Demonstrations to Improve Care for Dually Eligible Beneficiaries: State Perspectives on Year 1

October 30, 2014
2:30 – 4 p.m. ET

For audio dial: 877-585-6241
Passcode: 266290

Implementing New Systems of Integration for Dual Eligibles (INSIDE) is supported by The Commonwealth Fund and The Scan Foundation.
A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care

- **Priorities**: (1) enhancing access to coverage and services; (2) integrating care for people with complex needs; (3) advancing quality and delivery system reform; 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.
I. Welcome and Introductions
II. Implementation and Beyond – An Update of States’ Integration Efforts
III. State Perspectives on the First Year of Their Demonstration Programs
   a. Virginia
   b. Washington State
   c. Minnesota
IV. State Reaction from Massachusetts
V. Questions and Answers
Welcome and Introductions

Michelle Herman Soper
Senior Program Officer
Center for Health Care Strategies

Carolyn Ingram
Senior Vice President
Center for Health Care Strategies

Cynthia Jones
Director
Virginia Department of Medical Assistance Services

Alice Lind
Manager, Grants and Program Development
Washington Health Care Authority

Pamela Parker
Project Consultant
Minnesota Department of Human Services

Erin Taylor
Policy Analyst
MassHealth, Massachusetts
Executive Office of Health and Human Services
Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to panelists.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
The Affordable Care Act (ACA) Created Unparalleled Opportunity to Advance Integration

2010
ACA establishes the Medicare-Medicaid Coordination Office (MMCO) in CMS

2011
MMCO articulates Medicare-Medicaid integration goals

2012
States submit demonstration proposals

2013-2014
States begin financial alignment demonstrations

CHCS Center for Health Care Strategies, Inc.
## Accomplishments to Date*

<table>
<thead>
<tr>
<th>12</th>
<th>Demonstration MOUs</th>
<th>CA, CO, IL, MA, MI, MN, NY, OH, SC, TX, VA, WA</th>
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<tbody>
<tr>
<td>8</td>
<td>Implemented Demonstrations</td>
<td>CA, CO, IL, MA, MN, OH, VA, WA</td>
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<tr>
<td>5</td>
<td>Three-way Contracts</td>
<td>CA, MA, IL, OH, VA</td>
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<tr>
<td>2</td>
<td>MFFS Demonstration Final Agreements</td>
<td>CO, WA</td>
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*As of October 2014
Key Activities to Advance Future Integration Efforts

- Negotiating new state-federal partnerships and building state oversight capacity
- Stratifying populations and engaging individuals in assessments and care planning
- Advancing administrative alignments
- Identifying state and health plan best practices
- Communicating with stakeholders post-implementation
- Implementing new enrollment processes, quality measures, and encounter reporting requirements
- Identifying opportunities for integration outside of the Financial Alignment Initiative
Virginia Model Highlights

1. Capitated Model: Reimbursement is blended & risk adjusted based on Medicaid, Medicare, and Medicare Advantage data.

2. Three-way contract between CMS, DMAS, and health plans referred to as MMPs (Medicaid-Medicare Plans).

3. High-quality, person-centered care that includes care coordination and is focused on member needs and preferences.

4. Behavioral Health Homes created in partnership with CSBs for individuals with Serious Mental Illness (SMI).

5. HealthKeepers
   Humana
   Virginia Premier
   Three Medicare-Medicaid Plans

An advantage to Virginia of the Medicare/Medicaid Model is shared savings, which provides funding for care coordination and improves quality.
Flexibility in the 3-Way Contract

- Required behavioral health homes for SMI population
- Emphasis on transitions between settings of care
- Waived Skilled Medicare hospital stay
- Followed Medicaid rules for Telehealth
- Required standard fiscal agent for consumer directed services
- Required Plans to describe how they will reimburse nursing facilities; minimize administrative burdens
Implementation Timeline

- **MOU**
  - Competitive process for MMP selection
  - Multiple-step readiness reviews
  - Ensure adequate provider networks

- **Summer-Fall 2013**
  - Contracts signed
  - Extensive systems testing

- **December 2013**
  - March 2014-Present
  - Phased in Enrollment
  - Ongoing Outreach & Education
  - Contract Monitoring
  - Program Evaluation

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Tammy Whitlock, Division Director of Integrated Care & Behavioral Services
# Virginia Enrollment

<table>
<thead>
<tr>
<th>Region</th>
<th>Active Opt-ins</th>
<th>Passive Opt-ins</th>
<th>Opt-outs</th>
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<tbody>
<tr>
<td>Central Virginia</td>
<td>1547</td>
<td>9495</td>
<td>7977</td>
</tr>
<tr>
<td>Northern Virginia</td>
<td>246</td>
<td>1672</td>
<td>1261</td>
</tr>
<tr>
<td>Roanoke</td>
<td>423</td>
<td>4796</td>
<td>3259</td>
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<tr>
<td>Tidewater</td>
<td>1118</td>
<td>7568</td>
<td>7601</td>
</tr>
<tr>
<td>Western/Charlottesville</td>
<td>289</td>
<td>2744</td>
<td>1823</td>
</tr>
<tr>
<td><strong>Total Members</strong></td>
<td><strong>3623</strong></td>
<td><strong>26275</strong></td>
<td><strong>21921</strong></td>
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</tbody>
</table>

Table includes members with a future enrollment begin date.

Northern VA – An additional 3,500 individuals are scheduled to auto-enroll in CCC 11/1/2014.
Changes in Latitude...Changes in Attitude

TIME FOR A REORG!!!

• Created a new Deputy Director of Complex Care and Services

• Created a new Division for Behavioral Health and Integrated Care

• Hired Director for the Office of Coordinated Care and Outreach Specialist
Cultivating Stakeholder Education

- Early Stakeholder engagement through Advisory Committee—meets quarterly
- Weekly calls
- Monthly Stakeholder Updates
- Regional Townhall Meetings (upcoming events posted to DMAS website)
- Ongoing presentations by request
- MMPs worked together to combine provider training
## Ongoing Outreach

### CCC UPDATE CALLS
Every Tuesday 12:30-1:30pm and Friday 10am-11am
To join the call dial: 1-866-842-5779
Pass Code – 6657847797 #

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### Great forum!
Stakeholders ask their questions and DMAS/MMPs learn about beneficiary & provider experiences with CCC

### CCC Team conducting 7 calls every week

<table>
<thead>
<tr>
<th>Monday Provider Calls (LTSS)</th>
<th>Friday Provider Calls</th>
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<tbody>
<tr>
<td><strong>Adult Day Services</strong></td>
<td><strong>Hospitals and Medical Practices</strong></td>
</tr>
<tr>
<td>1:30-2p Conference Line 866-842-5779 Conference code 7143869205</td>
<td>11-11:30am Conference Line 866-842-5779 Conference code 8047864114</td>
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<tr>
<td><strong>Personal Care, Home Health &amp; Service Facilitators</strong></td>
<td><strong>Behavioral Health</strong></td>
</tr>
<tr>
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<td>11:30am-12pm Conference Line 866-842-5779 Conference code 8047864114</td>
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<tr>
<td><strong>Nursing Facilities</strong></td>
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<tr>
<td>2:30-3p Conference Line 866-842-5779 Conference code 7143869205</td>
<td></td>
</tr>
</tbody>
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VICAP & Ombudsman

DMAS

Sharing beneficiary concerns & trends

Partnership for outreach

Ombudsman

VICAP

Problem Resolution
Challenges and Lessons

• Enrollment
  – Enrollment/Disenrollment functions coupled with member choice
  – No limit to opt-in/out
  – Multiple avenues to make enrollment changes

• Systems issues
  – Unable to perform end-to-end testing before going live
  – IT/data system changes and upgrades due to mandated program changes
  – Unable to obtain the Medicare claims history data from CMS
  – Lack of Medicare encounter data

• Anticipating program challenges
  – Number of letters to beneficiaries/Enhancing clarity of letter content
  – Design of enrollment/disenrollment only at start of a month
The Provider Factor

- Strategies to counter providers attempting mass opt-outs
- Single case agreements allow enrollees to continue with current provider
- Providers holding out on contracting creates enrollment confusion or worry for beneficiary
- Engaging providers in multiple settings and methods
Stakeholders Make it or Break it!

• Engage Stakeholders Early!
• Maintain regular and accessible forums for stakeholder feedback
• When working with Health Plans, Education on Dual sub-populations can be vital to engagement
• No such thing as too much communication!
While making a routine call to member, the Humana Care Coordinator (CC) reported the member expressed serious depression and potential to harm herself. CC was able to get the member to agree to a behavioral health (BH) referral and immediately called her primary care physician (PCP). An integrated care team meeting was convened and it was decided the member should visit the emergency room, where she was able to re-start her medications for stabilization. About a week later the member committed to keeping her PCP appointment while agreeing to assistance from BH team for case management as primary.
Next Steps . . . .

• Transition CCC to mandatory managed care on the Medicaid side
• Expand the CCC to the rest of the state
• Determine how best to move the remaining non-duals and home and community based care waiver services into managed care
Who is Eligible for CCC?

- Full benefit Medicare-Medicaid Enrollees (entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits)
- Participants in the Elderly or Disabled with Consumer Direction Waiver
- Residents of nursing facilities
- Age 21 and Over
- Live in designated regions (Northern VA, Tidewater, Richmond/Central, Charlottesville, and Roanoke)
Who is *not* Eligible for CCC?

- Individuals not eligible include those in:
  - ID, DD, Day Support, Alzheimer's, Technology Assisted HCBS Waivers
  - MH/ID facilities
  - ICF/IDs
  - PACE (although they can opt in)
  - Long Stay Hospitals
  - Money Follows the Person (MFP) program
  - Hospice
  - Other Comprehensive Coverage (TPL)
Enrollee Benefits

1. One system to coordinate care
2. One ID card for all care
3. 24/7 local call center with access to beneficiary records
4. Unified appeals process
5. Person-centered care coordination
6. Expanded Benefits
Weekly Contract Monitoring Team (CMT)
Meetings with each health plan to review:

- Marketing Materials
- MMP Staffing
- Complaints
- Provider Training & Feedback
- Network Review

- Dashboard
  - Claims & Processing Time
  - Customer Service Line
Continuity of Care

• Keep Providers that are In-Network
• Care continues with current providers for up to 180 days
• Afterwards, will need to choose In-Network providers
• During transition providers bill the MMP, not Medicare & Medicaid
Evaluation

• Evaluation Advisory Committee:
  – 12 members representing aging, physical disability, nursing facility, ID/DD, hospital, and health plan communities

• DMAS/George Mason biweekly team meetings

• Focus Groups & Interviews to collect data and develop in-depth understanding of the CCC Program
  – DMAS, Providers, MMPs
  – site visits: AAA, AD, CSB, Townhalls
  – Observations of MMP Care Management Activities

• Enrollee Survey Questionnaire

• Evaluation *Notes from the Field* reports posted to DMAS webpage [http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx](http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx)
Health Homes
The Washington Managed FFS Demonstration
State Strategies for Integrating Care For Duals Include …

• Health Homes in all systems
  ➢ Rolled out regionally
  ➢ Health Homes for “duals” and “Medicaid only”

• Fully Capitated Model
  ➢ A single benefit that includes medical, long-term care, mental health and substance abuse services
  ➢ Paid through capitated contracts with health plans that combines related funding
Service Needs for High Risk/High Cost Medicaid-Only Beneficiaries Overlap

Data for Blind/Disabled Category: 29% served by Aging & Long-Term Services Administration
Service Needs Overlap for High Risk/High Cost Beneficiaries who are Eligible for Medicare & Medicaid

95% served by ALTSA

- Long Term Care (LTD)
- Developmental Disabilities (DD)
- Serious Mental Illness (SMI)
- Alcohol and Drug Abuse (AOD)
Authority for Health Home

• Federal law – Section 2703, Affordable Care Act
• State law – SSB 5394 (passed in 2011)
• State Plan Amendments (July and October 2013)
• Additional authority under Duals Demonstration for Shared Savings for Duals
Health Home “Umbrella”

• Health Homes receive a monthly electronic enrollment file on a monthly basis.
• Health Homes build a network of Care Coordination Organizations that serve mental health, long-term care, and medically complex clients.
• Health Home Leads may also provide care coordination services directly.
Payment for Health Home Services

Up to once a month fee paid for Health Home services:

- $252 for outreach, engagement and health action plan
- $172 for intensive care coordination services
- $67 for maintenance
Health Home Design Challenges: Different Authorities

- 1945 State Plan Amendment – 2703 Health Homes
  - Population inclusions (managed care/FFS)
  - SPA approval takes time
  - Eight quarter limit to 90/10 match
- MFFS Final Agreement
  - Mandatory core measures don’t align with mandatory Health Home measures
  - SPA must be signed before Final Agreement is signed
  - Savings sharing has a high bar
**Health Home Implementation Challenges**

**Challenge:** Health Home Lead organizations operate differently; Care Coordinators subcontract with multiple organizations

- Health Home Lead organizations use different platforms for reporting Health Action Plans
- Lead organization requirements varied, e.g. how often to call, when to submit an encounter for a “low intensity” month

**Solution:** Increased standardization

- Common policy for “due diligence” in outreach
- Common policy for high and low intensity designation
Health Home Implementation Challenges

**Challenge:** HCA requires the use of HIPAA transactions to report Health Home encounters

- Some leads struggled to develop reporting systems
- Engagement rate under-reported due to data lag: based on encounters, 13% (June 2014)
- Even including completed Health Action Plans, engagement is low at 15% overall (Sept 2014)

**Solution:** Identify ways to improve outreach and engagement

- New smart assignment method for duals piloted in July improved contact information for 50% clients
Next Steps

• Finalize enrollment of all Duals
• Health Home Remodel
  ➢ Technical Assistance from Center for Health Care Strategies (site visit in August)
• Theme: Sustainability
  ➢ Increase engagement
  ➢ Potential payment restructure
  ➢ Standardized processes/communication tools
  ➢ Data to support clinical improvement
  ➢ Ways to streamline program
Success to Date

• Over 370 Care Coordination staff trained to use a common assessment tool and care plan

• September 2014 Snapshot:
  ➢ 7961 dual eligibles enrolled
  ➢ 1167 Initial Health Action Plans received

• Health Home Leads are working together to resolve issues and share best practices
Resources

Websites:

http://www.hca.wa.gov/medicaid/health_homes/Pages/index.aspx

http://www.altsa.dshs.wa.gov/stakeholders/duals/

Alice Lind – Alice.Lind@hca.wa.gov
CMS-Minnesota Federal State Partnership to Align Administrative Functions for Improvements in Medicare Medicaid Beneficiary Experience

Pamela Parker, MPA
Special Needs Purchasing
Minnesota Department of Human Services
Pam.parker@state.mn.us
651-431-2512
Integrated Managed Care in Minnesota

• 1995: First approved state Medicare/Medicaid demonstration (MSHO)

• 2005-2006: Expanded Medicare/Medicaid MLTSS program for seniors statewide through contracts with 8 D-SNPs

• Seniors: 90% (49,000) of Medicaid seniors enrolled in MLTSS (all settings and levels of care) under two options:
  – Minnesota SeniorCare Plus (MSC+): 13,300 enrollees, coordinates Medicare, enrollment mandatory
  – Minnesota Senior Health Options (MSHO): 35,300 enrollees, integrates Medicare, enrollment voluntary

• People with Disabilities <65: 50% (48,500) enrolled, includes behavioral and physical health, no MLTSS
  – Special Needs BasicCare (SNBC): Voluntary program with opt out/passive enrollment, navigation and coordination of Medicare
  – Not able to integrate with Medicare due to loss of most D-SNPs for this group
Enrollment by Setting of Care 1996 and 2014

<table>
<thead>
<tr>
<th>Setting of Care</th>
<th>1996</th>
<th>2014</th>
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<tbody>
<tr>
<td>Community</td>
<td>14,837</td>
<td>20,045</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>30,104</td>
<td>12,968</td>
</tr>
<tr>
<td>Elderly Waiver</td>
<td>4,726</td>
<td>22,598</td>
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</table>

Total = 49,667

Total = 55,611
Challenges Under SNP “World”

• No “seat at the table” for States with Medicare to resolve new or ongoing conflicts or to work toward further alignment/efficiencies

• Wanted clarification of Medicare inclusion in state payment and delivery reforms

• No clear authority for many integrated features
  – Integrated benefit determinations, integrated provider billing and claims processing
  – Integrated enrollments (State TPA role)
  – Integrated member materials (not able to use FAD materials)
  – 30 day difference in time allowed for submission for grievance and appeals
  – Integrated MOC, assessments and care coordination
  – Still separate Medicare and Medicaid requirements for QA QIPs/PIPs/CCIPs

• Growing number of incidents threatened operational integration
  – Disapproval of all MIPPA contracts in 2012 and 2014
  – Differences in tracking requirements for processing enrollments
  – New 365 day assessment tracking policy
  – Must buy down Part D and guess at LICS benchmarks, constant fear of premiums

• Important to be part of the new demo process, vs caught in “no-man’s land”
MN MOU GOALS

• **Summary:**
  – 3 year demo (through 2016) for MSHO/MSC+ seniors eligible to enroll in MSHO
  – Builds on current FIDE-SNP platform for MSHO seniors along with key FAD features, D-SNPs remain D-SNPs, not MMPs
  – No new procurement/applications needed, seamless transition to demo status for current and new members in 8 current MSHO D-SNPs for 65+ population
  – Current SNP and Medicaid financing and rates parameters
  – Medicare and Medicaid contracts remain separate, but were amended
  – <65 Disability population NOT included, still pursuing separate non-SNP demo

• **State Goals:**
  – Joint State role with CMS in Medicare SNP communications and oversight
  – Improve SNP platform to align with and support State Payment and Delivery Reforms as developed through stakeholder efforts
  – Preserve/enhance integrated administrative and operational features and reduce reliance on informal CMS Medicare SNP policy agreements
  – Improve integrated D-SNP administrative efficiency and alignment
What Does this Alignment Demo Do?

• Provides ongoing State role in SNP communications and oversight
  – CMS-State Contract Management Team
  – Addresses access, quality, program integrity, financial solvency, complaints, health and safety, compliance, etc. through sharing of information
  – Address concerns that would reduce integration
  – State access to CMS HPMS (delayed due to CMS systems issues)

• Integrated Model of Care
  – State allowed to incorporate State MLTSS requirements (integrated assessment and care plan requirements) into MOC
  – State role in MOC reviews

• Role for State in Network Reviews
  – Requires new network reviews for MN plans tailored to dual populations
  – State role in exceptions process
  – Coordination of Medicare-Medicaid network adequacy standards

• Integrated Grievance and Appeals
  – Provided Medicare waiver for integrated grievance and appeals, simplification of notices
What Does this Alignment Demo Do?

- **Coordination of Integrated Member Materials**
  - State develops model materials with D-SNP workgroup and provides to CMS
  - Coordinated State materials reviews with CMS RO reviews, provides review coordinator at RO
  - RO liaison for communications to State
  - Retains integrated Member Handbook (Evidence of Coverage), Summary of Benefits, member notices and communications,
  - Can use FAD materials and clarification of file and use for integrated member materials (can actually use changes MN has proposed!)

- **Authority to continue integrated operations and improvements**
  - Integrated enrollments and simplification of forms
  - Allows State TPA enrollment role and allows extended time frames for Medicaid verification
What Does this Alignment Demo Do?

• Support for MN Payment and Delivery Reforms
  – Medicaid Health Care Home payments can be merged with Medicare Primary Care payments
  – Specifically allows Integrated Care System Partnerships (ICSPs)
  – ICSPs are payment and delivery reform projects included in State contract requirements that cross Medicare and Medicaid services
  – SNPs typically pay integrated PMPMs for care coordination and primary care and/or share savings, waive 3 day hospital stays, and provide in lieu of hospital days and individual service substitutions under such partnerships

• Support for Continued Integrated Benefits and Payments
  – Allows integrated benefit determinations (necessary to continued support of payment and delivery reforms)
  – Integrated provider claims functions (instructions to auditors to allow in reviews, with appropriate allocation documentation)
  – Allows flexibility in bid margins in limited situations to reduce likelihood of member premiums
  – Language preserved to work toward waiver of Part D co-pays
What Does this Alternative Demo Do?

- Agreement with CMS to work toward more unified Quality Metrics
  - Opportunity to propose and/or test more relevant measures for potential Star Ratings, including LTSS measures and adaptation of provider level measures for plan level
  - Integration of Medicare and Medicaid CAHPs surveys
  - HOS surveys in additional languages (Somali)
  - Integrated PIP/QIP using Medicare formats with State input into topics
- Modest grant funds to support demonstration
  - Staff for project management, evaluation and reporting
  - Funding to continue to build dual data base
  - Small outreach effort to educate diverse communities of MSC+ members about enrollment options including MSHO
- State access to Medicare data
  - (JEN iMMRS system)
- Formal CMS evaluation
  - Tailored to D-SNP platform base and MN MOU specifics
Summary

- D-SNPs remain important vehicle for states in integration of MLTSS
- Use MN D-SNP MOU to explore pathways toward improved CMS/D-SNP/State collaboration
  - MMCO cites MN Demo as potential precedent for other states working with D-SNPs
  - MN MOU aligns with recommendations by MedPAC, State Medicaid Director’s Association (NAMD) and NGA for better coordination between States and D-SNPs
  - Need multiple integration models depending on variable Medicare payments and alignment with State markets and delivery reforms
- Further improvements in D-SNP platform needed:
  - Expand CMTs to other states with D-SNP MLTSS programs
  - CMS, States and D-SNPs can do more to maximize integration under MIPPA contracts
  - Permanent reauthorization of D-SNPs needed for program stabilization
  - Improvement in risk adjustment for people with disabilities needed
  - Medicare Star ratings must consider socio-demographic and economic factors and be better targeted to needs of dual populations
- Much thanks to Melanie, Tim, Stacey and the entire MMCO team!
Reaction

Erin Taylor
Policy Analyst
MassHealth
Massachusetts Executive Office of Health and Human Services
Questions?

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Contact Information

- Michelle Herman Soper  msoper@chcs.org
- Carolyn Ingram  cingram@chcs.org
- Cindi Jones  cindi.jones@dmas.virginia.gov
- Alice Lind  Alice.Lind@hca.wa.gov
- Pam Parker  Pam.parker@state.mn.us
- Erin Taylor  erin.taylor@state.ma.us
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