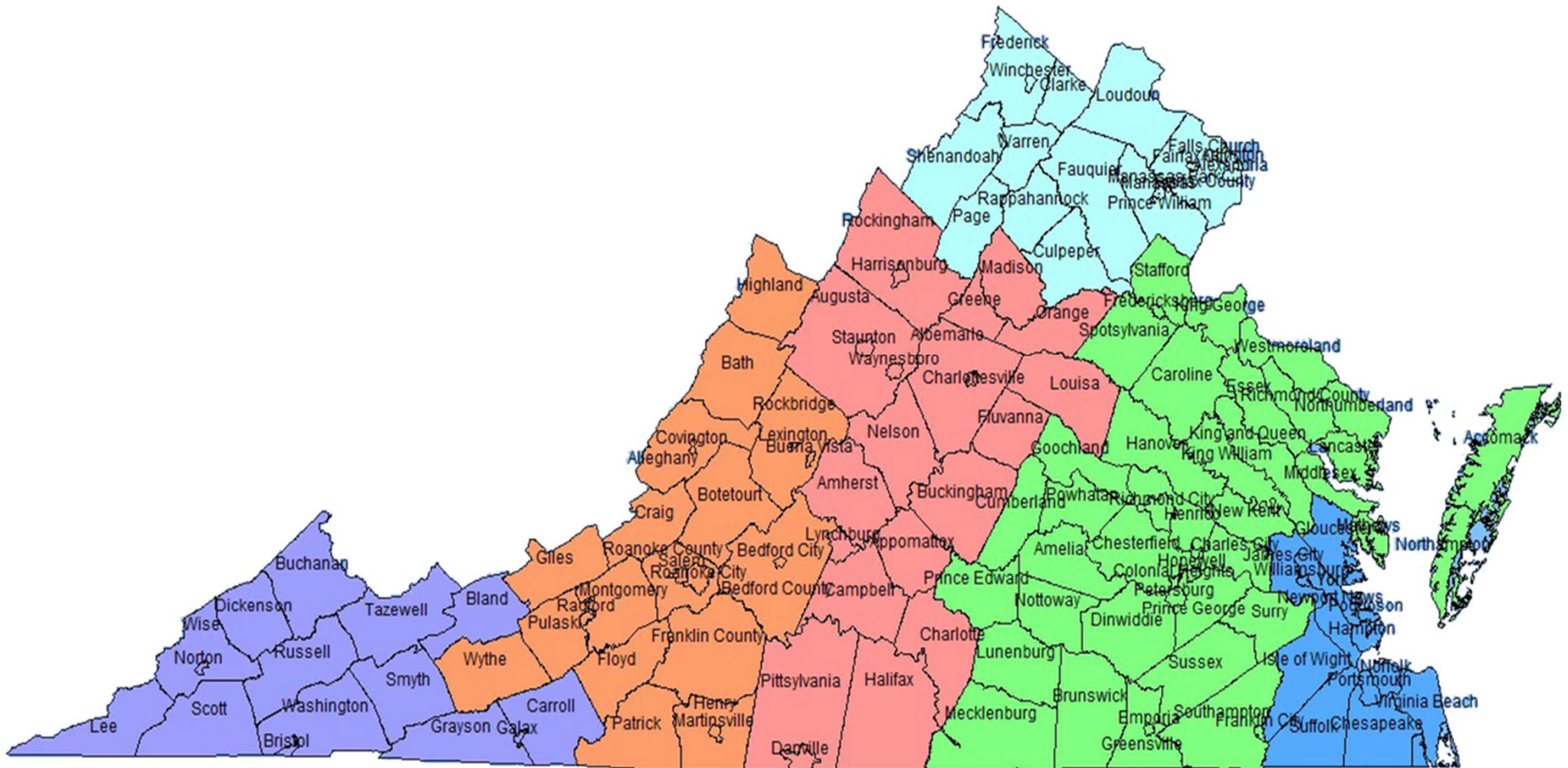
MLTSS contracted health plans will need to have in place an approved Certificate of Quality Assurance from the Center for Quality Health Care Services and Consumer Protection, Office of Licensure and Certification, Virginia Department of Health, pursuant to §32.1-137.1 through §32.137.7 Code of Virginia, and 12VAC5-408-10 et. seq. for all region(s) in which the health plan intends to operate prior to MLTSS contract signing (if selected).

National Committee for Quality Assurance (NCQA) Health Plan Accreditation

Each MLTSS contracted health plan selected will be required to obtain NCQA accreditation for its Virginia Medicaid line of business. Plans who are not NCQA accredited would be required to adhere to DMAS' timeline of milestones for achieving NCQA accreditation. Further, all contracted plans would be required to comply with NCQA guidelines at contract signing, based on the most current version of NCQA Standards and Guidelines for the Accreditation of MCOs. Plans would also be required to comply with and participate in comprehensive onsite reviews at dates to be determined by the Department and must attain Interim Accreditation Status from NCQA by the end of the eighteenth (18th) month of operations (onset of delivering care to MLTSS members), and obtain NCQA accreditation status of at least "Accredited" within 36 months of MLTSS start date.

MLTSS Regional Map

Virginia Medicaid's Regional Map for Managed Long-Term Services and Supports (MLTSS)



Southwest

Roanoke / Alleghany

Western / Charlottesville

Northern / Winchester

Central

Tidewater

MLTSS Program Launch

Proposed

2
0
1
7

2
0
1
8

Date	Region	Totals *
March-April	Tidewater	8,000
May-June	Central	11,000
July – August	Charlottesville/Western	13,000
September – October	Roanoke/Alleghany	4,500
September – October	Southwest	12,500
November – December	Northern/Winchester	13,500
Starting in January 2018	CCC Demonstration <i>(Transition plan is to be determined with CMS)</i>	67,000
Total	All Regions	129,500

Source – VAMMIS Data; *Approximate totals based upon MLTSS targeted population as of June 2015

Additional information by region and population is provided in your packet

MLTSS and National Trends

- Many states are moving LTSS into managed care programs and towards payment/outcome driven delivery models
 - LTSS spending trends are unsustainable
 - Managed care offers flexibility not otherwise available through fee-for-service
 - Affordable Care Act emphasis on care coordination/integration of care

Virginia's MLTSS efforts are consistent with National trends

CMS MLTSS Guidance

- In summer 2013 CMS published MLTSS guidance for states based on best practices for establishing and implementing MLTSS programs
 - clarifies expectations of CMS from states using section 1115 demonstrations or 1915 (b) (c) combined waivers
 - includes 10 key elements that CMS expects to see in MLTSS programs

CMS Guidance

10 Key Elements of MLTSS

1. Adequate planning and transition strategies
2. Stakeholder engagement
3. Enhanced provision of HCBS
4. Alignment of payment structures with MLTSS programmatic goals
5. Support for beneficiaries
6. Person-centered processes
7. Comprehensive and integrated service package
8. Qualified providers
9. Participant protections
10. Quality



Transformation Efforts Underway

Virginia is pursuing a comprehensive 1115 Demonstration Waiver

- 1 Managed Long-Term Services and Supports (**MLTSS**) – aligning with Medicare to transform care and enable individuals with the most complex and high-cost needs to thrive in the community
- 2 Delivery System Reform Incentive Payment (**DSRIP**) – improve Virginia's Medicaid delivery system to achieve high-value care and the most medically complex enrollees with significant behavioral, physical, and developmental disabilities can live safely and thrive in the community

Also leveraging the work of Virginia's State Innovation Model grant

Additional information about DSRIP is available at: http://www.dmas.virginia.gov/Content_pgs/dsrip.aspx

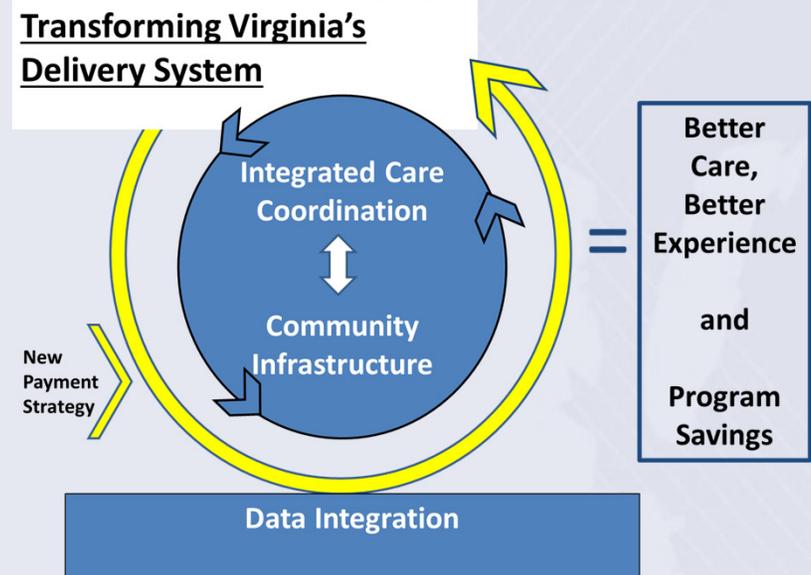


Transforming Virginia's Medicaid Delivery System

In 5 years, Virginia envisions a Medicaid delivery system where high-value care is the norm and even the most medically complex enrollees with significant behavioral, physical, sensory, and developmental disabilities can live safely and thrive in the community

Four Transformation Steps:

1. Invest in Data Integration
2. Integrate Service Delivery
3. Build Community Capacity
4. Advance How DMAS Pays for Services



For More Information and to Submit Written Comments

- MLTSS updates are available on-line at:
http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx
- Send MLTSS Comments to:
 - VAMLTSS@dmas.virginia.gov
- Delivery System Reform Incentive Payment (DSRIP) updates are available on-line at:
http://www.dmas.virginia.gov/Content_pgs/dsrip.aspx
- Send DSRIP Comments to:
 - DSRIP@dmas.virginia.gov

MLTSS Next Steps. . .

- RFP (publish, evaluate, negotiate, readiness, award)
- Work with CMS
 - 1115 Waiver (DSRIP/MLTSS)
 - Regulations
 - Readiness review
 - MCO Contracts
- Systems enhancements
- Ongoing stakeholder and member engagement, outreach and education
- Program launch in regional phases
- Ongoing program monitoring and evaluation

Other References

- Implementing Medicaid Reform in Virginia (Report to the General Assembly of Virginia, January 2014)

[http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD62014/\\$file/HD6.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD62014/$file/HD6.pdf)

- CMS Technical Assistance Tools for MLTSS:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html>

MLTSS Model of Care (MOC)



Overview

- Refine
- Streamline
- Restructure



Refine



- Request for public comment
 - Comments received from 8 advocates, 2 providers, and 10 health plans
 - Themes identified under each element
 - Comprehensive review of comments
 - Identified which suggestions applied to MOC vs. RFP vs. contract language

Refine

More than 30 edits made to MOC in response to public comment, including:

- Language to strengthen requirement for person-centered approach

- Language to clarify requirements for dual-eligible participants

- Require additional detail regarding staffing, training (staff and providers), etc

- Clarification of requirements related to care management activities, HRA, ICT, and POC



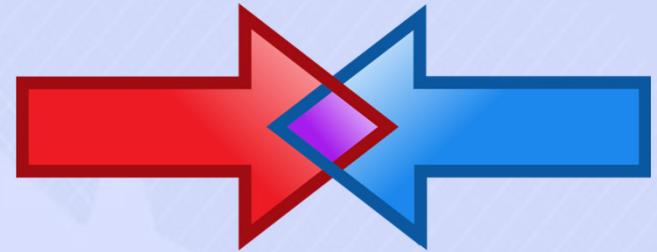
Refine

- Input from LTC, DBHDS, Behavioral Health
 - Incorporate requirements for Tech and Alzheimers Assisted Living Waivers
 - Increased specificity related to serving individuals with ID/DD and BH needs
- Lessons learned from CCC
 - Additional clarification and specificity related to training, HRA, ICT and POC requirements

Streamline

CCC MOC includes 14 required elements

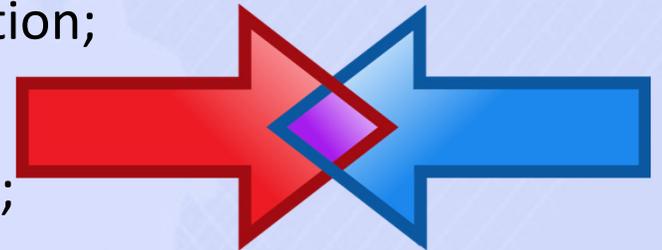
1. Description of the Plan-specific Target Population;
2. Measurable Goals;
3. Staff Structure and Care Management Goals;
4. Interdisciplinary Care Team;
5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
6. Model of Care Training for Personnel and Provider Network;
7. Assessments;
8. Individualized Care Plan;
9. Communication Network;
10. Care Management for the Most Vulnerable Subpopulations;
11. Performance and Health Outcomes Measurement;
12. Hospital and Nursing Facility Transition Programs;
13. Enhanced Care Management for Vulnerable Subpopulations; and,
14. Partnering with Community Care Management Providers



Streamline: MLTSS MOC 10 Elements

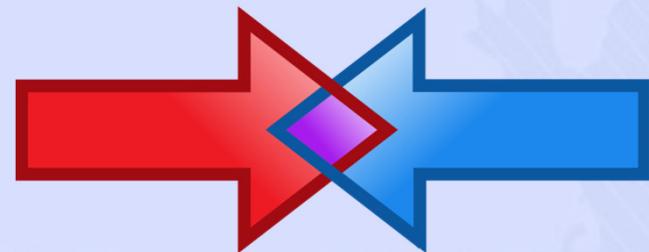
Review of each element to determine duplication within the MOC and other RFP areas

1. Description of the Plan-specific Target Population;
2. Measurable Goals;
3. Staff Structure and Staff and Provider Training;
4. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols and Training
5. Assessments;
6. Interdisciplinary Care Team;
7. Individualized Care Plan;
8. Communication Network;
9. Care Management; and,
10. Transition Programs



Streamline

- Combined all training requirements and included under Staff Structure
- Combined all care coordination requirements under one element
- Removed some language that was duplicative of requirements in other RFP sections
 - Quality
 - Care management



Restructure

- Reorganized required elements for a logical flow
 - HRA before ICT
 - Plan of care to follow ICT
 - Outcomes and transition based on Care Management
- Result is streamlined document which addresses needs of MLTSS population and input from stakeholders



Decision Points for Input

1. Timeframe for completion of initial HRA, ICT and POC at program launch
2. Requirements for timeframe for reassessments for NF residents

Comments to:

[vamltss@dmas.virginia.](mailto:vamltss@dmas.virginia.gov)

[gov](mailto:vamltss@dmas.virginia.gov)

