



Department of Medical Assistance Services



# Dual Eligible Financial Integration Demonstration Stakeholder Meeting

Managed Care Organizations  
March 26, 2012

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



## Dual Eligible Demonstration Goals:

- Improve health, health care, quality of life;
- Provide all acute, long term care and behavioral health services by one integrated entity.
- Combine Medicaid and Medicare benefits, payments and process to reduce burden, address cost shifting, provide person-centered care.
- Realize savings from reduced unnecessary utilization.
- Provide care in setting of choice – least intensive setting that best meets enrollee needs.



## Population will include:

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



## Population will exclude:

- Individuals < 21 years old;
- Individuals in the following Home and Community Based Services Waivers:
  - Individual and Family Developmental Disabilities;
  - Intellectual Disabilities;
  - Day Support;
  - Alzheimer's;



## Population will exclude:

- Individuals in State mental hospitals, ICF/MR facilities, Residential Treatment Facilities, long stay hospitals;
- PACE participants (although they may choose to opt in);
- Individuals enrolled in Money Follows the Person;
- Individuals enrolled in Hospice at the time of implementation; and,
- Individuals with other comprehensive group or individual health insurance.



## Services Under Capitation

- **Medicare** services:
  - Medicare A, B services, and D;
- **Medicaid** acute and long term care services:
  - Current Medicaid state plan primary and acute care services, including behavioral health and transportation services.
  - All EDCD waiver services:
    - Including adult day health care, personal care (agency and CD), personal emergency response systems and medication monitoring, respite care (agency and CD), transition coordination, transition services.



## Services Under Capitation

- **Medicaid** acute and long term care services:
  - Nursing facility care.
  - New and additional services:
    - Person-centered care coordination;
    - 24-hour/7 days a week access line;
    - Disease and chronic care management (if applicable); and,
    - Health plans may add supplemental/enhanced services, such as dental care, vision, and hearing.



## CMS requirements

- Heavy reliance on Medicare
  - Submit information via CMS HPMS website, including:
    - Networks
    - Benefit package
    - SNP Model of Care (MOC)
    - Part D pharmacy networks
    - Formulary
    - Medication Therapy Management Plan
    - There will be zero cost sharing under the demonstration
  - State determines LTC network adequacy, credentialing and plan solvency.
- MCO integrated benefit information will be included in the Medicare Plan Finder tool.



## SNP Model of Care

- Description of target population
- Measurable goals
- Staff structure and care management goals
- Interdisciplinary care teams
- Provider networks with specialized expertise and use of clinical practice guidelines and protocols
- MOC training for personnel and network
- Health risk assessment
- Individualized care plan
- Integrated communication network
- Care management for most vulnerable subpopulations
- Performance and health outcomes measurement
- State specific requirements (optional)
- Plans granted approval for 1 – 3 years, based on MCO score (85% + = 3 years; 75%-84% = 2 years; 70%-74% = 1 year; <70% not approved).
- Opportunity to improve score based on feedback.



## CMS Medicare Spring Conference

- April 11 and 12 Hunt Valley, Maryland
- Webcast option
- Register at:

<http://CMSDRUGHealthPlanEvents.org/cms/index.php/events/cms2012-spring-conference/>.

After conference download webcast at:

[www.CMSDrugHealthPlanEvents.org](http://www.CMSDrugHealthPlanEvents.org).



## Enrollment

- Passive enrollment with opt out
  - CMS will not allow mandatory enrollment.
- Medicare open enrollment period.
- Can opt out at open enrollment and anytime thereafter.
- Can change plans at any time.

## Core Elements of Capitated Model

- Strong primary care base;
- Comprehensive provider network;
- Care coordination;
- Interdisciplinary care teams;
- Person-centered plan of care;
- 24/7 call in lines;
- Transition coordination;
- Data-sharing, and communications system;
- Quality monitoring; and,
- Adequate consumer protections (e.g., choice of providers; access to a unified set of grievances and appeals rights; and, customer service assistance).

## Reimbursement

- Plans will receive a capitation rate that will reflect the integrated delivery of the full continuum of Medicare and Medicaid benefits.
  - In past, cost of care coordination could not be offset by Medicaid savings (savings on acute care services would go to Medicare); this model provides shared savings to resolve issue.

## Reimbursement

- Rates will be developed by CMS in partnership with States based on baseline fee-for-service spending in both programs and anticipated savings that will result from integration and improved care management.
- Rate will be risk adjusted.
  - Part D portion of the rate will be based on the standardized national average bid amount and will be risk adjusted in accordance with the rules that apply for all other Part D plans.
- CMS requires that rates provide upfront savings to both CMS and States.

## Reimbursement

- CMS and its actuary will work with States and its actuary to determine the portion of the capitated payment paid by CMS (for Medicare) and the State (for Medicaid).
- Rates will be risk-adjusted.
- Plans will be subject to quality & performance withholds (1, 2 and 3 percent in Years 1, 2 and 3, respectively).
  - Can earn back if meet objectives; 1<sup>st</sup> year objectives *may* be process measures (e.g., submitting encounter data).



## Quality Monitoring

The demonstration will include monitoring to ensure that individuals receive, and MCOs are accountable for providing, high quality care.

- DMAS and CMS will monitor:
  - Provider network adequacy
  - Grievances and appeals
  - MCO quality improvement plans
  - MCO Model of Care and Medication Therapy Management Programs
  
- Types of quality measures may include:
  - HEDIS or HEDIS type measures appropriate for the enrolled population
  - Hospital admissions and readmissions
  - Emergency Room use
  - Up to date individualized care plans
  
- External Quality Review Organization and Independent Evaluation



## Supplementary Benefits

- Plans can offer supplementary benefits to attract enrollees;
  - Should there be an agreed upon set of enhanced benefits required for all plans, to reduce plan switching?

- Depends on what the MA will offer and what people have in October 2013 – can be significant reduction compared to their MA plan – ties to auto-assignment process and if need benefits to entice someone to join plan
- If MA plans offer more attractive benefit, need to be able to respond and offer benefits that will attract enrollees



## Health Risk Assessment

- Should DMAS require that each plan use the same HRA tool?

- Depends – it is important in absence of transition files – can stratify members by risk – creates risk score of member – need best practice tool or develop one to auto calculate scores and assign members based on risk
- Since risk is ours would say no – if have specific questions to look for – our responsibility is to look for those things – can be expensive if duplicate – not sure what expect to gain – our tool to manage risk
- Assuming CMS risk adjust – historic utilization pattern from state – use SNP model of care so individually assessing – what will we use to allow us to put people into services currently covered by waivers
- Are we doing individual risk adjustment or using Medicare model?



## Interdisciplinary Care Teams (ICTs)

- How can MCOs foster the use of interdisciplinary care teams?
- How can ICTs operate and communicate?
- How will activities be documented and shared with providers?

- Built into MOC – will have a lot of health tools – develop a policy of which cases require that level of discussion – for bulk of population really not necessary
- Need to integrate BH and SA into the ICTs – large preponderance of co-morbidities
- Providers really don't want all info – they want to know the exceptions, when it's critical and when to intervene – typically ask for “management by exception” model



## Care Coordination

- Effective, person-centered care coordination is key to the success of the demonstration and will be a required demonstration feature. Several stakeholders have stressed the 'high touch' needs of dual eligible individuals.
- What issues should DMAS consider when developing care coordination requirements in a RFP and contract with MCOs?

- Depending on acuity of member and functional status in home assessments are required – effective telephonic model – initial visit with member in so many days – follow-up done – most at risk assessed immediately
- Needs to be timely – move from claims based info – need robust real time info share
- Individual MOC we customize accordingly – how create environment to ensure safety - if caregiver can be monitored – can't specify in RFP but ask for individualized POC and SNP MOC – include specific things you want to measure – info, not necessarily data, need to be timely – build trust relationship – not all individuals are high touch – regular monitoring



## Transitions

- How can MCOs implement effective transitions from hospitals and nursing facilities?
- What issues should DMAS consider when developing transition requirements in an RFP and contract with MCOs?

Financially at risk so effective transition is in our best interests to manage – think about transition measures in quality measures

## Communication

- MCOs will be expected to have communication networks that include at least one of the following:
  - Web based network;
  - Audio conferencing; and
  - Face-to-face meetings.
  
- What issues should DMAS consider when developing communication requirements in an RFP and contract with MCOs?

- Incentive for members not to jump to other plans – consider other incentives to reduce churning – evaluate what other states doing
- Once January starts other states require stay for specified amount of time to establish relationship – depends on offerings of MA plans and state option – TN and OH asking for lockins
- Takes period of time to gain trust and change behavior – disservice to allow to change plans without specific exceptions
- Less than statewide program – integrate both programs to improve quality – critique is that program is not statewide – failing to incorporate SWVA excludes Carilion – reconsider and make statewide to expand into western regions
- Can you exclude them moving back into FFS since no lockin
- Network adequacy rules established for MA established for Medicare, county by county model – non congruent for where duals live – look at exception process more liberally and look at locations of duals – states have discretion on which model to use
- Let each MCO create own supplemental benefit creates competition
- Allow MCOs to participate in section of regions? Don't need to participate in all 4 regions but must cover the entire region
- Reimbursement as Medicare or Medicaid rate to hospital and physician from the MCOs? Will it impact UPL?
- Several states have indicated won't be windfall – using historic spend with savings off top – helpful to have position as trying to build network so provider know what to expect regarding reimbursement



## Behavioral Health

- How can MCOs better meet the needs of individuals who have behavioral, social and medical needs, including those in NFs?
- What issues should DMAS consider when developing requirements in an RFP and contract with MCOs regarding meeting all the needs of individuals with complex behavioral health needs?

- Co-locate and integrate BH into care management model
- RFP should not be overly prescriptive – part of POC includes BH and what specifically should be addressed but not how to handle it

## Dual Demonstration

- What additional operational issues need to be considered/addressed?
- What recommendations do you have as DMAS moves forward?

- Enrollment – rules are consistent – who owns eligibility file – Medicaid become owner of process
- Create stakeholder meetings and include MCOs on nuts and bolts and operational issues
- Can use assistance with LTC population not in SNF – non-traditional providers – how to deal with coding in order to pay providers and simplified contracts
- Encounter data – standard Medicaid submission with pass thru to Medicare?



## Letters of Support

The proposal will be posted by DMAS for a 30-day public comment period mid-April. CMS will post for additional 30-day public comment period June - July.

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

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

Send proposal comments and letters of support to DMAS electronically at [dualintegration@dmas.virginia.gov](mailto:dualintegration@dmas.virginia.gov) or to DMAS 600 East Broad Street, Richmond, VA 23219. Your support is greatly appreciated.