

**Care/Service Coordination for Duals
Under the Financial Alignment Demonstration
July 27, 2012**

Meeting Notes

I. Welcome and Introductions from DMAS staff and Workgroup Members

II. Presentation

- a. Paula Margolis and Karen Kimsey reviewed the care/service coordination Powerpoint presentation. [access presentation at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx]
- b. Input was requested from stakeholders on:
 - i. Data analysis on the Demonstration population that would be useful.
 - ii. Additional Model of Care elements that DMAS should include as part of the Demonstration.
 - iii. Suggestions for either item can be submitted to dualintegration@dmas.virginia.gov.

III. Workgroup Member Input

Workgroup members had the opportunity to provide input on the issues that are important to the individuals that they serve and how organizations can meet their needs, as DMAS moves forward with the Duals Demonstration. Highlights of what each Workgroup member said appear below.

Brian Smith, Molina Healthcare

- MCOs have to be outwardly faced in the community--it's just not in primary care, it's within all services, including and critically speaking, behavioral health.
- A substantial amount of this population deals with significant behavioral issues, social issues, access to care issues, and fundamental living issues that have to be integrated into the program.
- Molina has items that they would like DMAS to consider, change, etc., but described Virginia's program as pretty reasonably based and established.
- Molina Healthcare is very interested in working with everyone, including providers, DMAS, and other MCOs to launch the program.

Catherine Harrison, Department of Aging and Rehabilitative Services

- When talking about person-centered practices within the framework of care coordination it is important that we don't lose sight of the individuals that this project is looking to assist.
- Individuals have a wide variety of diagnoses, so one size will not fit all (even for individuals with the same diagnoses).
- Various comfort levels about moving outside the medical model, but in the long-run, moving outside the medical model will help provide wrap-around services to prevent some medical issues later.
- Will require some out of the box thinking and non-traditional services for some individuals.
- Critical to look at the needs of individuals. Many individuals have established relationships with community partners, so keeping that in mind and making sure everyone is educated about who provides what now, and where that can be built upon, expanded, and improved is important too.

Bill Miller, Optima Health Plan

- Optima Health Plan wants to work with people who are already serving the dual eligibles. The MCOs can't provide all the answers for this type of population because it's a difficult population to manage.

- Know there are a lot of groups that are involved with serving this population in the community.
- Optima is anxious to learn about existing services, understand what people are already doing, and developing partnerships. Need to learn together.
- Stressed that as an MCO, they are not looking to run the entire show. This is a project that requires collaboration and cooperation among lots of different providers across different settings. MCOs need to learn about those and understand what various agencies/organizations bring to the table.

Marcia Tetterton, Virginia Association for Home Care and Hospice

- Advocates for true chronic disease management programs in the Commonwealth and see this project as an opportunity for this to occur.
- Reiterated the need for high touch chronic disease management.
- Excited to see basic and enhanced care coordination options within the decision matrix.
- Other things starting to see in medical care include more evidence-based care that looks at episode pathways throughout the health care system and looking at where we get the best outcomes based on that evidence-based care. Medicaid needs to do a lot more research in this area. Some real abilities to improve care and save the system money.
- Need to identify and manage the disease states of patients and all their co-morbid conditions.
- Need to adhere to some national evidence-based guidelines.
- Need to integrate preventative care into the clinical management model.
- Need to teach patients self-management skills and provide support that is needed for self-management.
- Set measureable goals and outcomes for the individuals and the overall program.
- Believes can see an overall reduction in acute medical expenditures if the program is done correctly and the coordination can lead to reductions in unnecessary/inappropriate medications and rehospitalizations.
- One linchpin will be care transitions, how to manage these transitions, and finding the most cost effective and best outcome settings for these individuals.

Kathryn L. Pryor, Virginia Poverty Law Center

Described the following concerns:

- Eligibility for coverage and services and protection of due process rights.
- Ensuring that educational materials are linguistically and culturally appropriate, written at 6th grade level, and available in alternative formats (e.g., braille).
- Transition periods and making sure individuals are covered for at least 6-12 months with their current providers, drug, and treatment plans.
- Ensuring that rebalancing efforts are continued and that there are financial incentives for MCOs to provide long-term care services and supports to persons that do not yet need nursing home level of care as a way of enabling persons to continue living in their homes.
- Adequate networks with specialists in geriatrics, behavioral health, etc.
- Person-centered planning is an important part (e.g., control over who is involved in the care planning process, convenient/accessible care planning meetings, and provision of easily understandable information and notices).
- Recognition that people can take risks (e.g., using the consumer directed model) while also recognizing the need for provisions of good backup plans to limit risks.
- Self-directed option needs to continue.
- Be sure people can choose and that funding will be available for care coordination by Centers for Independent Living (CILS), Community Services Boards (CSBs), and other organizations with proven expertise.

- Hope that there is an independently housed, conflict-free, and adequately funded Ombudsmen that will provide free help in navigating the program, helping individuals understand the benefits, and helping with enrollment decisions.
- Recommend a simplified and integrated appeals process that includes many of the positive aspects of Medicaid (e.g., benefits pending appeals, advance notices, good notices that clearly state what the problem is, ability to bypass internal appeals process to go to the external process).

Bonnie Gordon, Virginia Association of Personal Care Providers

- Even though individuals are given information written at the 6th grade level, if allow for passive enrollment, they won't get it. This means many individuals will end up being potentially removed from home care providers because the providers are not members of MCOs (stated wasn't sure how the credentialing piece would work under the Demonstration).
- Personal care aides are often why individuals get out of the hospital or a nursing facility. Would like to help raise awareness that personal care aides are an important part of the health care spectrum and need consideration.
- Concerned about timely billing and payment. MCOs don't tend to work that way.
- The current rates are low and unsure if current rates will be maintained of if there is room for something else under an MCO model.
- Stressed that cash is a critical part of the viability of home care providers. If they can't bill timely they will not make it given the current rates.
- The last time the MCO model was considered, it was apparent that there was a huge need for education.

Laura Lee Viergever, Virginia Association of Health Plans

- Looking forward to partnering with DMAS, the plans, and the people around the room.
- Here to work with everyone to find areas where we can work together and learn from each other.

Lory Phillippo, Virginia Adult Day Health Services Association

- Relayed a story of care transition and management in her agency that illustrated an already functioning system of care and the complexity of the individuals they serve. She described a 93 year old dual eligible woman who the center has been serving for 14 years. She's at the agency 5-6 days a week and she lives with her son, who is her family care giver. The woman receives home care in the morning and then goes to the adult day center during the day, and then receives transportation back home. The woman is severely diabetic, has had vascular disease, has swallowing issues, and cognitive impairment/seizure disorders, among other conditions. The woman was unresponsive while sitting in her wheel chair that morning. The RN and LPN responded, the woman was assessed, EMS was called, and the MSW called the woman's son. The Center provided information to EMS from their electronic medical record.

Linda Redmond, Virginia Board for People with Disabilities

- The Board has advocated for necessary wraparound services and supports so that individuals with disabilities can age in place in the community and still be part of the community with natural supports and relationships.
- As we talk about care coordination, we can't lose sight of the individual and the need for effective communication with individuals.
- Can't underestimate how important it is to help a client understand the value of a medical procedure, medications, or other interventions.
- Hopes a psychosocial component is built into care coordination because some of the barriers to a person taking care of him/herself include nonmedical issues.

- Hopes a team model is built into the program because often medical care is siloed, but effective communication sometimes has to be a mutual discussion rather than just sharing information. A team component is needed among providers.

John Pezzoli, Department of Behavioral Health and Developmental Services (DBHDS)

- Explained that if you take DMAS' case management definition and power it up by significant levels of intensity, outreach, and complete involvement in almost every sphere (e.g., life needs, community needs) you describe CSB intensive case management.
- Case management is a model for community supports and for the integration of behavioral health and health care.
- Individuals with SMI and concurrent health needs are some of the least healthy populations and have the shortest life expectancies in our community.
- CSBs aim to be, and are, the sole behavioral health home for persons with SMI and that many CSBs are becoming medical homes (or homes for medical coordination) for persons with extensive needs.
- A wide variety of people are served by CSBs, so DBHDS wishes the Demonstration target population was broader. But, within the target population, approximately 3,600 persons have SMI. Many, if not most, of these individuals may be linked to CSB case management or are in need of stronger links.
- Described intensive case management as an excellent service for some and an adequate service for many.
- DBHDS conducts person-centered planning with everyone, so they can contribute ideas regarding person-centered planning technologies, approaches and models.

Carter Harrison, Alzheimer's Association

- The Alzheimer's Association provides some care coordination, but not at the level others discussed (the Association is not a service provider). Care coordination is mostly provided when an individual is in a crisis situation like changing from one care setting to another.
- Individuals with Alzheimer's/dementia are not always served well in the existing system, so sees this as an opportunity to improve.
- Hopes that areas of focus for this project include behavioral health and behavioral health problems in NFs and other care settings (there are not a lot of resources available to NFs or ALFs for people with behavioral health issues related to dementia).
- Cautions that decision making is important and that individuals with dementia are severely cognitively impaired and that it can be frustrating when information is left for these individuals to review knowing full well that they can't do it and that his/her care giver needs to do so, with some level of input from the individual.
- Training for people who will be delivering care coordination is important. It is the Association's experience that people who need help are often in crisis situations. People calling the helpline have temporary detention orders or their loved ones have wandered off. These same types of calls are what the care coordinators will receive, so they need to be prepared to deal with crises around transitioning from one care setting to another.

Lora Epperly, Virginia Health Care Association

- Pointed out that LTC/skilled nursing does not look like LTC 5-10 yrs ago. In most centers today they have 2-3 distinct patient populations: (1) traditional LTC residents who live within a center; (2) skilled nursing patients who receive rehab or skilled nursing care to help them go back to the community; and, (3) in some centers, they have secure memory care units that take care of individuals with dementia or Alzheimer's disease.
- Hopes the Demonstration keeps the patient at the center as it moves forward, because without those individuals being the driving force, lose a lot in determining effective ways to provide health care for these individuals.

- Encouraged focusing on the whole health care continuum because each organization/agency has very specific roles and capabilities that can help redefine health care for the dual eligible population.
- Concerned about access to care and access to quality care. In some communities, skilled nursing centers may be the only 24 hour/day care delivery centers. Some may have critical access hospitals, but LTC/SN may be the only place that is open 24 hours/ day.
- Everyone wants to be a good steward of resources (e.g., financial, human resources, etc). The health care delivery system is changing, as are the places where people receive care, and is seeing patients with a greater increase in acuity. Need to make sure the resources necessary to take care of people follow them to where they are going.
- Not looking to pass the cost on or to move the cost to the next care level; need to make sure that the appropriate resources are in the areas where clients are being served.
- Need to consider the regulatory and licensure implications in going forward with the Demonstration.

Lynn Vogel Cline, Anthem

- As one of the six Medicaid MCOs in Virginia, Anthem currently serves an ABD population. Although the ABD population is not close to the needs of the duals, Anthem has employed care coordination strategies, such as community outreach and intense treatment planning that involves behavioral health, medical management, care coordination, social work, and looks at the total needs of ABD members, including having staff available to assist members get to appointments.
- Understands that they have a lot to learn about the unique additional services (e.g., LTSS).
- Have concerns around the ability to establish long-term relationships with clients and getting involved with particular clients to learn about the treatment providers involved in their care. Looking for opportunities to minimize barriers to continuous enrollment with a particular health plan and individuals' continued Medicaid eligibility. Believes that churning impedes care coordination efforts and the plan's ability to maximize outcomes.

Courtney Tierney, Virginia Association of Area Agencies on Aging

- Supports looking at different standards that currently exist for providing care coordination.
- Suggested that DMAS look into the Coleman Model of Care Transitions, which is a CMS-approved evidence-based model to reduce hospital readmissions for persons with chronic diseases.
- Concerned about individuals with Alzheimer's disease and dementia.
- Stressed that materials need to be readable and understandable.
- Would like to see an Ombudsman help people navigate the program and help individuals make decisions. Would be especially important at the beginning of the program.

Craig Connors, Riverside Health System

- Dual eligibles are a heterogeneous population, so one size will not fit all.
- Social determinants of care cannot be overestimated. The dual eligibles have chronic illnesses, cognitive limitations, low health literacy, and either disjointed or incomplete care giver support networks.
- The MCOs will need to deflect cost through utilization trends at the individual level through trusted relationships.
- Best way to prevent emergency department use, unnecessary hospitalizations, and NF placements is to have personal care that the family trusts in the home.
- The fundamental concept needs to be scaleable and efficient or it will break us as a country.
- Social determinants and trust building need to be built into the care management model.
- Basic and enhanced levels of care management are a good start, but need to be more specific about implementing care management models that are appropriate to the target population. Although not easy, need to create efficient standardized models of care. The only way to do so is by establishing

strong local partnerships with local providers. Telephonic and written care management and disease management work well for the general adult population, but they don't work well for a lot of dual eligible individuals.

Mary Ann Bergeron, Virginia Association of Community Services Boards

- Serious Mental Illness (SMI) can rob individuals of living skills. Medications that control symptoms can contribute to primary health problems.
- Need constant outreach because e-mails, phone calls, and literature don't work.
- Life expectancy is much shorter for persons with SMI than the general population. One reason is because these individuals have difficulty accepting and accessing primary care.
- CSBs and MCOs have existing partnerships.
- Having primary care either at the behavioral health site or coordinated by the behavioral health site needs to be included in the Demonstration.
- Relationships can't be disrupted or disruptive-they need to be continued and improved.
- Minimize administrative burdens (need to co-incide with what's already in existence, such as Electronic Health Records (EHR)). Many providers have not had the resources to investment in EHR infrastructure and the potential administrative burden could prevent these providers from working with the target population.

Denise Croce, MajestaCare

- Traditional care management doesn't work any more, so we need to change the way we do care management. It's really a buy-in between providers, managed care, and community organizations.
- Need comprehensive networks.
 - The population has been receiving care for their chronic conditions for a long time through specific providers. So, they are hesitant to change. Disrupting the stability could jeopardize their mental and physical health.
 - Need medical providers, but also need to engage nontraditional providers because of the social and environmental aspects that impact the populations.
- This population has changed over the last 10 years. Their primary focus may be their child or grandchild; their own health care has taken a backseat, but we need to keep their health in focus.
- Need to encompass care givers in treatment plans.
- Need to be flexible.
 - Individualized care plans can include the basic and enhanced models, but really need to work with care management teams and providers to make sure they are utilizing their expertise/skills to make sure people maintain/improve their health conditions.
- Need to think outside the box.
- Integrating data is important.

Karin Ferguson, CareNet

- Talking and working with members doesn't work if they do not have the basic necessities to live (e.g., heat, food, water). So, you need to start at the bottom and provide these services first before can move up and talk about benefits, waivers, their disease(s).
- Building trusting relationship is important because members need to know there is worth in what we do before they accept us.
- Make it as simple as possible, so providers can understand waivers, acronyms, etc. We need to get back to the simple basics of providing care for our members.
- Look at individuals holistically.
- Have to be able to reach members. Once we are in their home, we have the opportunity to work from the bottom up.

Ed Maitland, Virginia Premier Health Plan, Inc.

- Dual eligibles are an extremely diverse population with various illnesses and acuities.
- Need to focus on remaining flexible and driving quality outcomes.

Rhys Jones, Amerigroup

- Duals are a very heterogeneous group.
- Special Needs Plan (SNP) Model of Care (MOC) is a good starting point, but it stops short of getting into behavioral needs and LTSS needs. SNP MOC needs to feed into other evaluative processes to get at total spectrum of care.
- CMS and states will come up with historical cost build ups for how much services cost in the past. This means that plans and providers will operate the Demonstration with discounted rates. Need to find administrative savings to provide services while reducing administrative redundancies and inefficiencies.
- Passive enrollment is a good way to develop a critical mass to achieve the Demonstration and demonstrate outcomes. In favor of transitional care arrangement for six months as DMAS included in the proposal.
- Apply Medicare definitions of medical necessity and coverage criteria to all legacy Medicare-covered services; for Medicaid legacy services, use Medicaid definition and criteria.
- The Demonstration won't exist in vacuum. Medicare Advantage (MS) plans, PACE, and SNPs will continue to exist outside of the Demostration. Urged DMAS to think about how to make the Demonstration competitive compared to existing programs.
- No one has tried an arrangement like this before-providing a comprehensive package of services to dual eligibles in a discounted environment. Suggest including risk corridors in the approach, so that the state, CMS, and the MCOs are in this together for downside and upside risk.

Anna James, Troutman Sanders, sitting in for Robert Sonnessa, Magellan Health Services

- Integrated care teams that incorporate behavioral health providers in partnership with primary care providers are important.
- Holistic approach is important due to link between medical and behavioral health.
- Person-centered approach can lead to better outcomes.

Katie Roeper, Department for Aging and Rehabilitative Services

- Important opportunity to leverage progress with Aging and Disability Resource Centers (ADRCs), which are a combination of partnerships and technology around Virginia.
- The cornerstone for ADRC is service coordination, information, referral, and assistance. They use technology networks to get that done.
- Building unique client profiles, so that one exists for clients across the state within network. It's an opporutnity to build e-community records that contain everything that ever happened to an individual outside his/her medical record. Helps reduce the number of people that fall through the cracks. The records are built on a database of nearly 30,000 programs and services that support this population. Information is shared through a consent system (e.g., HIPAA and the Virginia Attorney General).
- This is a way to easily automate information sharing across providers, which saves time and money and provides better support to individuas (e.g., individuals don't need to repeat story every time they go to different provider, know when individuals arrived at referrals and are being served).

David Adams, Centra Health, representing Virginia Hospital & Healthcare Association

- The opporunity with dual eligibles is a big one to bite off because these individuals are unique; some are receiving their primary and psychiatric care in the ER and there is a lack of behavioral health support in skilled nursing facilities.

- Questions how we will address provider relationships. PMPM is passe and described managed care in the 1990's. Need to figure out how to really structure relationships and the coordination of care that this population needs to keep them healthy and out of the hospital.
- A lot of great energy, thought, and excitement around the medical home concept. It's a great model, but it takes a lot of money, so the question becomes "How will the money change hands?". Are the MCOs really prepared to invest in much higher levels of patient-centered medical homes that could result in lower admissions to hospitals?
- Recommends looking at successes associated with the PACE model. They are the experts in keeping people out of the hospital.
- Need to create new provider/payor relationships that will have meaningful effects at the local level.
- Urged DMAS to not miss out on providers who have stepped up. Could do another smaller pilot beyond the main one for comparison purposes to see which systems, which providers, which health systems achieve the best outcomes.

Kristen Krzyzewski, ValueOptions

- Cannot underestimate the behavioral needs of the population. Often times until you work with individuals to control their behavioral health needs, you can't get to their physical needs.
- Urges co-locating behavioral health providers with primary care providers as much as possible.
- The role of peer supports in the community is critically important.
- Long-term care services and supports, including home and community-based services, is a third leg for which the MCOs need to develop expertise. It takes a significant effort to build networks, educate providers, and build in-house care coordination capabilities. Encouraged the state to help MCOs and providers come together and build relationships.
- Encourage incentives to members for participation in care coordination. It's part of the design in other states. Needs to be further defined, but the concept is good.
- A significant proportion of the target population is institutionalized. Need to think about special care management models for these individuals, such as more intensive care coordination on site for them.
- Technology is important, but stressed that we should not replicate systems for each provider and for each MCO. Suggested that everyone come together to create a platform that all can use.

Maureen Hollowell, Virginia Association of Centers for Independent Living

- Maintain a strong focus on person-centered planning and independent living.
- Maintain a strong focus on consumer direction.
- Nurse delegation needs to be looked at and used more often.
- Need to ensure that very competent individuals conduct the care coordination and care management. Competencies need to include social competencies in addition to medical competencies.
- Need to make sure the public is aware of what is going on. DMAS' website is good, but it's important to provide information to individuals with disabilities and their families so they know there is a thoughtful process going on and that there are opportunities to provide input.

IV. Closing Remarks

Karen Kimsey concluded the meeting by thanking all the Workgroup members and stakeholders for attending. She indicated that:

- DMAS would summarize the meeting, disseminate the summary, and post it on the DMAS website (http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx).
- Additional meetings will be scheduled to discuss particular topics (e.g., available providers, outreach, transitions, technology, training, etc.).
- In accordance with the Appropriations Act, DMAS will form an Advisory Committee that will provide general oversight to this project.