



*Department of Medical Assistance
Services*



Dual Eligible Financial Integration Demonstration Stakeholder Meeting

Individuals, Families & Advocates
March 28, 2012



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The Issues:

- Dual eligible individuals:
 - Often have complex health care needs;
 - May have physical, intellectual and behavioral disabilities;
 - See multiple providers
 - need to navigate complex medical, behavioral, social and long-term services and supports systems.



The Issues:

- Medicare and Medicaid were not designed to work together; result, lack of access to:
 - Comprehensive care coordination
 - Disease management
 - Integrated care teams
 - Seamless service delivery
 - Quality measurement/monitoring
- Confusion
 - two sets of rules,
 - overlapping benefits with different requirements.



For Dual Eligible Individuals

- Challenges:
 - Understanding two programs;
 - Coordination of benefits (who pays for what?);
 - Balance billing (receive bills when they should not);
 - Obtaining service authorizations;
 - Coordination of care;
 - Communication among PCPs, specialists, long term services and supports case managers, and hospitals;
 - Multiple insurance cards.

Experience of Medicare-Medicaid Enrollees: Finding From Focus Groups in Five States.
Thomson Reuters Healthcare, December 2011.



For Providers

- Confusion - two sets of rules, overlapping benefits with different requirements, (e.g., pre-authorization, benefit limits, appeals timelines, reporting requirements, audits, etc.).
- Poor communication between providers.
- Incomplete knowledge of individual's condition, test results, prescriptions, etc.
- Limited resources or incentives to coordinate services.



For Payors

- Incentives to shift costs;
 - May result in service provided in less preferred settings (e.g., ED, hospital or nursing facility);
 - Contributes to undesired patient outcomes;
 - Contributes to excess growth in health care expenditures and less than optimal allocation of resources;
 - Excess growth can lead to consideration of rate freezes or cuts, benefit cuts, eligibility limits and other measures designed to reign in out-of-control spending.



Dual Eligible Financial Alignment Demonstration

- CMS Medicare-Medicaid Coordination Office and Innovation Center three-year demonstration.
- Opportunity to align Medicaid and Medicare financing and rules.
 - Three-way contract between CMS, State and an Managed Care Organization (MCO).
 - MCOs paid a blended rate to provide all covered Medicare and Medicaid services.
 - Allows for treatment decisions that are not driven by payment source.



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.



Dual Eligible Demonstration Goals:

- Provide care in setting of choice – least intensive setting that best meets enrollee needs.
- Realize savings by reducing unnecessary utilization.



Care Coordination

- Virginia has the goal of providing person-centered care coordination to dual eligible individuals.
 - Care coordination is not a Virginia Medicaid State Plan service and not included in the EDCD waiver.
 - Allows Virginia to add care coordination as an important service for individuals who choose to participate in this program.
 - Will help the individual and their families better navigate the health care system.



Population – Will Include:

- Full dual eligible individuals (receive Medicare parts A, B and D and *all* Medicaid benefits),
- Live in demonstration regions (Northern VA, Tidewater, Richmond - Central, Charlottesville - Western),
- Adults (21 years and older),
- In Elderly and Disabled with Consumer Direction and HIV/AIDS waivers,
- Technology Assisted waiver enrollees in year two.



Population – Will Exclude:

- Individuals less than 21 years old;
- Individuals in the following Home and Community Based Services Waivers:
 - Individual and Family Developmental Disabilities;
 - Intellectual Disabilities;
 - Day Support;
 - Alzheimer's;
- Individuals enrolled in Hospice at the time of implementation (those who enter hospice after implementation may continue to be included).



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 with other comprehensive group or individual health insurance.



Core Elements of Capitated Model

- Strong primary care base;
- Comprehensive provider networks;
- Care coordination;
- Interdisciplinary care teams;
- Health risk assessments;
- Person-centered plan of care;
- 24/7 call in lines;
- Health Education;
- Transition coordination between care settings;
- Information-sharing and communications system;
- Disease and Medication Therapy Management Programs;
- Accessible communications.



Strong Beneficiary Protections

- Stakeholder input throughout the demonstration;
- Passive enrollment with opt out:
 - Implementation coincides with Medicare open enrollment period (October – December);
 - Beneficiary information in mail and on CMS Medicare Plan Finder tool on www.medicare.gov;
 - Access to star ratings for companies with Medicare Advantage plans;
 - No passive enrollment into plans if parent company MA plan has rating of 'consistently low performing';



Strong Beneficiary Protections

- Passive enrollment with opt out, cont'd.
 - Can opt out at open enrollment and anytime thereafter;
 - Can change plans at any time;
- Zero cost sharing;
- Choice of providers – at least two MCOs in each region;
- Unified set of grievances and appeals rights;
- One customer service assistance line to call for all services - available 24/7.
- Quality monitoring;



Strong Beneficiary Protections - 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 MOC score (85% + = 3 years; 75%-84% = 2 years; 70%-74% = 1 year; <70% not approved).



Strong Beneficiary Protections

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 may offer supplementary benefits to attract enrollees:
 - Which non-Medicare/Medicaid benefits are most valued by individuals?
 - Should there be an agreed upon set of supplementary benefits required by all plans, or should it be flexible?

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19

- Most requested is dental and preventive maintenance – study of use of ER for dental needs – may be opportunity for savings
- Dentures should be included – vision is issue in VA along with paying for glasses
- Are there gaps in Medicare Pt D coverage – problems with assistance for over the counter prescriptions?
- Big gap between going between EDCD waiver and nursing home – other options such as ALF should be considered
- Audiology and hearing aids and over the counter prescriptions recommended by doctor but not covered
- Will the scope of services offered be expansive in terms of allowing CM determine what the person needs – e.g. limits on DME and items not covered today – need to allow flexibility – what can we do beyond medical services so individuals can remain safely at home
- Vision/dental/hearing – lack of patient centered planning – talking nutrition, safety, communication – everyone knows what's going on but must address nutrition and safety – can't exclude and call patient centered
- Involvement of BH supports – issues of limiting transfer of persons from one setting to another – real need for meaningful BH supports – involve special teams in facility and home environment
- Tracking device technology (GPS based) for persons with dementia
- DME – chairlifts and ramps to adapt to the home – environmental modifications
- Supports for caregivers – how to connect with services and community supports
- Like to see some mandates and some flexibility – require plans to have environmental modifications – have pot of money for that and other non-medical supports – vision and dental pervasive – test to see if providing these services does make a difference along with medication management
- Concept to create incentives for plans taking the risk – ideas of requiring something limits flexibility of things they want to do – compete based on supplementary benefits
- Concerned re process for setting capitated rate – make it attractive with enough add-ons and enough competition
- Some flexibility important – can't come up with one set of benefits for every individual – allow flexibility to target benefits for sub populations



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Dual Demonstration Option

- What would make this program an attractive option so that individuals will want to enroll?

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20

- Care coordination must have an excellent reputation – must be able to trust it as a medical and supportive model – no focus on the savings
- Simplification of paperwork – market as way to stop getting all letters and make delivery of services streamlined – “we take care of the paperwork” – current providers should be in networks to avoid switching doctors – network adequacy and protection of existing relationships – also holds true for drug regimen so not a shake up of current coverage
- Needs state and federal support – include the manual and as much info as possible
- Individual care manager as one “go to” person that individual relates to for services – 24 hour call line appealing and quality of info provided
- Not have a lot of growing pains when rolled out – having issues at time of enrollment will impact effective enrollment – fix issues before moving people in
- Don’t need to be marketed in order to enroll but to keep them from opting-out – serve those whose first language is not always English
- Complaint process built in that allows to raise issues with procedures and info and processes – different than appeal process, easy to use with quick turnaround – limited in provider base due to accessibility (e.g. equipment) - providers should be ADA compliant – market that we have ensured that basic requirements have been met by providers



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 parts of care coordination would be most helpful to individuals and their families?

- Concerned that care coordination designed for Alzheimer's population – lot of pieces that care coordination will need to figure out for this population that may be out of the general experience
- Flexible with time schedule for the family – very in touch and in tune with family and referrals in community and be very accessible – access within same day
- Look at Wagner's model which is self-empowering model
- Knowledge of care coordinators is critical as is accessibility of care coordinator – require plans to have 24/7 accessibility and be very clear – what about caseload standards and what is meaningful – required contact on regular basis that is monitored by DMAS
- Stress 24/7 telephone nurse CM not considered high touch
- Stable workforce with low turnover especially as forming relationships



Impact

- How do you think individuals can benefit from the demonstration?
 - If you have the opportunity to change how to get health care, what would you change?
 - How can this program improve the care individuals receive?

- Trying to coordinate what Medicare and Medicaid provides and where to advocate for what they need – homebound rule for DME and using Medicaid standard – use more appropriate standards used by Medicaid – which provider accepts Medicare and which accepts Medicaid can be frustrating
- Family members and caregivers don't know what each program provides – if this bridges gap it becomes huge benefit
- Transportation can be source of frustration – should incorporate coordinated transportation
- Transportation needs to get to appointment on time and doctors should be more flexible for those who are late
- Build into model additional time for PCP to work with and serve patient – PCP relationship is key - build into reimbursement rates extra time to work with patients
- Health education is important but should be interdisciplinary – receiving right care that the individual wants and understanding their options by empowering them
- Person directed care plan with effective care coordinator – placed in LTC settings that are not prepared to manage their needs – build in strong communication with care coordinator and staff at facility – maintain the individual with the interdisciplinary team that has all the info
- More services available through consumer directed – more than personal care and respite – assistive technology includes evaluation which can cost more than the item – more common sense used in determining individuals needs



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Dual Demonstration

- What recommendations do you have as DMAS moves forward?

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23

- Individuals with specialized needs should have consideration for staying with existing providers if they have unique needs
- Change model from opt-out to opt-in – consumer buy-in will help – tough message to explain you can opt-out before enrollment and then opt-out after enrolled – raise as policy and communication consideration - network adequacy is important - DMAS give preference to non-profit plans for demonstration – plans selected have strong MLR and bulk of payment going to services for population – control from outset those plans who think this is way to make big profit
- Safety of individuals with Alzheimer's or dementia – individuals may need more intense services and don't need to the barriers
- Those with developmental disabilities – needs important to consider – those 2000 in nursing facilities need to get the supplemental services and plans should be prepared to offer
- Those used to FFS who might experience friction with providers initially and what is only medically necessary –develop relationship with providers and care coordinators



Letters of Support

The proposal will be posted by DMAS for a 30-day public comment period mid-April and is due to CMS by May 31, 2012. CMS will post the proposal for an 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@dmass.virginia.gov or to DMAS 600 East Broad Street, Richmond, VA 23219. Your support is greatly appreciated.