



**Virginia Advisory Committee\***

**Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees**

**November 6, 2013, from 1:30 to 3:30 pm  
House Room D of the General Assembly Building  
Richmond, VA 23218**

**Meeting 4**

<b>I. Welcome and Introductions</b>	Cindi Jones Director, Virginia Department of Medical Assistance Services (DMAS)	1:30 pm
<b>II. National Updates</b>	Sarah Barth Director, Long Term Services, CHCS	1:40 pm
<b>III. Virginia Updates</b>	Tammy Whitlock Director, Division of Integrated Care and Behavioral Services, DMAS  Emily Carr Director of Virginia Office of Coordinated Care, DMAS	2:00 pm
<b>IV. Committee Member Focus Session 1:</b>  <i>Rates</i>	Bill Lessard Director of Provider Reimbursement, DMAS	2:35 pm
<b>V. Committee Member Focus Session 2:</b>  <i>Evaluation</i>	Gerald Craver, PhD Senior Research Analyst, DMAS	2:55 pm
<b>VI. Wrap Up and Next Steps</b>	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](mailto:CCC@dmas.virginia.gov).



## **Advisory Committee Members**

1. Alzheimer's Association (Carter Harrison)
2. Medical Society of Virginia (Mike Jurgensen)
3. Self-Advocate (Joan Manley)
4. State Long Term Care Ombudsman (Joani Latimer)
5. Virginia AARP (David DeBiasi; Bill Kallio will be attending 11/15/12 meeting)
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 attending 11/15/12 meeting/Steve Morrisette)
13. Virginia Hospital and Health Care Association (Chris Bailey)
14. Virginia Poverty Law Center (Jill Hanken; Kathy Pryor attending the 11/15/12 meeting)
15. Arc of Virginia (Jamie Liban)



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

November 6, 2013

**Sarah Barth, JD**

# Welcome and Introductions



**Sarah Barth, JD**

Director, Long-Term Services  
Center for Health Care Strategies

- ▶ **Priorities:** (1) enhancing access to coverage and services; (2) advancing quality and delivery system reform; (3) integrating care for people with complex needs; and (4) building Medicaid leadership and capacity.
- ▶ **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.
- ▶ **Funding:** philanthropy and the U.S. Department of Health and Human Services.

# Partnership Needed From the Beginning

*“During the first year of Medicare, superior health care has been provided for millions of aged Americans, and health standards have been raised for all Americans. This has come about because of cooperation between the Federal Government, physicians, insurance carriers, and the States. It would not have been possible without the strong support of each of these groups. We have forged a partnership for a healthier America.”*

**– President on the First Anniversary of Medicare**

# Who Are They Now? The Numbers.

- 10.2 million Americans are eligible for Medicare and Medicaid (known as Medicare-Medicaid enrollees or “dual eligibles”)
- 7.4 million are “full duals”
- 17.7% increase, from 8.6 million to 10.2 million between 2006 and 2011 (One in five Medicare enrollees)
- In comparison, the number of Medicare-only beneficiaries grew by only 12.5%

Sources: *Data Analysis Brief Medicare-Medicaid Dual Enrollment from 2006 through 2011*, Prepared by Medicare-Medicaid Coordination Office, February 2013.

# Who Are They Now? The Trends.

- Those under the age of 65 increased in number by 15.6% since 2006 while those over the age of 65 increased by only 5.2%
- Half qualified for Medicare because of disability (physical or mental) rather than age
- More likely to be younger, female, and of racial/ethnic minority status
- Nearly one-fifth have three or more chronic conditions
- Those over the age of 65 are much more likely to have been diagnosed with three or more chronic conditions
- Those under age 65 are more likely than elderly beneficiaries to have been diagnosed with a mental illness
- More than 40 percent, use long-term services and supports

Sources: *Data Analysis Brief Medicare-Medicaid Dual Enrollment from 2006 through 2011*, Prepared by Medicare-Medicaid Coordination Office, February 2013; *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies*, CBO, June 2013.

# Spending on Duals and Delivery System Trends

- In 2009, the federal and state governments spent more than \$250 billion on dual eligibles' health care benefits
  - ▶ Represent 13% of combined population of Medicare beneficiaries and aged, blind, or disabled Medicaid beneficiaries and 34% both programs' total spending
- Full benefit Medicare-Medicaid enrollees' managed care enrollment rate grew by 7.4 percentage points, from 7.8% in 2006 to 15.2% in 2011

Source: *Data Analysis Brief Medicare-Medicaid Dual Enrollment from 2006 through 2011*, Prepared by Medicare-Medicaid Coordination Office, February 2013.

# At the Center: The Individual

- I decide where and with whom I live.
- I make decisions regarding my supports and services.
- I work or do other activities that are important to me.
- I have relationships with family and friends I care about.
- I decide how I spend my day.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect.



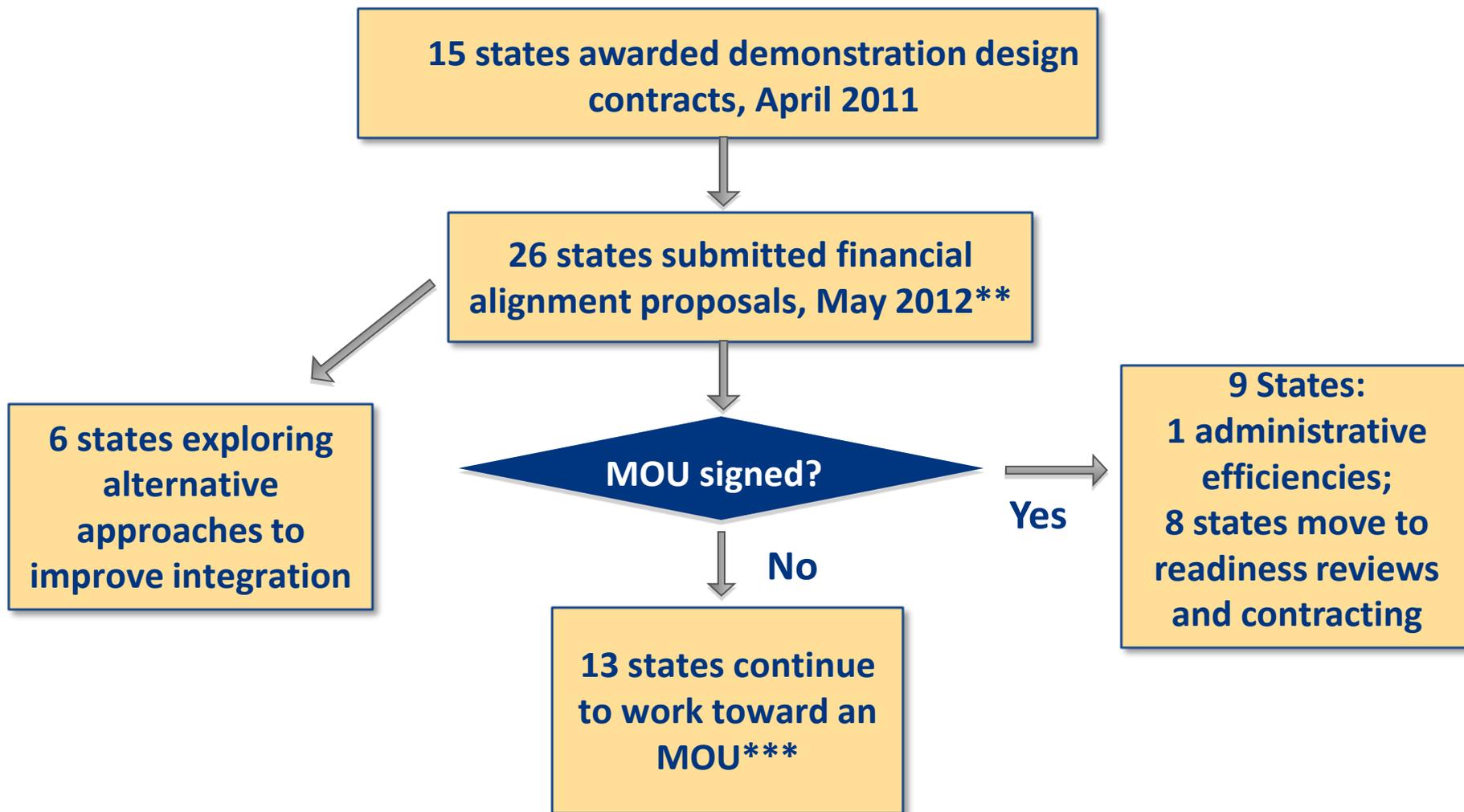
# What Are the Goals of Integrated Care?

- ▶ Creates one accountable entity that delivers primary/ preventive, acute, behavioral, and long-term services and supports
- ▶ Aligns Medicaid & Medicare services and financing to streamline care, reduce inefficiencies, and eliminate 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**



# Testing Innovative Integrated Financing and Delivery Models\*



\* As of November 2013

\*\* Includes all 15 states awarded a demonstration design contract

\*\*\*WA is counted twice: signed MFFS MOU; pending capitated MOU

# Financial Alignment Demonstration 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 Financial/Administrative Alignment Demonstrations Approved by CMS, October 2013\*

State & Financial Model	Total Estimated Enrollees	Target Population <sup>a</sup> and Geographic Area	Earliest Effective Enrollment Date
California (Capitated)	456,000	Adults, 8 counties	April 2014
Illinois (Capitated)	135,825	Adults, 21 counties grouped into 2 regions	January 2014
Massachusetts (Capitated)	90,240	Non-elderly adults, 1 partial and 8 full counties	October 2013
Minnesota (N/A)	36,000	Adults ≥ 65 enrolled in the Minnesota Senior Health Options program statewide	September 2013
New York (Capitated)	170,000	Adults, 8 counties who require nursing facility or nursing home diversion and transition HCBS waiver services or more than 120 days of community-based LTSS <sup>f</sup>	July 2014
Ohio (Capitated)	115,000	Adults, 29 counties grouped into 7 regions	March 2014
Virginia (Capitated)	78,600	Adults, 104 localities grouped into 5 regions	February 2014
Washington (Managed FFS)	21,000	High cost/high risk adults, statewide except in 2 urban counties <sup>i</sup>	July 2013

# Next Steps for Demonstration States

- ▶ Nine states have signed a Memorandum of Understanding (MOU) with CMS: MA, MN, WA, OH, IL, CA, VA, NY, SC
- ▶ Key decision points in MOU development:
  - ▶ Rates, benefits, performance measures, enrollment
- ▶ Procurement and readiness reviews
- ▶ Final step before “going live”
  - ▶ Capitated: CMS/state/plan 3-way contract (MA: July 11, 2013)
  - ▶ MFFS: CMS/state final agreement (WA: June 28, 2013)
- ▶ Enrollment of Medicare-Medicaid beneficiaries
  - ▶ Late 2013 and 2014
  - ▶ Generally phased in
    - ▶ Voluntary opt-in period
    - ▶ Passive enrollment with monthly opt-out option

# Spotlight: Readiness Reviews

- **Major Areas of Review**

<b>Assessment Process</b>	<b>Monitoring of First-Tier, Down Stream, and Related Entities</b>
<b>Care Coordination</b>	<b>Organizational Structure and Staffing</b>
<b>Enrollee Protections</b>	<b>Provider Networks</b>
<b>Enrollee &amp; Provider Communications</b>	<b>Systems Testing</b>
<b>Enrollment</b>	<b>Utilization Management</b>

- **Focus Areas: LTSS & BH**

# Top Areas of Interest

- **Person-Centered Care/Self-Directed Services**
- **Reaching the Hard to Serve**
- **Adequate Provider Networks & Credentialing**
- **Care Coordination/Care Transitions**

# States and CMS are Working Together to:

- Engage stakeholders at every level in design and implementation
- Build on existing relationships between state Medicaid agencies, providers, and beneficiaries
- Ensure beneficiary protections under Medicare
- Include quality standards and rigorous evaluations
- Establish payment strategies that encourage provider participation and create potential state and federal savings



The **Integrated Care Resource Center (ICRC)**: Established by CMS to help states advance integrated care delivery for dual eligibles. CHCS, with Mathematica Policy Research, coordinates state technical assistance and online resources. Visit [www.integratedcareresourcecenter.com](http://www.integratedcareresourcecenter.com)

# States Working Together

- Implementing New Systems of Integration for Dual Eligibles (INSIDE) supported by The SCAN Foundation and The Commonwealth Fund
- Supports 16 states implementing programs of integrated care through group learning and innovation sharing, as well as opportunities to work with federal partners
- Arizona, Arkansas, California, Colorado, Idaho, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, and Washington



# Thank you!



# Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

## Committee Member Focus Session 1

Emily Carr, Director of the Office of Coordinated Care  
Virginia Department of Medical Assistance Services  
Medicare-Medicaid Financial Alignment Demonstration  
Advisory Committee Meeting  
November 5, 2013

# Phases of Review



- Desk review – Summer 2013
- On- Site review- September/  
October 2013
- Network adequacy - October/  
November 2013

# Desk Review

- CMS & DMAS released Readiness Review document
- Issued desk review letter to plans in negotiation
- Plans submitted documents for desk review
- CMS & DMAS reviewed desk review materials
- Desk review deficiency notices sent

# On- Site Review



- Site visits
  - *Enrollee and Provider Communications*
  - *Enrollee Rights, grievances and appeals*
  - *Organizational structure and staffing*
  - *Interdisciplinary Care Team (ICT)*
  - *Performance and quality improvement*
  - *Provider network; accessibility, provider training, adequacy standards*
  - *Health Risk Assessments*
  - *Community partnerships*
  - *Systems review*

# Network Review

- Network validation letter sent to plans
- Plans submitted Medicaid & Medicare networks
- CMS & DMAS conducted review
  - Plans submitted contract signature pages
  - NORC called providers
- Plans received network deficiencies
- Plans submit updated/ corrected networks

# Final Readiness Determinations



- Pre- enrollment validation
- Establish and test connectivity
- Review organizational staffing, hires
- Communications and outreach



# Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

## Committee Member Focus Session 2

Tammy Whitlock, Division Director of Integrated Care and Behavioral Services  
Virginia Department of Medical Assistance Services  
Medicare-Medicaid Financial Alignment Demonstration  
Advisory Committee Meeting  
November 5, 2013

- Governed by the Virginia Public Procurement Act (VPPA)
- Virginia continues negotiations with three Medicare/Medicaid plans (MMPs)
  - Healthkeepers
  - Humana
  - Virginia Premier

# 3-Way Contract Overview



- The Financial Alignment Demonstration requires a 3-way contract by CMS, DMAS and the MMPs
- Sets the terms and conditions for the Demonstration
- Details regarding participating plans responsibilities
- Includes 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
- State review period: September
- Final federal review: October
- CMS send final contract to plans and state for signature: November
- Plans and State sign contracts: December

# 3-Way Contract

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

# 3-Way Contract Highlights



- Expansion of Telehealth as a covered service
- “Landmark for the nation,” increases the availability and scope of telehealth services  
*(Karen S. Rheuban, M.D. Chair, Board of Medical Assistance Services)*
- Care coordination for all enrollees
  - Behavioral Health Homes

# 3-Way Contract Highlights



- Integration of EDCD Waiver and NF LTSS services, Behavioral Health and traditional medical care in one coordinated service delivery system
- Integrated appeals process (Medicare/Medicaid)



# 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  
November 6, 2013

# Medicaid Rate Setting Responsibilities

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- 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

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- Based on DMAS FFS and administrative costs pre-demonstration
  - What DMAS would have spent absent the demonstration
  - 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

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- 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

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- 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 keep nursing home eligible members in the community
  - Will also pay NHE rate for two additional months if member shifts to community well

# Risk Adjustment

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- 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

# Member Enrollment Mix Adjustment

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## Adjustment Frequency

- DMAS will calculate demonstration population mix at beginning of voluntary enrollment to determine NHE blended rate to pay all plans
- DMAS will recalculate plan enrollment mix at beginning of passive enrollment and three months after beginning of passive enrollment to determine NHE blended rate to pay each plan
- DMAS will recalculate plan enrollment mix every six months beginning January 1, 2015 to determine NHE blended rate to pay each plan

# Member Enrollment Mix Adjustment

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## Enrollment Status

- Enrollment status will be determined at the beginning of the program (or enrollment if later) and will remain unchanged through 2015
- Enrollment status for 2016 will be determined at the beginning of 2015 or enrollment if later and will remain unchanged through 2016
- Enrollment status for 2017 will be determined at the beginning of 2016 or enrollment if later and will remain unchanged through 2017

# Medicare and Medicaid Rates

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- Draft Medicare and Medicaid rates have been shared with negotiating plans
- Conceptually both rate setting processes are similar: what Medicare or Medicaid would have paid absent the demonstration minus negotiated savings
- Final rates will be published along with the methodologies as soon as they are finalized
- Rate information will be available on CCC home page



# *Commonwealth Coordinated Care Program Evaluation Overview*

Stakeholder Advisory Committee  
November 6, 2013

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Gerald A. Craver, PhD



# Overview

- **Evaluation Team**
- **Evaluation Advisory Committee**
- **Evaluation Plan**
- **Next Steps**
- **Questions, comments, or concerns**



## Evaluation Team

- Composed of both internal and external evaluators
- Department of Medical Assistance Services
  - Gerald Craver, PhD
  - Meredith Lee, MPH
  - Elizabeth Smith, RN
  - Jodi Manz, BA
- George Mason University
  - Alison Cuellar, PhD
  - Gilbert Gimm, PhD



# Evaluation Advisory Committee

- A group of individuals assembled based on expertise to advise on how best to conduct an evaluation and use its findings
- Five Key Functions
  - Stakeholder Engagement
  - Maximizing External Credibility
  - Political Conciliation
  - Methodological Integrity
  - Promotion of Use



# Evaluation Advisory Committee Members

1. **Jack Brandt** (*Partnership for People with Disabilities*)
2. **Debbie Burcham** (*Chesterfield CSB*)
3. **Emily Carr** (*DMAS*)
4. **Parthy Dinora** (*Partnership for People with Disabilities*)
5. **Sheryl Garland** (*Virginia Commonwealth University*)
6. **Maureen Hollowell** (*Endependence Center, Inc.*)
7. **Betty Long** (*Va. Hospital & Healthcare Association*)
8. **Linda Redmond** (*Va. Board for People with Disabilities*)

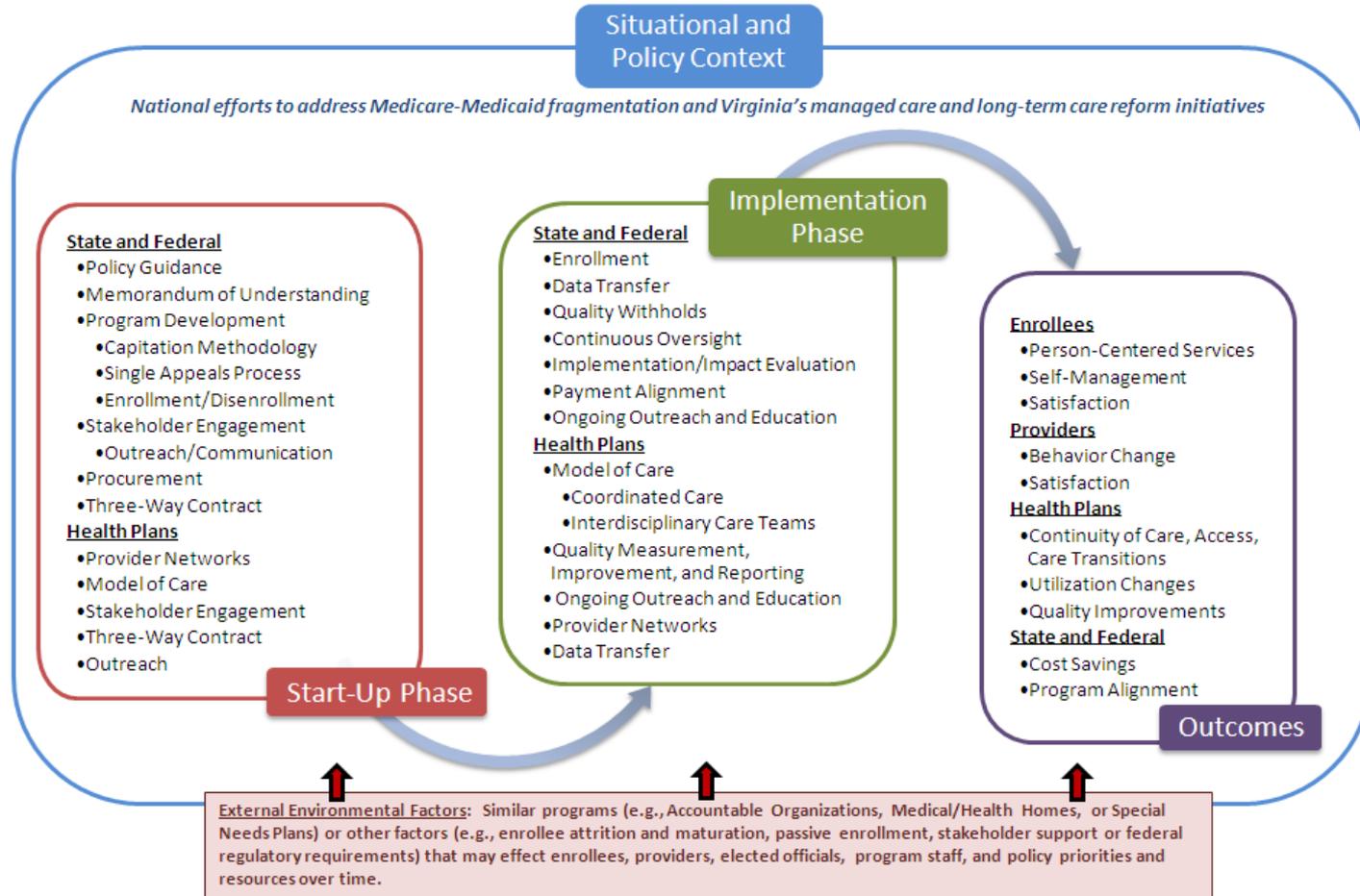


# Conceptual Framework

- The evaluation will provide feedback on selected dimensions of the Commonwealth Coordinated Care (CCC) Program's performance over time from two perspectives
  - **Implementation** (e.g., assessing various processes to identify best practices and/or areas for improvement)
  - **Impact** (e.g., examining the program's effect on outcomes to judge overall success)



# Commonwealth Coordinated Care Logic Model





# Mixed Methods Research Design

- The evaluation will use a “concurrent” mixed methods research design
  - Qualitative Component (DMAS)
  - Quantitative Component (GMU)
- Complies with guidance from the Center for Medicare and Medicaid Innovation for evaluating new payment and service delivery models as well as the design of the national evaluation of state financial alignment demonstrations



# Qualitative Component

- In-depth examination of the “**whys**” and “**hows**” of the CCC Program using interviews, focus groups, observations, and document reviews to gain insights into how the program is working by studying it in person, over time, and from diverse perspectives (i.e., program staff, health plan staff, providers, and enrollees)
  - Multisite study (one location in each region)
  - January 2014 to December 2017



# Quantitative Component

- Demographic/Enrollment Analysis to identify important characteristics of individuals who enroll/disenroll from the program
- Satisfaction/Experience Survey to describe important patient care attitudes, opinions and behaviors of enrollees
- Analysis will run through May 2015
- Additional surveys may be performed as well as a longitudinal study to examine program's impact on utilization/cost outcomes over time



## Next Steps

- Working with agency management and the evaluation advisory committee to refine the evaluation plan
- Recruiting additional evaluation advisory committee members
- Evaluation formally begins with three-way contract (contains evaluation requirement)



*Department of Medical Assistance Services*



# Questions, Comments, or Concerns

<http://www.dmas.virginia.gov/>