



Department of Medical Assistance Services



Dual Eligible Financial Integration Demonstration

Behavioral Health
Community Long Term Care

March 23, 2012



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



Dual Demonstration Overview

- CMS opportunity to align Medicare/Medicaid finances and some processes –runs for three years.
- Enroll dual eligible individuals into managed care organizations (MCOs).
- Covers all Medicare and Medicaid benefits under a capitated model.



Population

- Will include:
 - full-benefit dual eligibles who are:
 - Aged 21 and over;
 - Eligible for Medicare A, B and D;
 - Eligible for full Medicaid benefits;
 - In EDCD waiver participants
 - Technology Assisted waiver in Year 2;
 - Residing in nursing facilities;
 - Some individuals in Assisted Living Facilities.



Payments

- MCOs receive capitation payments determined by CMS and States blending Medicare and Medicaid funds.
- Payments reflect the expectations for savings.
- Allows DMAS to share Medicare savings to help pay for new care coordination services.
- Strong care coordination components



Enrollment

- Passive enrollment with opt out option
 - Potential enrollees receive information during Medicare open enrollment period (Oct – Dec).
 - Can select demonstration, PACE, Medicare Advantage (MA)/SNP plan, or FFS.
 - If don't make a selection, will enroll in demonstration plan.
 - Can change plans or opt out to MA, FFS, PACE and any time.



Person-Centered Care Coordination

- Health Risk Assessments
- Interdisciplinary care teams
- Individualized care plans
- Use of evidence-based practices
- Levels of coordination based on needs (basic/enhanced)
- Coordinate referrals to non-covered supportive services
- Technology to assist communication between team members/providers/enrollees
- Hospitalist and care transition programs
- Health Education
- 24/7 nurse advice line



Tasks overview

- Stakeholder input throughout entire demonstration;
- DMAS drafts a proposal and posts for 30 day public comment period Mid-April to Mid May;
- Submit proposal to CMS by May 31; second 30 day public comment period June - July;
- CMS and state develops a Memorandum of Understanding for state participation in the demonstration (signals acceptance into demonstration);
- Develop Health Plan Request for Proposals;
- Release final Request for Proposals;



Tasks overview, cont'd.

- Interested plans respond to RFP and submit information to HPMS website;
- DMAS submits 1915(b)(c) waiver application to CMS;
- CMS and state make plan selections;
- CMS and state conduct health plan readiness review;
- Three-way contracts signed (CMS, DMAS and health plans);
- Beneficiary notification/open enrollment period;
- Demonstration start – runs three years;
- National evaluation of demonstration;
- If successful, program can be made permanent.



Dual Eligible Demonstration

- How can the demonstration add value to the way you serve clients?
 - What needs would you like to see the demonstration help meet for individuals who use your services?
 - What are *your* needs that the demonstration may help meet in serving demonstration enrollees?

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- EDCD waiver has no care coordination or case management – staff at adult day care provide this – care coordination would be great benefit – make sure MCOs communicate and coordinate – e.g.. Logisticare – providers are absorbing costs for transportation process – work with providers and coordinate services - manage coordination activities to help manage costs
- Client – how define person centered care – meets needs of client not the MCO – need high touch chronic DSM program – challenge will be flexibility to provide person centered care with siloed regs with Medicare and Medicaid – e.g. home health and face to face encounters
- Bringing all services no matter funding stream to wrap around individuals – least confusing for clients and caregivers but maximize funding streams – concern for outliers with chronic conditions – how deal with these to adequately address and coordinate – ability of various groups doing coordination now to have free flow of info with MCOs to make person centered
- Opportunity to improve long term care screening process all the way through authorization of services – condense the process
- BH: currently missing sub-acute environment for services – no residential or partial hospitalization option to stabilize – quicker access to outpatient services
- How passive enrollment will occur and what will recipients receive re: providers available to them and about track record of care that is provided under the MCO and in the PACE program – individual choice is based on information – describe preventive care and wellness and the aspects of the program – what MCOs will truly provide person centered care
- Robust ombudsman program for providers and clients - independent review process for long-term care services to ensure person centered care happens – verification portal for those moving in and out
- Population does not include ICF/MR – define “some” individuals in ALFs
- How is it that ALF providing these services can be considered a provider?
- Medication management plans to provide stability and prevent “bouncing”
- Will Medicare acknowledge LPC credential?



Dual Eligible Demonstration

- How would you like to see the demonstration impact:
 - The way you interact with Virginia Medicaid?
 - The way you interact with Medicare?
 - How you serve your clients?

- Pt D and Pt D plans is a challenge – is this absorbed under the MCO to eliminate challenge
- Like to see new system have high level of integrity – such disparity between regs, manuals and application – new policies developed in manner that is clear and concise and not have providers jump through requirements – move away from model LTC has developed in the past – impact availability of services to all with disabilities, communication needs – providers can do programmatic changes/modifications for those with disabilities
- Provider never again have to interact with Medicare – frustrating beyond comprehension – dealing with state agencies and processes – ensure coordination by other state agency regulations – intra state regs

Dual Eligible Demonstration

- How would you define care management in the context of the services you and your organization provide?
- What ideas do you have for building on your care management processes to improve transitions and eliminate gaps in care?

- Not just working with client but caregiver and family – involve them in holistic approach to be part of the solution
- Transitions of care from hospital to home care setting – very little with discharge planning from hospital – info may not get to provider and getting PA – huge gap – issue of timeliness of electronic info
- UAI process getting backlogged – UAI requirements for federal programs – ability to share info so each entity does not have to do – technology available to all providers
- BH – PATH model – no service or collaboration gaps
- Definition – person centered care – flush out very thorough definition based on setting
- Difference between care management and case management – need clear definition
- CM unique by person – honor and build system that honors that – focus on empowerment , guidance and education – involve families and dignity of risk of how to use services
- Be sure physical/medical and BH needs addressed in integrated way
- Voice of consumer through advisory or ombudsman included within the MCO
- Developing core principles and core values
- Make sure physical/medical and “psycho/social” needs addressed in a continuum that honors individual’s desires to be involved in decision making processes
- Transition – recommendations of various providers on their level to move to another provider – follow through on recommendations – best practices in transitions – stay away from requirements and regulations



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Dual Eligible Demonstration

- What do you see as the single most important improvement that the demonstration could bring to enrolled individuals?
- What operational issues need to be addressed to serve individuals in the demonstration?
- What concerns/recommendations do you have as DMAS moves forward?

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- Better handle on DME process between Medicare and Medicaid
- High touch provider community-based chronic DSM program
- Concerned how payment handled by MCOs for PC providers – 30 day prompt pay will be issue – go live date of 2014 may be problematic for all providers due to health care reform and may set providers up for failure
- Concerned about 1 card especially for those who go in and out of the program – will this card cover the MCO
- Align co-pays, patient pays as best as can
- 7 different waivers, ICF, SNFs – individuals on waiting lists – focus on breaking down silos between institution and waiver
- Components of system and types of data collection expectations and quality measures to be used
- DMAS staff training – challenge of contacting DMAS and getting same answer and understanding
- Continue this communication model - more info to put out about process that is concise and brief for communication to members



Letters of Support

DMAS is gathering letters of support to include with the proposal package. Letters of support must be included in the proposal sent to CMS by May 31. Please send your letter of support to DMAS care of Cindi B. Jones by May 20, 2012 but address the letter to:

Melanie Bella
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Proposal comments and letters of support may be sent to DMAS electronically at dualintegration@dmas.virginia.gov or to DMAS 600 East Broad Street, Richmond, VA 23219. Your support is greatly appreciated.