



Virginia Advisory Committee*

Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

**July 31, 2013, from 1:30 to 3:30 pm
House Room D of the General Assembly Building
Richmond, VA 23218**

Meeting 3

I. Welcome and Introductions	Cindi Jones Director, Virginia Department of Medical Assistance Services (DMAS)	1:30 pm
II. National Updates	Sarah Barth Director, Long Term Services, CHCS	1:40 pm
III. Virginia Updates A. MOU B. Rates	Emily Carr Director of Virginia Office of Coordinated Care, DMAS Bill Lessard Director of Provider Reimbursement, DMAS	2:10 pm
IV. Committee Member Focus Session 1: <i>Health Plan Procurement, Readiness Review, 3-way Contract</i> A. Health Plan Procurement: Update B. Readiness Review: Status and timeline C. 3-way Contract: Status and timeline	Karen Kimsey Deputy Director, Complex Care and Services, DMAS	2:40 pm
V. Committee Member Focus Session 2: <i>Education and Outreach</i> A. Communications Activities: Presentations, toolkit materials, website, and trainings B. Outreach	Kristin Burhop Complex Care and Services Advisor, DMAS	3:00 pm
VI. Wrap Up and Next Steps	Cindi Jones	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 CCC@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 (Marci 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

July 31, 2013

Sarah Barth, JD



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



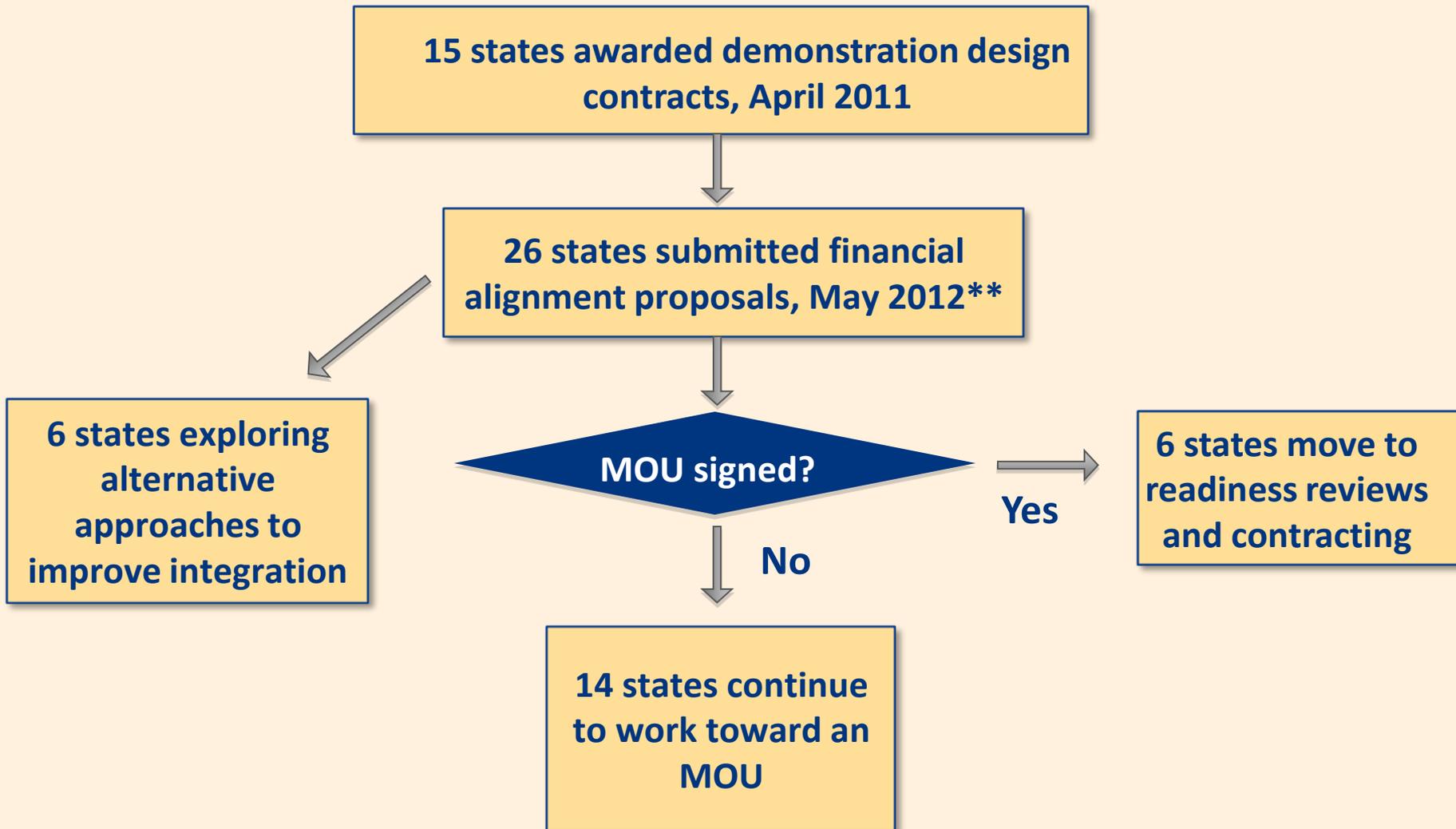
What is Integrated Care?

- ▶ Creates one accountable entity to coordinate delivery of primary/preventive, acute, behavioral, and long-term services and supports
- ▶ Blends/aligns services and financing to streamline care, reduces inefficiencies and eliminates cost shifting
- ▶ Promotes the use of home- and community-based services and improvements in quality of life and health outcomes
- ▶ Provides high-quality, person-centered care

Section 2602 of the Affordable Care Act created the Medicare-Medicaid Coordination Office and new opportunities to advance integration



States are Testing Innovative Integrated Financing and Delivery Models*



Financial Alignment Models

Capitated

CA, ID, IL, MA, MI, NY, OH, RI,
SC, TX, VT, VA, WA*

- Joint procurement of high-performing health plans
- Three-way contract: CMS, state, health plan
- Single set of rules for marketing, appeals, etc.
- Blended payment, built-in savings
- Voluntary, passive enrollment with opt-out provisions

Managed Fee-For-Service (MFFS)

CO, CT, IA, MO, NC, OK, WA*

- FFS providers, including Medicaid health homes or accountable care organizations
- Seamless access to necessary services
- Quality thresholds and savings targets

State Demonstration Activity (as of July 31, 2013)

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

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

State Demonstration Activity (as of July 31, 2013)

	STATE	CMMI CONTRACT?	TARGET LAUNCH YEAR	MODEL
12	NC	Yes	2013	MFFS
13	OH	No	2013	Capitated
14	OK	Yes	2013	MFFS
15	OR	Yes	2014	DEMO*
16	RI	No	2014	Capitated
17	SC	Yes	2014	Capitated
18	TX	No	2014	Capitated
19	VT	Yes	2014	Capitated
20	VA	No	2014	Capitated
21	WA	Yes	2013 (MFFS) 2014 (Cap)	Both
22	WI	Yes	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

- ▶ Six states have signed Memoranda of Understanding (MOU) with CMS: MA, WA, OH, IL, CA, VA
- ▶ Key decision points in MOU and contract development:
 - ▶ Rates, Benefits, Performance measures, Enrollment
- ▶ State-based procurements
 - ▶ Health plans selected in CA, MA, IL, OH, and WA (cap. model)
- ▶ Final step before “going live” for capitated states: 3-way contract between CMS, states and plans
 - ▶ MA first state; others with MOUs are in the wings
- ▶ Enrollment of dual eligible beneficiaries
 - ▶ Late 2013 and 2014
 - ▶ Generally phased in, with voluntary opt-in period then passive enrollment with monthly opt-out option

Health Plans Selected by States

(as of 7/2013)

State	Health Plans
California	Alameda Alliance for Health, Anthem Blue Cross, CalOptima, Care 1 st , Care More, Community Health Group, Health Net, Health Plan of San Mateo, Inland Empire Health Plan, Kaiser, L.A. Care, Molina Health Care, Santa Clara Family Health Plan, SCAN
Massachusetts	Commonwealth Care Alliance, Fallon Total Care, Network Health
Illinois	Aetna, BlueCross/Blue Shield, IlliniCare (Centene), Meridian, Molina, Health Alliance, HealthSpring, Humana,
Ohio	Aetna, Buckeye (Centene), CareSource, Molina, United
Washington (capitated model)	United, Regence BlueShield

State Approaches to Medicare-Medicaid Integration

APPROACH	STATE
Developing nuanced payment and financing methodologies	MA*, OH*, IL*, CA*, VA*
Designing targeted interventions to identify high-risk individuals through linked data systems	WA*, MO
Establishing new care coordination bridges across services	MI, SC
Requires plans to contract with community supports	MA*, OH*
Engage key stakeholders throughout design and implementation processes	CA*, VA*
Developed readiness review standards that address a continuum of acute, BH and LTSS needs	MA*, CA*

***Signed MOU with CMS**

NOTE: Several states have developed many approaches listed above; this list provides examples of a few in each.

States and CMS are Working Together to:

- ▶ Engage stakeholders at every level in design and implementation
- ▶ Develop readiness review standards (e.g., OH)
- ▶ Ensure beneficiary protections under Medicare
- ▶ Include quality standards and rigorous evaluations
- ▶ Build on existing relationships between state Medicaid agencies, providers, and beneficiaries
- ▶ Incorporate payment strategies to encourage provider participation and offer potential savings for state and federal partners





Thank you!



Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

Virginia Update

Emily Carr, Director of the Office of Coordinated Care
Virginia Department of Medical Assistance Services
Virginia Advisory Committee
July 31, 2013

Commonwealth Coordinated Care

Goals of the CCC program

Improve Access
to Care

Promote
Person-Centered
Planning

Promote
Independence in
Community

Right Care
Right Time
Right Place

Cost Savings for
State and Federal
Government

Signed MOU



- In May Virginia became the 6th state with a signed MOU
 - Massachusetts (capitated model)
 - Ohio (capitated model)
 - Illinois (capitated model)
 - California (capitated model)
 - Washington State (managed fee-for-service model)

- Purpose of MOU:
 - Principles for CMS and DMAS to implement and operate the CCC program
 - Activities CMS and DMAS will conduct in preparation for implementation
 - Signifies that a state is accepted into the Demonstration

Virginia MOU Sections

- Demonstration Authority
- Contracting Process
- Enrollment and Disenrollment Process
- Delivery Systems
- Beneficiary Protections
- Appeals and Grievances
- Reporting
- Quality Management
- Financing and Payment
- Evaluation
- Additional terms and appendices

Stakeholder Input and Support

- Requests put in the MOU
 - Use of behavioral health homes for SMI population
 - Emphasis on transitions between settings of care
 - Waived Skilled Medicare hospital stay
 - Followed Medicaid rules for Telehealth
 - Required standard fiscal agent for consumer directed services
 - Required Plans to describe how they will reimburse nursing facilities; minimize administrative burdens

Virginia MOU Highlights

- Focus on consumer engagement;
 - Public meetings
 - Monitoring both individual and provider experiences
 - Surveys
 - Focus groups
 - Website updates
 - Data analysis
- Savings percentage applied
 - Savings in year 3 will be reduced to 3% if 1/3 of plans experience losses exceeding 3% of revenue in all regions in which those plans participate in year 1

Virginia MOU Highlights

- Plans shall have
 - Beneficiary input process
 - Systems for monitoring quality of services and care
 - Beneficiary input on governing boards that represent diversity of population
- 3/4 year demonstration January 2014- December 2017
- Financing and Payment
 - Sophisticated risk adjustment model (4 categories)
 - Based on age, under/ over 65
 - Residence based in nursing facility or community

Public comments on Demonstration

- Will see administrative simplification and service efficiencies through; unifying licensure, oversight and administrative processes
- DMAS and MCOs should offer opportunities to providers to engage
- Pleased to see inclusion of behavioral health homes, hope they are co-located within or near CSBs
- Strategies should be developed for education regarding long term services and supports

Public comments continued

- Recommend the use of medical nutrition therapy services through referrals to registered dietitians
- Encourage plans to provide education and access to oral health
- Support integration of primary and behavioral health to reduce silos, clinicians need experience in working with serious mental illness
- Proceed cautiously so that neither beneficiary access nor provider viability is compromised

Achievements and Progress

- Received approval for 1932(a) State Plan Amendment to CMS (allows for voluntary managed care program)
- Savings adjustments
- MMIS systems changes in progress 39% complete
- Update on procurement process
- Rate setting
- Guidance documents
 - Marketing
 - Enrollment
 - Reporting

Activities Underway

- Meeting weekly with Outreach and Education workgroup
- Hire staff for Office of Coordinated Care within DMAS to provide full attention to the CCC program
- Finalize Three Way contract in the fall with input from stakeholders
- Continue to develop evaluation program with beneficiary and stakeholder input and partnership with GMU
- Participate in CHCS initiative, INSIDE (Implementing New Systems of Integration for Dual Eligibles)

Activities Underway

- Continue discussion of topics that need to be operationally defined prior to launch (e.g. Patient pay)
- DARS submitted grant application for options counseling for VICAP; submitting application for ombudsman funding
- Continue comprehensive education and outreach plan, engaging stakeholders and enlisting assistance from national experts
- Weekly calls with CMS

Next Steps:

Virginia Demonstration Timeline

Date	High Level Activity
July	<ul style="list-style-type: none">-Continue negotiations regarding VICAP grant funding with CMS-Finalize readiness review documents-Release Medicaid portion of the rates-Begin readiness reviews-Begin draft 3-way contract-Enter into negotiations with selected health plans
August	<ul style="list-style-type: none">-Continue readiness reviews-Continue resolution of outstanding operational issues-Release Medicare portion of the rates-Continue working with CMS; marketing, contract, quality
September	<ul style="list-style-type: none">-Finalize negotiations and post intent to award for selected health plans-Finalize Medicare and Medicaid rates-Sign 3-way Contract
October	<ul style="list-style-type: none">-Begin Education and Outreach BLITZ (ongoing)

Next Steps: Virginia Demonstration Timeline

Month	High Level Activity
November-December	-Continue to prepare for implementation
January 2014	-Opt-in enrollment begins in Central and Tidewater regions
May 2014	-Passive enrollment begins in Central and Tidewater regions -Opt-in enrollment begins in Western/Charlottesville, Northern Virginia, and Roanoke regions
August 2014	-Passive enrollment begins in Western/Charlottesville, Northern Virginia, and Roanoke regions



Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

Rates

William Lessard, Director of Provider Reimbursement
Virginia Department of Medical Assistance Services
Virginia Advisory Committee
July 31, 2013

Medicaid Rate Setting Responsibilities

- DMAS is responsible for developing the Medicaid capitation rate component
- PWC is the DMAS contract actuary and will issue a qualified actuarial certification of the rates consistent with 42 CFR 438.6(c)
- CMS oversight of the rate setting process
- Milliman is the CMS contract actuary
 - Validate the estimate of projected Medicaid costs
 - Issue a rate report with Medicare and Medicaid rates

FFS Equivalent Rate Methodology

- Based on DMAS FFS and administrative costs pre-demonstration
 - What DMAS would have spent
 - No explicit administrative load or non-FFS costs
- Adjusted for program changes
- Trended to the rate year
- Net of demonstration savings in Memorandum of Understanding between CMS and DMAS
 - 1% CY14 and CY15 (Demonstration Year One)
 - 2% CY16 (Demonstration Year Two)
 - 4% CY17 (Demonstration Year Three)

Demonstration Savings

- Savings applied equally across the Medicaid and Medicare rate components (except Part D)
- Actual savings expected to be greater on Medicare services
 - Reduced hospitalization (Medicare primary payer)
 - Reduced nursing facility utilization (Medicaid primary payer)
- Possible savings modification if Part D spending results in materially higher or lower savings
- CY17 savings could be reduced to 3% if one-third of plans experience losses in CY14-CY15
- Will monitor plans with MLRs less than 90%

Rate Cells

- Over and Under Age 65
- Regions
 - Phase One-Central Virginia and Tidewater/Eastern Shore
 - Phase Two-Northern Virginia, Southwest/Roanoke, Western/Charlottesville
- Community Well and Nursing Home Eligible (NHE)
- NHE is a “blend” of NHE-Institutional (after 20 days) and NHE-Waiver
 - Blended NHE rate to incentivize plans to shift members from institutional to home and community based care
 - Will also pay NHE rate for two additional months if member shifts to community well

Risk Adjustment

- In general, the rating categories (rate cells) group members with similar costs
- DMAS will make an annual retroactive Member Enrollment Mix Adjustment to reflect differential enrollment experience and changes in population trends for the NHE-Institutional and NHE-Waiver rate subcomponents



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Committee Member Focus Session 1

Karen Kimsey, Deputy Director of Complex Care and Services
Virginia Department of Medical Assistance Services
Medicare-Medicaid Financial Alignment Demonstration
Advisory Committee Meeting
July 31, 2013

Overview

- Procurement Process- timeline
- Readiness Review- sections, communication with plans, process, timeline
- 3-way Contract- process, sections, timeline, Advisory Committee input

Duals RFP Procurement Process

- Governed by the Virginia Public Procurement Act (VPPA)
- Virginia has entered into negotiations with three Medicare/Medicaid plans (MMPs)
- Negotiation process will last a few months and will include Readiness Review and Rates
- Finalize negotiations and post Intent to Award in the fall

Readiness Review

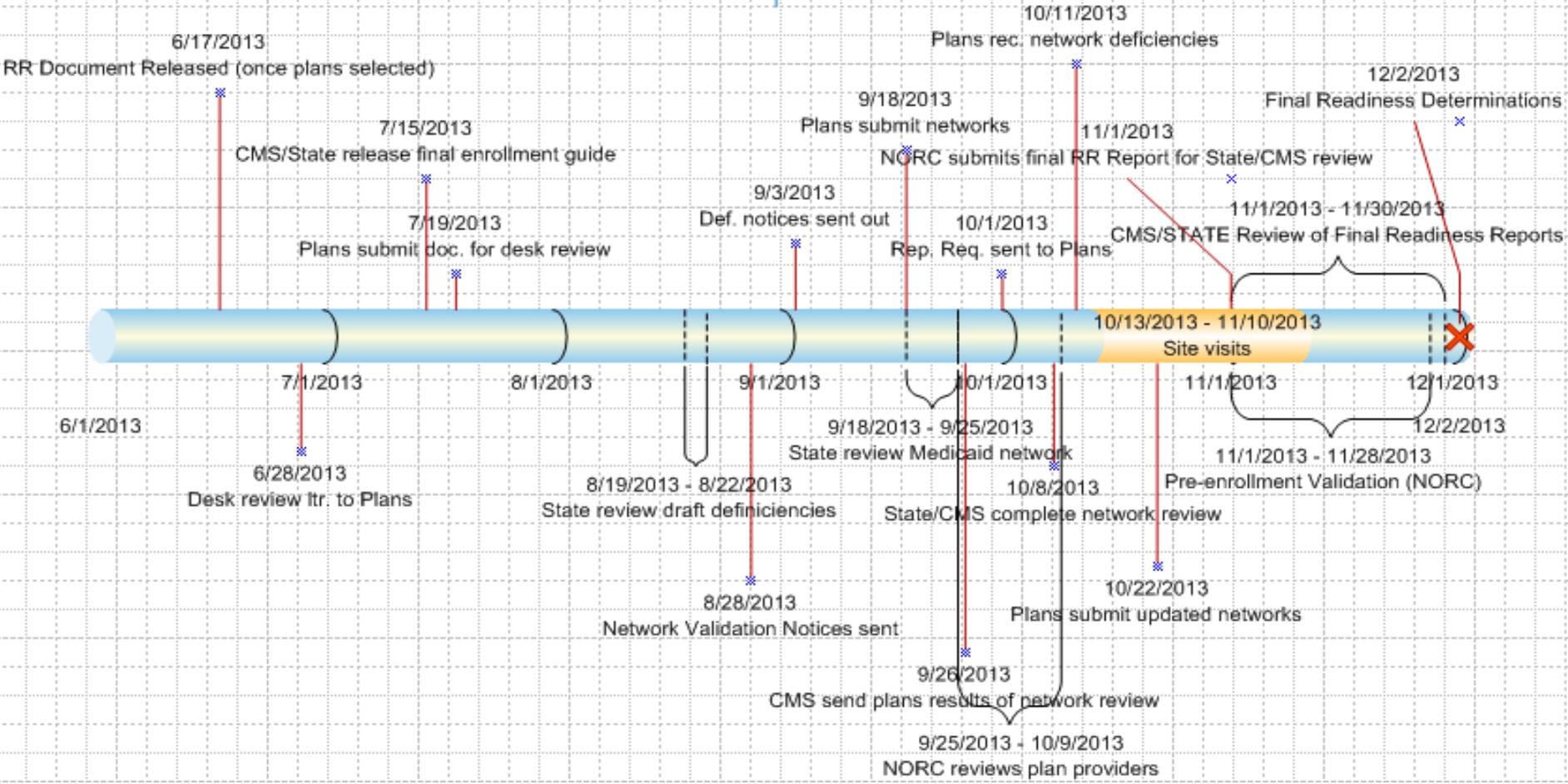
- Desk and on site reviews conducted by CMS Contractor
- Areas of review include
 - *Transition to New MMP and Continuity of Care*
 - *Assessment*
 - *Care Management and Interdisciplinary Care Team*
 - *Plan of Care/ Service Plan*
 - *Self- Directed Services; Consumer Direction*
 - *Coordination of Services*
 - *Transitions Between Care Settings*
 - *Confidentiality*

Readiness Review Cont'd

- Areas of review include
 - *Enrollee and Provider Communications*
 - *Enrollee Rights*
 - *Call Center support*
 - *Appeals and Grievances*
 - *Enrollee Choice of PCP*
 - *Organizational Structure and Staffing including staff training*
 - *Performance and quality improvement*
 - *Provider network; accessibility, provider training, adequacy standards*

Readiness Review Timeline

Readiness Review Timeline CCC Program



3-Way Contract Overview

- The Financial Alignment Demonstration requires a 3-way contract by CMS, DMAS and the MMPs in the Commonwealth Coordinated Care program
- Sets the terms and conditions for the Demonstration
- Details regarding participating plans responsibilities
- Includes submission of application, adherence to annual contract renewal requirements and guidance updates
- Outlines CMS and DMAS responsibilities

Contract Timeline

- Draft template shared with DMAS; DMAS and CMS begin contract discussions in July
- Initial federal review period (by legal counsel and entities): August
- State final review period: August -September
- Final federal review: September
- CMS send final contract to plans and state for signature: October
- Plans and State sign contracts: November

3-Way Contract

- Sections include:

- Enrollment
- Compliance
- Covered Services
- Care Delivery Model
- Grievances and Appeals
- Networks
- Access to services
- Quality Improvement
- Payment and Financial

Seeking Advisory Committee Input

- CMS/DMAS current negotiation process
- Massachusetts 3-Way Contract recently posted: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf>
- Please review Massachusetts Contract and provide input to DMAS on contract language; comments due by August 7, 2013
- Other stakeholders beyond Committee are welcome to comment
- Send comments to email (ccc@dmass.virginia.gov)



Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

Education and Outreach

Kristin Burhop, Complex Care and Services Advisor
Virginia Department of Medical Assistance Services
Advisory Committee Meeting
July 31, 2013

Overview

- Branding of Commonwealth Coordinated Care
- Outreach and Education Team
- Outreach and Education materials
- Outreach activities
- Your thoughts

Outreach and Education

- Outreach and Education is a key component in the success of the Duals Demonstration
- Branding of the Demonstration
 - New Name: Commonwealth Coordinated Care
 - New Logo:



Outreach and Education

- Outreach and Education workgroup meets weekly
- Representation from:
 - DMAS
 - DBHDS
 - DSS
 - VBPD
 - VDDHH
 - DBVI
 - DARS
 - CIAC
 - Senior Medicare Patrol
 - Self-advocate

Outreach and Education

- Outreach materials currently under development include:
 - Master PowerPoint
 - Fact Sheet
 - Webinar
 - Improved website
 - Toolkit that includes: Fact sheet, Map of Demonstration regions, FAQs, Plan options brochure
 - “Faces of Duals” document

Outreach and Education

- Current Outreach activities:
 - Presentations, conference calls and meetings with stakeholder groups
 - Daily responses to CCC mailbox
- Future Outreach activities:
 - Trainings to VICAP Counselors and Ombudsman
 - Continued presentations, conference calls and meetings with stakeholder groups

Your Thoughts on Outreach

- Who should we be reaching out to?
- What additional materials should we develop for our outreach?