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        | Emily Carr 
Director of Virginia Office of Coordinated Care, DMAS  
Bill Lessard 
Director of Provider Reimbursement, DMAS | 2:10 pm |
| A. MOU                       |                                                 |         |
| B. Rates                     |                                                 |         |
| IV. Committee Member Focus Session 1: |                 
*Health Plan Procurement, Readiness Review, 3-way Contract*  
Karen Kimsey  
Deputy Director, Complex Care and Services, DMAS | 2:40 pm |
| A. Health Plan Procurement: Update |                                 |         |
| B. Readiness Review: Status and timeline |                                 |         |
| C. 3-way Contract: Status and timeline |                                 |         |
| V. Committee Member Focus Session 2: |                 
*Education and Outreach*  
Kristin Burhop  
Complex Care and Services Advisor, DMAS | 3:00 pm |
| A. Communications Activities: Presentations, toolkit materials, website, and trainings |                                 |         |
| B. Outreach                  |                                                 |         |
| 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 Phillipo)
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*

- **15 states awarded demonstration design contracts, April 2011**
  - **26 states submitted financial alignment proposals, May 2012**
    - **6 states exploring alternative approaches to improve integration**
      - MOU signed?
        - Yes: 6 states move to readiness reviews and contracting
        - No:
          - **14 states continue to work toward an MOU**

* As of July 2013
** Includes all 15 states awarded a demonstration design contract
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

* As of June, 2013
## State Demonstration Activity (as of July 31, 2013)

<table>
<thead>
<tr>
<th>State</th>
<th>CMMI Contract?</th>
<th>Target Launch Year</th>
<th>Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>2013</td>
<td>Capitated</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td>2013</td>
<td>MFFS</td>
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<tr>
<td>3</td>
<td>Yes</td>
<td>2014</td>
<td>MFFS</td>
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<td>4</td>
<td>No</td>
<td>2014</td>
<td>Capitated</td>
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<tr>
<td>5</td>
<td>No</td>
<td>2013</td>
<td>Capitated</td>
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<tr>
<td>6</td>
<td>No</td>
<td>2013</td>
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<td>7</td>
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<tr>
<td>8</td>
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<td>2014</td>
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<tr>
<td>9</td>
<td>Yes</td>
<td>2013</td>
<td>DEMO*</td>
</tr>
<tr>
<td>10</td>
<td>No</td>
<td>2014</td>
<td>MFFS</td>
</tr>
<tr>
<td>11</td>
<td>Yes</td>
<td>2014</td>
<td>Capitated</td>
</tr>
</tbody>
</table>

* 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)

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<th>CMMI Contract?</th>
<th>Target Launch Year</th>
<th>Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>NC</td>
<td>Yes</td>
<td>2013</td>
<td>MFFS</td>
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<tr>
<td>OH</td>
<td>No</td>
<td>2013</td>
<td>Capitated</td>
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<tr>
<td>OK</td>
<td>Yes</td>
<td>2013</td>
<td>MFFS</td>
</tr>
<tr>
<td>OR</td>
<td>Yes</td>
<td>2014</td>
<td>DEMO*</td>
</tr>
<tr>
<td>RI</td>
<td>No</td>
<td>2014</td>
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<tr>
<td>SC</td>
<td>Yes</td>
<td>2014</td>
<td>Capitated</td>
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<tr>
<td>TX</td>
<td>No</td>
<td>2014</td>
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<td>VT</td>
<td>Yes</td>
<td>2014</td>
<td>Capitated</td>
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<tr>
<td>VA</td>
<td>No</td>
<td>2014</td>
<td>Capitated</td>
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<tr>
<td>WA</td>
<td>Yes</td>
<td>2013 (MFFS) 2014 (Cap)</td>
<td>Both</td>
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<tr>
<td>WI</td>
<td>Yes</td>
<td>2013</td>
<td>DEMO*</td>
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</tbody>
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* 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)

<table>
<thead>
<tr>
<th>State</th>
<th>Health Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Alameda Alliance for Health, Anthem Blue Cross, CalOptima, Care 1&lt;sup&gt;st&lt;/sup&gt;, 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</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Commonwealth Care Alliance, Fallon Total Care, Network Health</td>
</tr>
<tr>
<td>Illinois</td>
<td>Aetna, BlueCross/Blue Shield, IlliniCare (Centene), Meridian, Molina, Health Alliance, HealthSpring, Humana,</td>
</tr>
<tr>
<td>Ohio</td>
<td>Aetna, Buckeye (Centene), CareSource, Molina, United</td>
</tr>
<tr>
<td>Washington (capitated model)</td>
<td>United, Regence BlueShield</td>
</tr>
</tbody>
</table>
# State Approaches to Medicare-Medicaid Integration

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

*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

http://dmasva.dmas.virginia.gov
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
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 dieticians
- 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

<table>
<thead>
<tr>
<th>Date</th>
<th>High Level Activity</th>
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<tbody>
<tr>
<td>July</td>
<td>- Continue negotiations regarding VICAP grant funding with CMS</td>
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<td></td>
<td>- Finalize readiness review documents</td>
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<td>- Release Medicaid portion of the rates</td>
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<tr>
<td></td>
<td>- Begin readiness reviews</td>
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<td></td>
<td>- Begin draft 3-way contract</td>
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<td></td>
<td>- Enter into negotiations with selected health plans</td>
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<tr>
<td>August</td>
<td>- Continue readiness reviews</td>
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<tr>
<td></td>
<td>- Continue resolution of outstanding operational issues</td>
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<tr>
<td></td>
<td>- Release Medicare portion of the rates</td>
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<tr>
<td></td>
<td>- Continue working with CMS; marketing, contract, quality</td>
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<tr>
<td>September</td>
<td>- Finalize negotiations and post intent to award for selected health plans</td>
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<tr>
<td></td>
<td>- Finalize Medicare and Medicaid rates</td>
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<tr>
<td></td>
<td>- Sign 3-way Contract</td>
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<tr>
<td>October</td>
<td>- Begin Education and Outreach BLITZ (ongoing)</td>
</tr>
<tr>
<td>Month</td>
<td>High Level Activity</td>
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<tr>
<td>November-December</td>
<td>-Continue to prepare for implementation</td>
</tr>
<tr>
<td>January 2014</td>
<td>-Opt-in enrollment begins in Central and Tidewater regions</td>
</tr>
<tr>
<td>May 2014</td>
<td>-Passive enrollment begins in Central and Tidewater regions</td>
</tr>
<tr>
<td></td>
<td>-Opt-in enrollment begins in Western/Charlottesville, Northern Virginia, and Roanoke regions</td>
</tr>
<tr>
<td>August 2014</td>
<td>-Passive enrollment begins in Western/Charlottesville, Northern Virginia, and Roanoke regions</td>
</tr>
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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

http://dmasva.dmas.virginia.gov
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.
Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

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
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
- 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@dmas.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 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?