

Virginia Advisory Committee*

Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

April 11, 2013, from 1:30 to 3:30 pm in House Room D of the General Assembly Building
Directions: 1000 Bank St, Richmond, VA 23218

Meeting 2

I. Welcome and Introductions	Suzanne Gore, Senior Executive Advisor, Virginia Department of Medical Assistance Services (DMAS)	1:30 pm
II. National Updates	Sarah Barth, Director, Long Term Services, Center for Health Care Strategies (CHCS)	1:40 pm
III. Virginia Updates	Paula Margolis, Policy and Research Manager, DMAS	2:10 pm
IV. Committee Member Focus Session 1: <i>RFP and MOU</i> A. RFP: Overview, Key Issues, and Timeline B. MOU: Status and Key Issues	Karen Kimsey, Deputy Director, Complex Care and Services, DMAS Suzanne Gore	2:25 pm
V. Committee Member Focus Session 2: <i>Education and Outreach</i> A. Communications Plan: Overview, Grant Opportunity, and Stakeholder List B. Logo/Tag Line Design	Karen Kimsey Kristin Burhop, DMAS	2:45 pm
VI. Wrap Up and Next Steps	Suzanne Gore	3:15 pm

*The Department will not hold a public comment period during this meeting; however, stakeholder input is very important to the Department and the Advisory Committee. If you have follow up questions or comments that you would like discussed during a future meeting, please submit them to Dualintegration@dmas.virginia.gov.

Advisory Committee Members:

1. Alzheimer's Association (Carter Harrison)
2. Medical Society of Virginia (Mike Jorgensen)
3. Self-Advocate (Joan Manley)
4. State Long Term Care Ombudsman (Joani Latimer)
5. Virginia AARP (Bill Kallio)
6. Virginia Adult Day Services Association (Lory Phillippo)
7. Virginia Association for Home Care and Hospice (Marc Tetterton)
8. Virginia Association of Area Agencies on Aging (Courtney Tierney)
9. Virginia Association of Centers for Independent Living (Maureen Hollowell)
10. Virginia Association of Community Services Boards (Mary Anne Burgeron)
11. Virginia Association of Health Plans (Doug Gray/Laura Lee Viergever)
12. Virginia Health Care Association (Hobart Harvey/Steve Morrisette)
13. Virginia Hospital and Health Care Association (Chris Bailey)
14. Virginia Poverty Law Center (Jill Hanken)



Update on Dual Eligible Demonstrations: Improving Care for Medicare-Medicaid Enrollees

April 11, 2013

Sarah Barth, Director of Long-Term Services
Center for Health Care Strategies

CHCS Mission

To improve health care access and quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

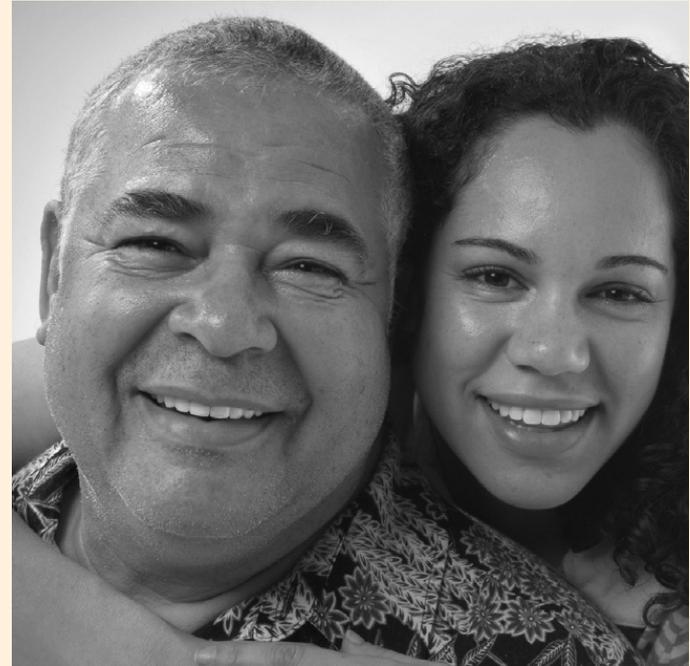
Our Priorities

- ▶ Enhancing Access to Coverage and Services
- ▶ Improving Quality and Reducing Racial and Ethnic Disparities
- ▶ Integrating Care for People with Complex and Special Needs
- ▶ Building Medicaid Leadership and Capacity



Who are Medicare-Medicaid enrollees?

- Receive both Medicare and Medicaid coverage
- Focus on “Full Duals” in CMS’ demonstration
- 58.8% age 65 or older
- 41.2% under age 65



10.2M Americans are eligible for Medicare and Medicaid (known as Medicare-Medicaid enrollees or “dual eligibles”) & 7.4M are “full duals”

Who pays for what services?

MEDICARE

- ▶ Hospital care
- ▶ Physician & ancillary services
- ▶ Skilled nursing facility (SNF) care (up to 100 days)
- ▶ Home health care
- ▶ Hospice
- ▶ Prescription drugs
- ▶ Durable medical equipment

MEDICAID

- ▶ Medicare cost sharing
- ▶ Nursing home (once Medicare benefits exhausted)
- ▶ Home- and community-based services (HCBS)
- ▶ Hospital once Medicare benefits exhausted
- ▶ Optional services (vary by state): dental, vision, HCBS, personal care, and select home health care
- ▶ Some prescription drugs not covered by Medicare
- ▶ Durable medical equipment not covered by Medicare

What does care look like for Medicare-Medicaid enrollees now?

WITHOUT INTEGRATED CARE INDIVIDUALS MAY HAVE:

- x Three ID cards: Medicare, Medicaid, and prescription drugs
- x Three different sets of benefits
- x Multiple providers who rarely communicate
- x Health care decisions uncoordinated and not made from the patient-centered perspective
- x Serious consideration for nursing home placement; Medicare/Medicaid only pays for very limited home health aide services

- Fragmented
- Not Coordinated
- Complicated
- Difficult to Navigate
- Not Focused on the Individual
- Gaps in Care

Quick review:

Financial alignment models

- Opportunity to create one accountable entity to coordinate delivery of primary/preventive, acute, behavioral, and long-term services and supports
- CMS provided states with two paths (aka “Financial Alignment Models”)



- 23 states are pursuing financial alignment or alternative demonstration models to improve integration between Medicare and Medicaid

State demonstration activity (as of April 8, 2013)

	STATE	SIGNED MOU	TARGET LAUNCH YEAR	MODEL
1	AZ	No	2014	Capitated
2	CA	Yes	2013	Capitated
3	CO	No	2013	MFFS
4	CT	No	2013	MFFS
5	ID	No	2014	Capitated
6	IL	Yes	2013	Capitated
7	IA	No	2013	MFFS
8	MA	Yes	2013	Capitated
9	MI	No	2013	Capitated
10	MN	No	2013	DEMO*
11	MO	No	2014	MFFS

* Note: Demo refers to an alternative approach to pursuing an integrated care demonstration outside of the financial alignment model.

State demonstration activity (as of April 8, 2013)

	STATE	SIGNED MOU	TARGET LAUNCH YEAR	MODEL
12	NY	No	2014	Capitated
13	NC	No	2013	MFFS
14	OH	Yes	2013	Capitated
15	OK	No	2013	MFFS
16	OR	No	2014	DEMO*
17	RI	No	2014	Capitated
18	SC	No	2014	Capitated
19	TX	No	2014	Capitated
20	VT	No	2014	Capitated
21	VA	Almost!!	2014	Capitated
22	WA	Yes (for MFFS)	2013 (MFFS) 2014 (Cap)	Both
23	WI	No	2013	DEMO*

* Note: Demo refers to an alternative approach to pursuing an integrated care demonstration outside of the financial alignment model.

Next steps for states

- Five states have signed Memoranda of Understanding with CMS
 - ▶ 2012: Massachusetts and Ohio (capitated); Washington (MFFS)
 - ▶ As of April 2013: Illinois and California (capitated)
- State-based procurement process
 - ▶ California, Massachusetts, Illinois and Ohio have selected potential demonstration plans (pending readiness review)
- Readiness review
 - ▶ Massachusetts in process
 - ▶ California posted tool online
- Three-way state contract between CMS, states and plans
- To access state documents other policy resources:
<http://www.integratedcareresourcecenter.com/icmstateresources.aspx>

Common hurdles in MOU development

- Rates
 - ▶ Risk mitigation
 - ▶ Joint development process
- Benefits
 - ▶ Continuation of supplemental benefits
- Outcome-Based Performance Measures
 - ▶ Combination of Medicare, demonstration “core” and state-specific measures
- Enrollment

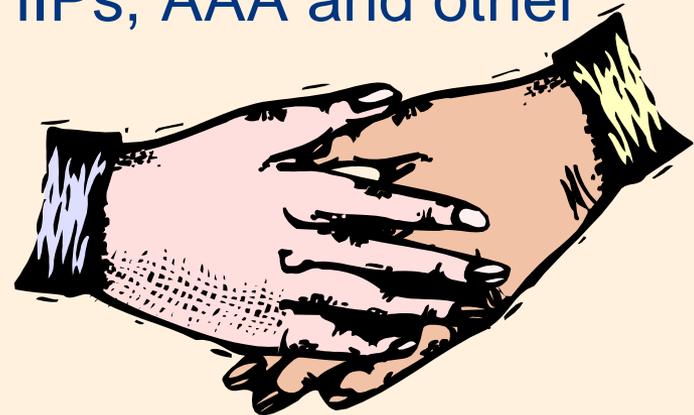


States and CMS are working thoughtfully and carefully to:

- Ensure beneficiary protections guaranteed under the Medicare program
- Include quality standards and rigorous evaluations
- Build on existing relationships between state Medicaid agencies, providers and beneficiaries
- Leverage experience of Medicaid agencies in:
 - ▶ Measuring the quality of services provided by health plans and other entities
 - ▶ Purchasing physical, behavioral, and long-term services and supports

States and CMS are working thoughtfully and carefully to:

- Engage stakeholders at every level in both design and implementation
 - ▶ Public stakeholder meetings and work groups
 - ▶ Opportunities for feedback on proposals, contracts or policies
 - ▶ Several demonstration-specific websites
 - ▶ Multifaceted communications and outreach plans
 - ▶ Coordination with ADRC/SHIPs, AAA and other systems entry points



States and CMS are working thoughtfully and carefully to:

- Incorporate payment strategies that encourage provider participation and offer potential savings for state and federal partners
- Show statistically meaningful results in quality, cost, and utilization measures
 - ▶ RTI will conduct both state-specific analyses; states will also monitor
 - ▶ Data from plan-reported measures, encounter data and qualitative data from site visits, interviews and focus groups



Thank you!



Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

Virginia Updates

Paula Margolis, PhD, Policy & Research Manager
Virginia Department of Medical Assistance Services
Virginia Advisory Committee

April 11, 2013

Virginia's Financial Alignment Demonstration

- Full benefit Medicare-Medicaid Enrollees including:
 - Age 21 and over;
 - Living in Demonstration regions;
 - Elderly or Disabled with Consumer Direction Waiver participants; and
 - Nursing Facility residents.
- Excludes:
 - State MH/MR Facilities;
 - Other waivers;
 - On spend down;
 - Hospice enrollees;
 - ESRD Medicare Benefit, unless already enrolled in Duals MCO;
 - Other comprehensive health coverage;
 - Changed LIS Part D plan January 1, 2014 (CMS requirement; will be eligible January 1, 2015);
 - Money Follows the Person;
 - PACE not passively enrolled but can opt in.

Virginia's Financial Alignment Demonstration

- Services
 - Medicare Benefits (A, B, D);
 - Traditional and community behavioral health services;
 - Person-centered care coordination;
 - Home and community-based waiver services;
 - Nursing facility services

Virginia's Financial Alignment Demonstration

- Program is voluntary; opt in and passive enrollment
- Capitated; at least 2 Managed Care Organizations in each region
- Regional phase-in
- Approximately 78,600 Medicare-Medicaid Enrollees

Region	Nursing Facility	EDCD Wavier	Community Non-waiver	Total
Central VA	4,430	3,762	16,135	24,327
Northern VA	1,935	1,766	12,952	16,653
Tidewater	3,031	2,492	12,575	18,098
Western/ Charlottesville	1,477	842	4,427	6,747
Roanoke	2,833	1,355	8,583	12,771
Total	13,706	10,217	54,672	78,596

Progress to Date

- Developed and submitted the design proposal to CMS.
- Received and incorporated stakeholder feedback into that proposal.
- Held initial Dual Eligible Advisory Workgroup meeting.
- Distributed Medicaid Memo to alert providers of the Demonstration.
- Developed Virginia-specific components of the Model of Care.

Progress to Date

- Submitted 1932(a) State Plan Amendment to CMS (allows for voluntary managed care program).
- Identified and submitted request for MMIS systems changes.
- Interested health plans submitted Medicare applications through CMS' Health Plan Management System (HPMS) on February 21, 2013.
 - Had to submit their Model of Care and preliminary network information by this date.
 - Plan Benefit Packages and formularies will be submitted in the upcoming months.

Activities Underway

- Published the Request for Proposal; proposals due no later than 10:00 am ET on May 15, 2013.
- Created a Care Coordination Office within DMAS to provide full attention to the Demonstration.
- Finalizing CMS/DMAS Memorandum of Understanding (MOU) that defines how specific areas of alignment will be achieved.
- Medicaid rate setting (working with our actuary).
 - Will be reviewed by CMS.

Activities Underway

- Amending the §1915(c) waiver authority for the EDCD Waiver.
- Developing a comprehensive education and outreach plan.
 - Engaging stakeholders and enlisting assistance from national experts to effectively communicate Demonstration;
 - Pursuing grant funding opportunities to help cover education and outreach costs;
 - An Enrollment Facilitator, Ombudsman and other community partners will play a critical role in beneficiary education.

Next Steps: Virginia Demonstration Timeline

Date	High Level Activity
April	<ul style="list-style-type: none">-Sign MOU with CMS-Begin development of readiness review documents-Develop education and outreach plan-Draft base Medicaid expenditure data book
May	<ul style="list-style-type: none">-Proposals due from MCOs (mid-month)-Release data book
June	<ul style="list-style-type: none">-Announce selected MCOs-Publish draft Medicaid rates
July	<ul style="list-style-type: none">-Submit outreach and planning grant to CMS-Finalize Medicaid portion of the rates-Begin readiness reviews-Draft 3-way contract
August	<ul style="list-style-type: none">-Continue readiness reviews

Next Steps: Virginia Demonstration Timeline

Month	High Level Activity
September	<ul style="list-style-type: none">-Finalize Medicaid capitation rates-Sign 3-way Contract
October	<ul style="list-style-type: none">-Begin Education and Outreach BLITZ (ongoing)
November-December	<ul style="list-style-type: none">-Continue to prepare for implementation
January 2014	<ul style="list-style-type: none">-Opt-in enrollment begins in Central and Tidewater regions
May 2014	<ul style="list-style-type: none">-Passive enrollment begins in Central and Tidewater regions-Opt-in enrollment begins in Western/Charlottesville, Northern Virginia, and Roanoke regions
August 2014	<ul style="list-style-type: none">-Passive enrollment begins in Western/Charlottesville, Northern Virginia, and Roanoke regions



Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

Virginia's Request for Proposals (RFP)

Suzanne Gore, Senior Executive Advisor
Virginia Department of Medical Assistance Services
Virginia Advisory Committee

April 11, 2013

Virginia's Financial Alignment Demonstration RFP

- DMAS Released the RFP on April 10, 2013.
 - http://www.dmas.virginia.gov/Content_pgs/alte-enrl.aspx

(Originally released as a RFA on April 5th; adjusted to a RFP and re-issued on April 10th to ensure eVA access)
- Minimum of 2 Managed Care Organizations in each region.
 - Prospective plans must apply for all eligible individuals in all localities within the region(s) in which they apply (exception applies in Tidewater region).

Applicants' Past Performance

- Plans' past performance is critical:
 - Will not consider a plan if it is under a Medicare enrollment and/or marketing sanction.
 - For Applicants with Medicare experience, will consider whether CMS has designated plan as a past performance outlier or “consistently low performing” in the previous 3 years.
 - For Applicants with Medicaid experience, will consider Medicaid sanctions during the past 3 years or any areas in which a corrective action plan was required.

Select RFP Requirements

- Model of Care (MOC);
- Quality Ratings, Quality Assurance and Evaluation;
- Relevant Experience;
- Network Composition;
- Access to Care Standards;
- Understanding of Covered Services;
- Nursing Facility Services;
- Consumer-Directed Fiscal/Employer Agent (F/EA) Services; and,
- Integrated Health Home Systems of Care.

Vignettes

- There are five vignettes included in the RFP.
- Written requirement:
 - Plans need to describe how they would apply their MOC to provide services and supports to individuals depicted in the vignettes.
 - Timeframe addressed should begin at initial enrollment and include the next 18 months.
- Presentations:
 - In-person presentations on the vignettes will be required.
 - 1-hour long presentations on a minimum of 2 of the vignettes.

Application Evaluation Criteria

- Applications will be reviewed for network adequacy for Medicaid services.
- Plans must demonstrate the capacity to meet all financial, management, and administrative capabilities outlined in the RFP.

Broad Criteria for Evaluating Applications

Criteria	Weight
Response to Model of Care Including Virginia-specific requirements	25%
Quality (Medicare and/or Medicaid)	20%
Demonstrated Understanding of Virginia's Medicare-Medicaid Enrollees and Provider Systems (including integrated health homes, nursing facilities, consumer-directed service delivery model)	20%
Experience with Population	15%
Past Plan Performance (including references, poor performance, sanctions, and unsatisfactory resolution of requested corrective action plans)	15%
Response to Vignettes (including written responses and in-person presentations)	5%

RFP Timeline

- Questions due to DMAS no later than 5:00 pm on April 19, 2013.
- Applications due no later than 10:00 am on May 15, 2013.



Medicare-Medicaid Financial Alignment Demonstration:

Memorandum of Understanding between CMS and DMAS

Karen Kimsey, Deputy Director of Complex Care and Services
Virginia Department of Medical Assistance Services
Medicare-Medicaid Financial Alignment Demonstration
Advisory Committee Meeting
April 11, 2013

Overview

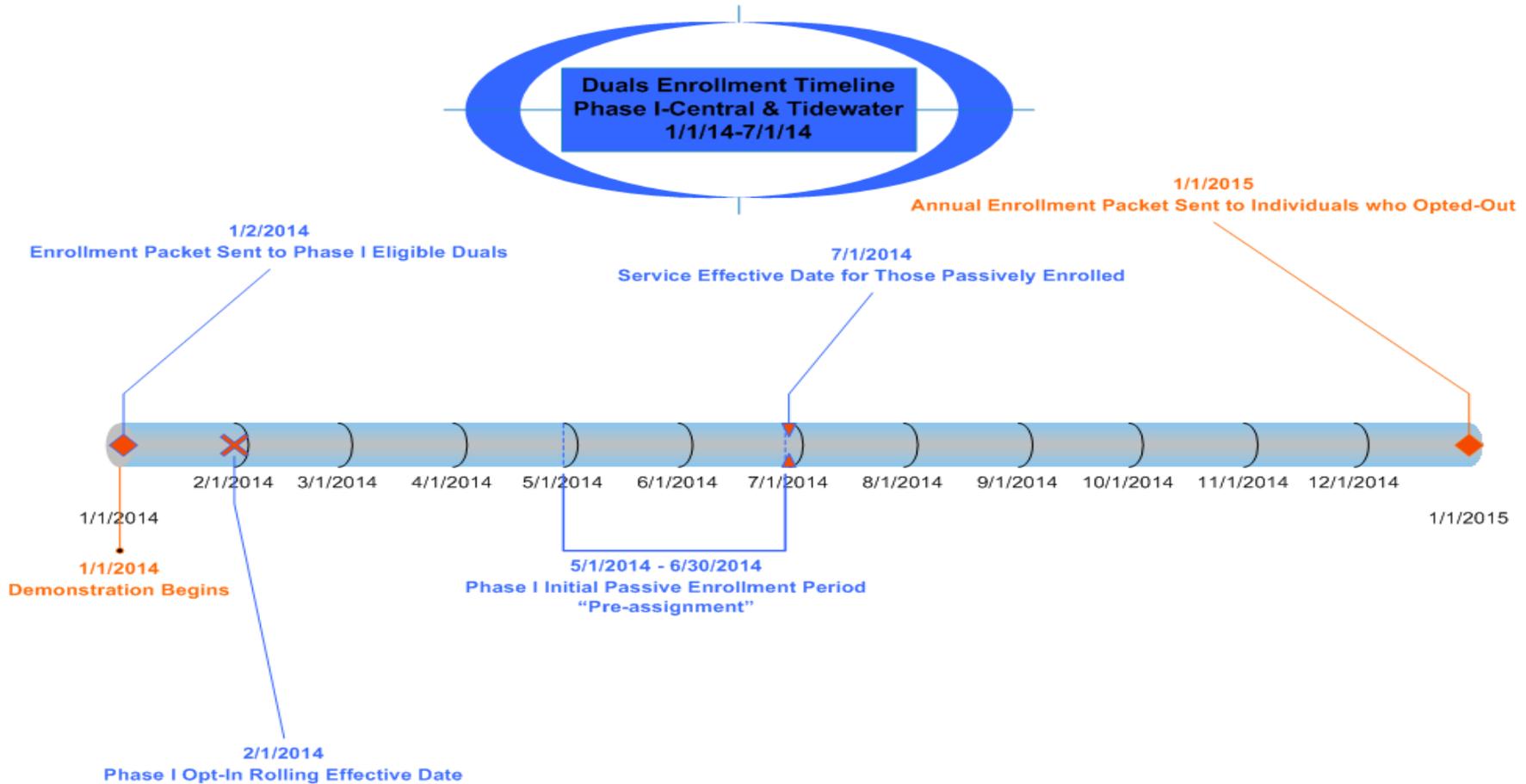


- CMS requires that states sign an MOU with CMS, in order to operate the Financial Alignment Demonstration (FAD).
- The MOU:
 - Specifies specific terms and conditions under which the FAD will operate in the state;
 - Specifies how Medicare and Medicaid will be aligned;
 - Signifies that a state is accepted into the FAD.
- To date, five states have signed an MOU:
 - Massachusetts (capitated model)
 - Ohio (capitated model)
 - Illinois (capitated model)
 - California (capitated model)
 - Washington State (managed fee-for-service model)

Overview of MOU Sections

- Eligible Populations
- Enrollment and Disenrollment Process and Timeframes:
 - Opt-in only period;
 - Passive enrollment;
 - Two enrollment phases, based on regions.

Proposed Enrollment Timeline- Phase I



Note

Passive Enrollment: After the initial pre-assignment period, any newly eligible individual will be placed in pre-assignment on a monthly basis. Those who are included in pre-assignment will be eligible the 1st day of the 2nd month after pre-assignment.

Opt-In Enrollment: After the first Opt-In effective date, those who opt-in prior to 5 days before the end of the month will be eligible for services the 1st day of the following month.

MOU Sections

- Beneficiary Protections:
 - Choice of plans and providers;
 - Continuity of care;
 - Enrollment assistance;
 - Ombudsman;
 - Person-Centered approach;
 - ADA, Civil Rights compliance;
 - Beneficiary participation on MCO governing boards;
 - Customer service;
 - DMAS/CMS day-to-day monitoring and oversight.

MOU Sections

- Quality Management:
 - Performance measures to ensure high quality of care;
 - Monitor opt-outs, grievances, etc.
 - External quality reviews;
 - External evaluation.
- Financing and Payment:
 - Blended capitation rates – CMS actuary reviews Medicaid base data and rates;
 - Savings adjustment;
 - Quality performance withholds;
 - Risk adjustment.

MOU Sections

- Delivery System Requirements:
 - MCOs use predictive modeling to identify vulnerable populations;
 - Each enrollee has a health risk assessment;
 - Individualized care plans;
 - Care management;
 - Network adequacy;
 - Timely access to services;
 - Covered benefits;
 - Model of care;
 - Integrated appeals - resolution timeframes;
 - Call centers;

Proposed Assessment and Plan of Care Expectations

	Implementation Health Risk Assessment (at program launch)	Implementation of MCO Plan of Care (at program launch)	Initial Health Risk Assessment (for new enrollees after program launch)	Initial Plan of Care (for new enrollees after program launch)	Reassessment and POC Review	As Needed POC Revised	Level of Care Annual Reassessment
Community Well	Within 90 days of plan enrollment	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.)	Within 60 days of enrollment	Within 90 days of enrollment	By POC anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
Vulnerable Subpopulation (Excluding EDCD & nursing facility)	Within 60 days of plan enrollment	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.)	Within 60 days of enrollment	Within 60 days of enrollment	By POC anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
EDCD Vulnerable Subpop	Within 60 days of plan enrollment (must be face-to-face)	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.) The POC must be developed and implemented by the MCO no later than the end date of any existing PA.	Within 30 days of enrollment (must be face-to-face)	Within 30 days of enrollment	By POC anniversary date, not to exceed 365 days (must be face-to-face)	Upon triggering event such as a hospitalization or significant change in health or functional status	Plan conducts annual face to face assessment (functional) for continued eligibility for the EDCD Waiver.
Nursing Facility Vulnerable Subpop	Within 60 days of plan enrollment (must be face-to-face and incorporate MDS)	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.)	Within 60 days of enrollment (must be face-to-face)	Within 60 days of enrollment	Follow MDS guidelines/time frames for quarterly and annual POC development	Upon triggering event such as a hospitalization or significant change in health or functional status	Plan works with facility on annual assessment (functional) for continued nursing facility placement.

MOU Sections

- Delivery System Requirements:
 - Transition requirements;
 - MCO solvency requirements;
- Benefits
- Marketing and outreach
- Continuity of Care
- Oversight framework:
 - Contract management framework;
 - Reporting, e.g.,
 - Utilization
 - Encounter data
 - 1915c waiver
 - Enrollment/disenrollment rates, etc.

Outstanding Items

- Items to be finalized:
 - Savings adjustment (pending data analysis by CMS);
 - Performance measures and quality withholds.
- Seeking advisory committee recommendation:
 - What do you think is the most important LTC issue to measure?
 - Challenge may be finding the balance in what we *want* to measure vs. the feasibility of standardizing that measure.

Your Feedback on Quality Measures

Domain	Potential Measure for Year 1	Should we Add an Enhanced Measure for Year 2?
1. Assessments	Percent of Enrollees with initial assessments completed within required timeframes, per Virginia's Model of Care requirements.	
2. Plans of Care	Percent of Enrollees with Plans of Care developed within specified timeframes	
3. Adjudicated Claims	Percent of adjudicated claims submitted to Participating Plans that were paid within the timely filing requirements.	
4. Hospital and Nursing Facility Transitions	Participating Plan has established work plan and systems in place for ensuring smooth transitions to and from hospitals, nursing facilities, and the community.	
5. Severe Mental Illness (SMI)	Recovery-oriented measures for persons with SMI receiving Mental Health Services (e.g., criminal involvement, employment status).	



Medicare-Medicaid Financial Alignment Demonstration:

Education and Outreach

Kristin Burhop & Karen Kimsey
Virginia Department of Medical Assistance Services
Medicare-Medicaid Financial Alignment Demonstration
Advisory Committee Meeting
April 11, 2013

Outreach and Education

- Outreach and education is vital to better care for beneficiaries and therefore program success
- Overview of Communication Workgroup Meeting
 - Representation
 - Work plan
 - Next steps
 - Join the workgroup! (kristin.burhop@governor.virginia.gov)
- Funding opportunity to support ADRC/SHIP outreach to Medicare-Medicaid enrollees after signing MOUs with CMS

Your Thoughts on Outreach

- Identifying internal and external stakeholders
 - Beneficiaries and family/representatives
 - Providers
 - Advocacy groups
 - Community social organizations
 - Sister agencies
 - Contractors
 - Local programs
- Modes and venues to reach stakeholders

Your Thoughts on a Logo

