Virginia Advisory Committee Meeting: Summary of Committee Questions
November 15, 2012

Updates from National and State Overview Presentations

- Virginia received a few questions from CMS last week related to special pops, e.g., how benefits will be coordinated for hospice and ESRD; coordination between people with IDD and EDCD waiver services and supports
    - Generally supportive of program design
- 1/1/14 implementation target
- Will send provider letter to notify/warn that health plans may be reaching out to ask them to join networks
- RFA will focus on how plans will deliver services and supports and how they will structure care coordination activities

Questions and Comments on National and State Overview Presentations

- What does the lack of flexibility in Medicare mean for hospice and acute benefits? Is there flexibility in benefit to structure benefits to individual needs?
    - limits to flexibility based on current Medicare parameters
    - we can take back specific questions to CMS if providers have specific concerns; some interest on NH side about looking at benefit components
- Plans should have discretion to determine benefit; e.g., will plan be able to decide if 3 day post acute care stay is not needed for person, and if so release them back to NF or home sooner—is there flexibility for plan to target care for each person—the point of integrated care?
- For states doing both models (capitated and managed fee-for-service), how can they pursue both?
    - Julie—explained that NY is pursuing both
- Think about provider education—state should have stepped up sooner to provider community to make sure they can plan ahead for 1/1/14 sufficiently –esp. with regard to warning them about how health plans will reach out to them. Send letter out ASAP
- Will state solicit plans before MoU?
    - Yes—will release RFA before MoU; state sees it as opportunity to work with partners early on
- Will organizations that are community-based but not part of Medicaid now be eligible to participate? Will they get the information letter going out to providers?
    - Yes—will make sure letter is available publicly
- Compressed time frame is concern for providers who are not used to using these types of quality metrics—how will state educate these providers on standards, reporting, etc.?

Provider network priorities focus group:

State questions—want feedback on LTC providers; BH providers, consumer direction, others

- What is there for people with dementia? Should not lump people with dementia into BH needs—wants more detail on that
- An evaluation requirement for plans could be to make them report how many providers in their networks are currently serving duals? Check if the network they have for enrollees will be less disruptive once demo starts
- Could the state take a more active role in managing plan data that is disseminated to frontline providers to better understand patient? Could be the plans' responsibility but thinks it would benefit from state involvement
- Identify which and how patients are using system effectively— what service sites/providers have the best outcomes and are least expensive— plans should provide this info
- Interested in how care coordination will be defined. For adults with dementia or SMI, care coordination needs could be very great, include natural support and family care
- Provider categories in presentation imply additional silos by provider--e.g., if someone has dementia, SMI, Physical disability and over 60—note that almost no duals are in one of the service categories
- Timely access to DME and assistive devices—is this a quality indicator? Plan monitoring standard?
- There are several services missing from slide that must be included—transportation, adult day care
- What about rural areas? There are fewer providers—will that be reviewed and promoted in plans? Transportation issues? Personal care aide going to visits with you?
- Silo issue. Potential for tremendous savings in avoiding NF patients going to hospital for routine procedures, e.g., UTI. Just wanted to illustrate this may be an area for savings
    - Same applies to care at home
- What happens to patients who are transferred from NF to hospital and then beds are gone in NF when they want to return—what if only location with available beds is out of network?
    - Also, what is the mechanism to address plans that have accepted several providers who are not meeting patients' needs; generating appeals—can we get this information easily for consumer feedback in terms of renewing contract with plan or making plan make changes in their network—how do we minimize provider issues in a plans network and to what extent will consumers be involved in that?
- Is there a provision for plans to include LTSS for those requiring less than a NF LoC so that they can remain in homes? If not can we ensure there is? (i.e., bridge services?)
    - DMAS - want to encourage this; depends on plan capacity and rates—but is high state priority to push for this
- Reiterate the importance of transportation and nutrition and getting food into house
- Dental care

Education and Outreach Focus Group: What is the best way to communicate information to stakeholder groups, esp. beneficiaries and providers?

- Strategy must be grassroots based; beneficiary outreach should focus on groups they already know and trust, e.g., churches, local senior centers—reach out to existing supports for beneficiaries and family members—this is likely more effective than phone calls, letters, etc.
- Before any material is mailed, do radio or TV PSAs to give a heads up that information is coming and to look for it
    - Materials should include clear, upfront contact info for enrollment broker and community supports
- Education for this population should be in context of family/full team of care decision makers. Also change the word "broker"—makes it sounds like there is a financial interest, not counseling—could be confusing for people
- Beneficiary needs to feel like a partner in this care program—not just a coverage program—this demo must be communicated that it is full plan for person's well-being for which they are partners
- Reference the Dept of Social Services upfront on beneficiary materials—they are used to seeing and may increase comfort level and trust
- Slogan for program? Make it catchy to get attention?
- Need to highlight choice of plan before passive enrollment begins. Also need to make sure it is clear enrollment broker is independent of any providers or plans. Include checklist/enrollment-decision document with issues they should consider in materials.
- Community meetings with plans and advocates/stakeholders would be helpful , e.g., "speed-dating" model
- Consumer/provider guides for what to look for in managed care plans—like prudent purchaser guides at consumer/provider level
- For community orgs that are not existing Medicaid providers—how do we find out about them to start communicating?
    - DMAS - Once info starts getting to AAAs, ILSs, ADRC , stakeholder networks, etc. providers will be reached and state will take requests for 101 trainings, info, etc.

<u>Quality Assurance Focus Group</u>

- Recommendation for quality measures that may provide savings opportunities:
    - Reduced use of inappropriate ED for services best provided in PC setting
    - Inpatient admissions for ambulatory care sensitive conditions
- Preventive care for SPMI—whoever is treating physician must understand trauma-focused care. How do PCPs understand issues with personal space, how to work with people with trauma history who may need more sensitivity and who are less likely to want to go to doc. FQHCs tend to understand this well.
- Measure consumer satisfaction, quality of life measures
- Don't think current quality measures represent sufficient paradigm shift to fully integrated care. How can we adjust them to be more person-centered? What about patients with several conditions?
- Make sure providers have access to patient data to help inform this ongoing discussion.

- Has state done analysis of population diagnoses? Is that how state gathered quality measures? Must include dementia-related measures—and could there be any groups left out of measures?
    - State—we have to somewhat adhere to CMS SNP structure
- Wants more quality information over email before they can adequate answer what 12th model of care model should be? What are options/comments, etc. so they can discuss more?
    - State--Measures are in MoU process—not RFAs—which gives more space to this timeline—ideally get a response in mid-Dec

Next steps:

- Meeting in March
- Email communication on issues with group and individually

Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees
Virginia Advisory Committee*

November 15, 2012, from 1:00 to 4:00 pm
NEW LOCATION: Virginia General Assembly Building, House Room D

Meeting 1

I. Welcome and Introductions	Cindi Jones, Director, Virginia Department of Medical Assistance Services (DMAS)	1:00-1:15 pm
II. National Updates	Julie Klebonis, Program Officer, Center for Health Care Strategies (CHCS)	1:15-1:30 pm
III. Virginia Updates	Karen Kimsey, Director of Policy and Research, DMAS	1:30-1:45 pm
IV. Questions on National and Virginia Updates from the Advisory Committee	J. Klebonis and K. Kimsey	1:45-1:55 pm
V. Overview of Focus Sessions	Greg Howe, Deputy Director, Medicaid Leadership Institute, CHCS	1:55-2:00 pm
VI. Committee Member Focus Session I: ***Access to Care and Provider Networks*** **Overview:** • Medical providers (Medicare) • Pharmacy providers (Medicare) • Long-term care providers (agency) • Long-term care (consumer directed) • Behavioral health providers • Review of planned priorities for providers **Share your priorities for:** • Travel time and distance • Choice of providers • Consumer Direction • Additional recommendations	Suzanne Gore (DMAS) and J. Klebonis (CHCS)	2:00-2:35 pm
BREAK		2:35-2:45 pm

VII. Committee Member Focus Session II: ***Education and Outreach*** **Overview of Stakeholders:** • Beneficiaries • Families/caregivers • Providers • Community organizations (e.g., clergy, senior groups, advocates) • Local partners (AAAs, DSS, CSBs, CILs, others) • Other state agencies **Share your thoughts on:** • Best modes of communication to reach various stakeholder groups • Timing of outreach efforts • Additional recommendations	K. Kimsey (DMAS) and Meredith Lee (DMAS)	2:45-3:20 pm
VIII. Committee Member Focus Session III: ***Quality Assurance*** **Overview:** • CMS core measures • 1915(c) EDCD waiver measures • Ensuring and measuring satisfaction **Share your thoughts:** • Do core and EDCD measures seem sufficient? • Should DMAS require a 12th optional Model of Care Measure? If yes, what should it be? • What other state measures should be included, if any?	G. Howe (CHCS) and Paula Margolis (DMAS)	3:20-3:50 pm
IX. Wrap Up and Next Steps	Cindi Jones	3:50-4:00 pm

*The Department will not hold a public comment period during this meeting; however, stakeholder input is very important to the Department and the Advisory Committee. If you have follow up questions or comments that you would like discussed during a future meeting, please submit them to Dualintegration@dmas.virginia.gov.

CHCS Center for Health Care Strategies, Inc.
Improving the quality and cost-effectiveness of publicly financed health care

Improving Care for Medicare-Medicaid Enrollees: National Update

November 15, 2012

Julie Klebonis, Program Officer
Center for Health Care Strategies

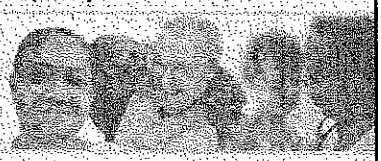
www.chcs.org

CHCS Mission

To improve health care access and quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

Our Priorities

- Enhancing Access to Coverage and Services
- Improving Quality and Reducing Racial and Ethnic Disparities
- Integrating Care for People with Complex and Special Needs
- Building Medicaid Leadership and Capacity



Current CHCS Engagement with States

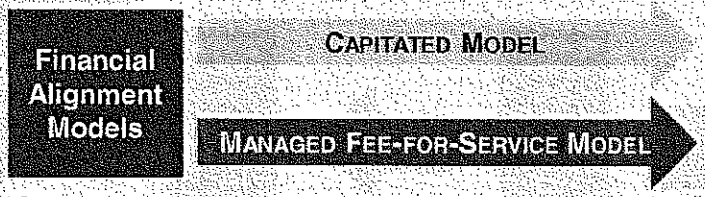
- **Integrated Care Resource Center (ICRC)**
  - Contract with the Medicare-Medicaid Coordination Office
  - Partnership with Mathematica Policy Research
  - Provide technical assistance (TA) to states: AZ, CA, CO, HI, IA, ID, IL, MA, MI, MN, NY, OH, OK, OR, SC, TN, VA, VT, WA
  - www.integratedcareresourcecenter.com
- **State Planning for a High Performance System for Dual Eligibles and Managed Long-Term Services and Supports**
  - Funded by The SCAN Foundation and The Commonwealth Fund
  - Convene quarterly in-person meetings and monthly calls
  - Provide TA to states: AZ, CA, CO, GA, MA, MN, NJ, NV, OK, OR, PA, RI, SD, TN, VA, VT, WA, WI

Medicare-Medicaid Coordination Office (MMCO)

- MMCO created by Section 2602 of the ACA
- Improve coordination between the Federal government and states for Medicare-Medicaid enrollees
- Focuses on:
  Program alignment; data and analytics; and models and demonstrations
- Developed two initial opportunities for states:
  - State Demonstrations and Financial Alignment Models

New Opportunities: Financial Alignment Models

- State Medicaid Director Letter, July 8, 2011
- Offers states two paths (aka "Financial Alignment Models"):



- Open to all states – but must pursue one of the two models
- State letter of intent was due October 1, 2011. 38 states responded
- 26 states ultimately submitted design proposals to CMS to officially move forward (due May 31, 2012).
- Up to 2.8 million beneficiaries included in demonstration proposals.

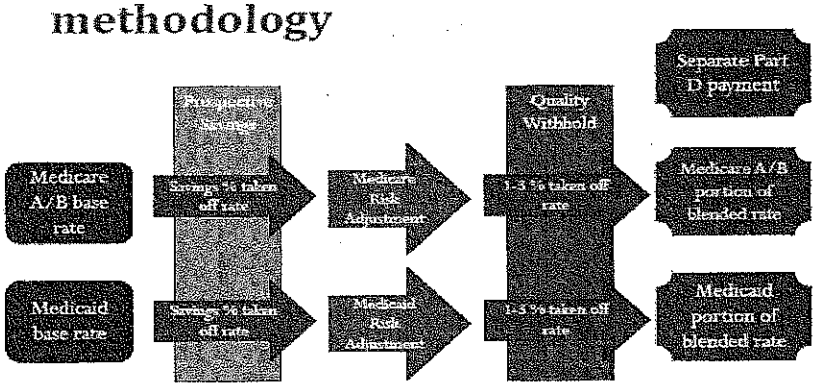
Next Steps for States

- States submitted proposals (May 2012)
- State-based procurement process
  - CA, IL, OH, and MA have selected plans
- Memorandum of Understanding development with CMS
  - MA (capitated) and WA (MFFS) have signed MOUs
- Rate development with CMS
- CMS Medicare and Medicaid Authority

Integrated Rate Development

(K. Sharaf, Oregon Office of Health Policy and Research)

Overview of CMS rate-setting methodology



- Based on CMS memo, "Joint Rate-Setting Process Under the Capitated Financial Alignment Initiative," May 2012

State Participation (as of November 8, 2012)

	State	Signed MOU	Target Launch Year	Model
1	AZ	No	2014	Capitated
2	CA	No	2013	Capitated
3	CO	No	2013	MFFS
4	CT	No	2013	MFFS
5	HI	No	2014	Capitated
6	ID	No	2014	Capitated
7	IL	No	2013	Capitated
8	IA	No	2013	MFFS
9	MA	Yes	2013	Capitated
10	MI	No	2013	Capitated
11	MN	No	2013	Demo
12	MO	No	2014	MFFS

State Participation (as of November 8, 2012)

	State	Signed MOU?	Target Launch Year	Model
13	NY	No	2014	Both
14	NC	No	2013	MFFS
15	OH	No	2013	Capitated
16	OK	No	2013	MFFS
17	OR	No	2014	Capitated
18	RI	No	2014	Both
19	SC	No	2014	Capitated
20	TN	No	2014	Capitated
21	TX	No	2014	Capitated
22	VT	No	2014	Capitated
23	VA	No	2014	Capitated
24	WA	Yes for MFFS	2013 (MFFS) 2014 (Cap)	Both
25	WI	No	2013	Demo

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Challenges & Opportunities of Integrated Care Demonstration

CHALLENGES

- Multitude of operational, administrative, oversight, and financial issues to work out
- Aligning Medicare and Medicaid requirements
- Timeline needed to be extended to ensure program success and coincide with Medicare Advantage timelines (to decrease confusion)
- The MMCO is trying to allow flexibility, but flexibility within Medicare rules is limited
- Delays in releasing guidance regarding this demonstration
- Working through a feasible rate methodology

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Challenges & Opportunities of Integrated Care Demonstration

OPPORTUNITIES

- Creates **one accountable entity** to coordinate delivery of primary/preventive, acute, behavioral, and long-term services and supports
- Promotes the use of **home- and community-based** services
- Promotes and measures **improvements in quality of life and health outcomes**
- Blends/aligns services and financing to streamline care and **eliminate cost shifting**
- Provides **high-quality, person-centered care**

Department of Medical Assistance Services

Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

Virginia Updates

November 15, 2012

Department of Medical Assistance Services

Virginia's Dual Eligible Proposal

- Submitted to CMS on May 31, 2012
- http://dmasva.dmas.virginia.gov/Content_atchs/altc/altc-icp5.pdf
- Under review by CMS; Virginia responding to their questions as they arise
- Target implementation date remains January 1, 2014

Department of Medical Assistance Services

Proposal Outline

- Virginia's model:
  - **Geographic areas** - Four regions of the state in 2014 expanding to an additional region in 2015
  - **Delivery Model** – Capitated; 2-3 Managed Care Organizations in each region
  - **Population** –adult, full benefit duals, including individuals enrolled in the Elderly and Disabled with Consumer Direction waiver and individuals in nursing facilities. Estimate 65,415 individuals eligible for enrollment in the first year
  - **Enrollment** – Passive with opt out option

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

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Proposal Outline Continued

- Virginia's model:
  - **Services** – Medicare Benefits (A, B, D); state plan primary and acute care services, including behavioral health; person-centered care coordination; LTSS waiver services; supplemental or enhanced benefits (e.g. vision, hearing) will be at MCO's option
  - **Reimbursement** – Blended, risk adjusted rate based on Medicaid, Medicare, and Medicare Advantage data. Savings adjustments taken 'off the top' and premium withholds to be paid to MCOs that meet quality performance thresholds
  - **Stakeholder involvement** – Meetings, emails and website, advisory group required through legislation

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

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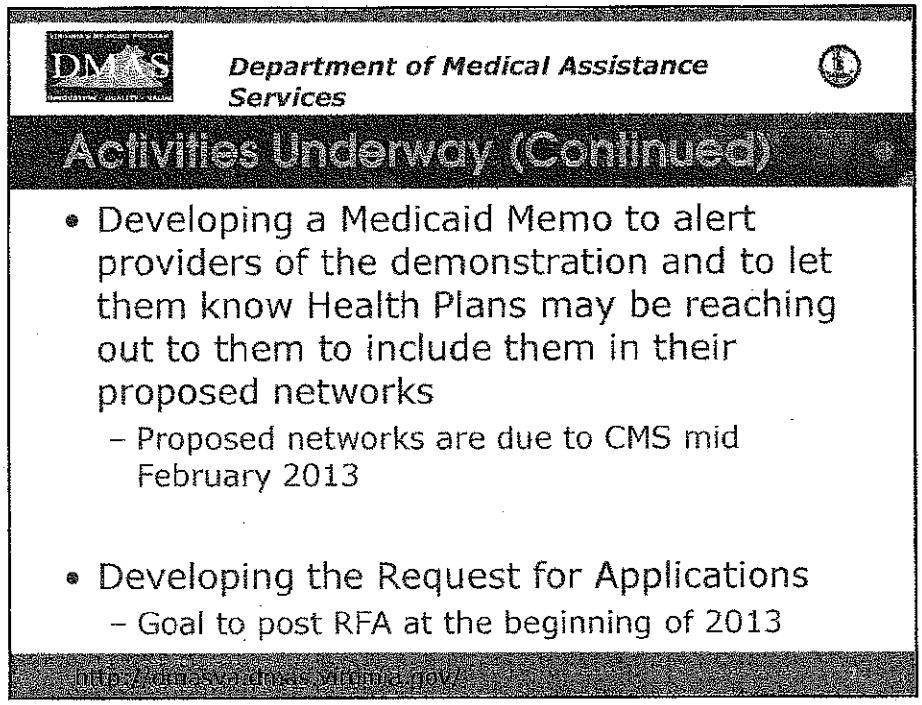
Activities Underway

- Medicaid rate setting (working with our actuary)
  - Will provide to CMS when it is complete
- Seeking federal authorities to operate demonstration
  - 1932(a) State Plan option
  - Amending the 1915(c) waiver authority for the EDCD Waiver

Department of Medical Assistance Services

Activities Underway (Continued)

- Completed and submitted a matrix outlining program components to CMS – how Virginia thinks it should operate
  - Enrollment
  - Network adequacy
  - Appeals
  - Quality
- Creation of a Care Coordination Office within DMAS


DMAS
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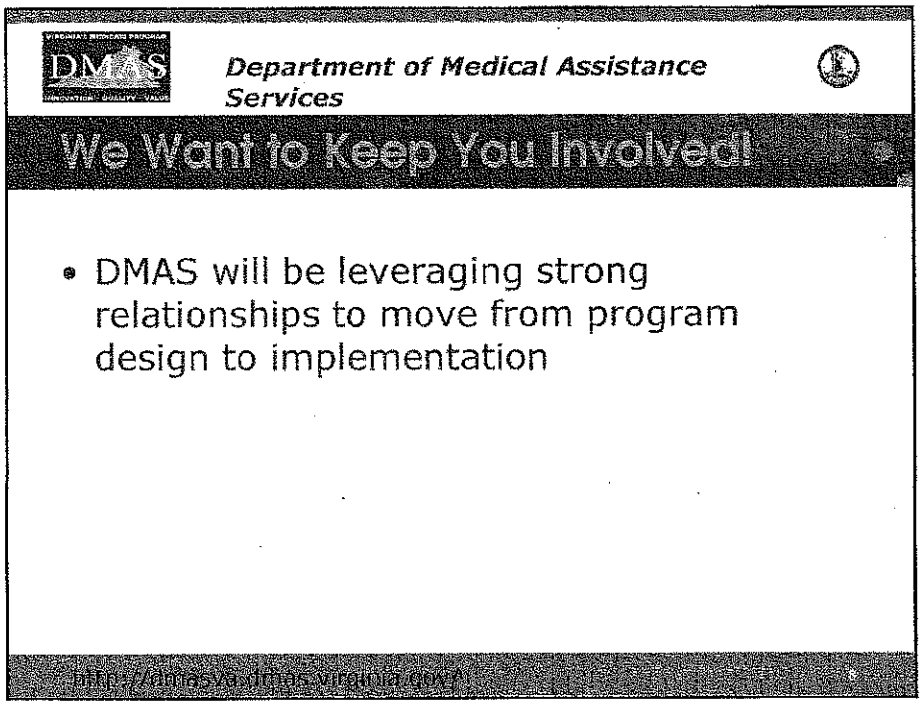
Activities Underway (Continued)
• Developing a Medicaid Memo to alert providers of the demonstration and to let them know Health Plans may be reaching out to them to include them in their proposed networks
– Proposed networks are due to CMS mid February 2013
• Developing the Request for Applications
– Goal to post RFA at the beginning of 2013
http://dmasva.dmas.virginia.gov/


DMAS
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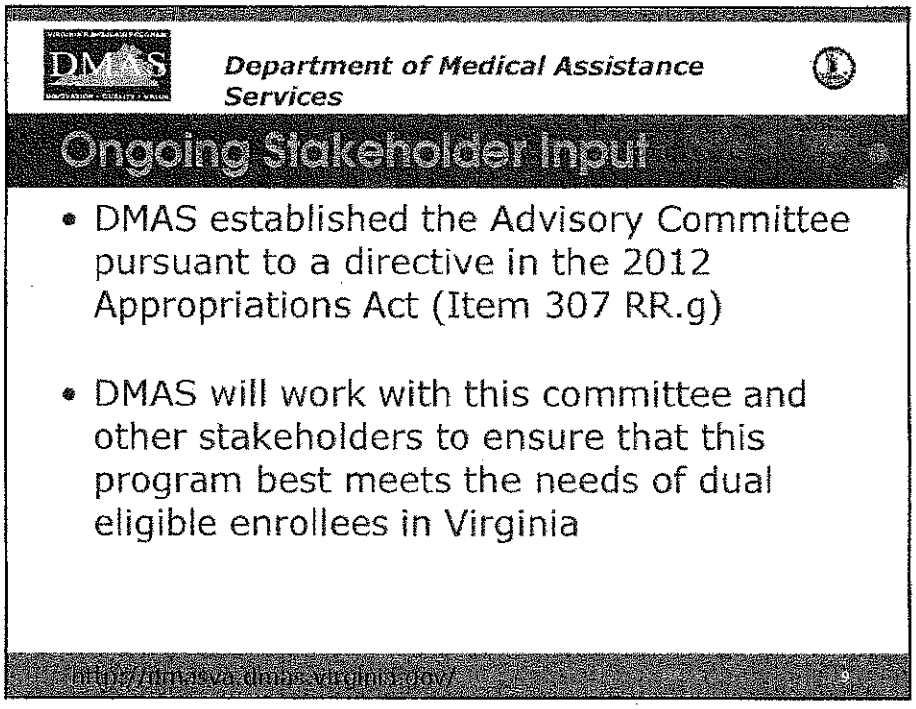
We Want to Keep You Involved
• DMAS will be leveraging strong relationships to move from program design to implementation
http://dmas.va.dhhs.virginia.gov/


DMAS
Department of Medical Assistance Services
Ongoing Stakeholder Input
• DMAS established the Advisory Committee pursuant to a directive in the 2012 Appropriations Act (Item 307 RR.g)
• DMAS will work with this committee and other stakeholders to ensure that this program best meets the needs of dual eligible enrollees in Virginia
http://hmnova.dmas.virginia.gov/
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Department of Medical Assistance Services

Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

Access to Care and Provider Networks

November 15, 2012

Department of Medical Assistance Services

Provider Types

- Long-term care providers
  - Agency (personal care, respite, adult day health, PERS monitoring, transition coordination, transition services)
  - Consumer Directed (personal care & respite)
  - Nursing Facility
- Behavioral health providers (CSBs and private providers)
- Medical Providers (Medicare)
- Pharmacy (Medicare)

Department of Medical Assistance Services

Pharmacy and Medical Services

- Pharmacy Providers (Medicare)
  - Submitted to and reviewed by the Centers for Medicare and Medicaid Services (CMS)
  - Must meet Medicare Part D standards
- Medical Providers (Medicare)
  - Medical provider networks will be submitted to CMS and reviewed at the federal level
  - Networks Specialty type and county geographic designation (e.g., large metro, metro, and micro, rural)

Department of Medical Assistance Services

Tailoring Services to Meet the Needs of Medicare-Medicaid Enrollees

Population	Program Strategies and Benefits
Individuals with physical disabilities	• Access to specialists and primary care providers with offices that are disability-accessible (including exam tables, scales, equipment, and offices); and • Access to providers who have expertise and experience serving people with physical disabilities.
Individuals with communication limitations	• Availability of member materials in accessible formats (e.g., Braille, audio, large font, compact disc, digital, reading-level appropriate, etc.); • Availability of bi-lingual materials and interpreters; • Availability of sign language interpreters to participate in appointments; • Access to assistive listening devices during appointments; and • Providing TTY and Relay telecommunication services for the deaf.

Department of Medical Assistance Services

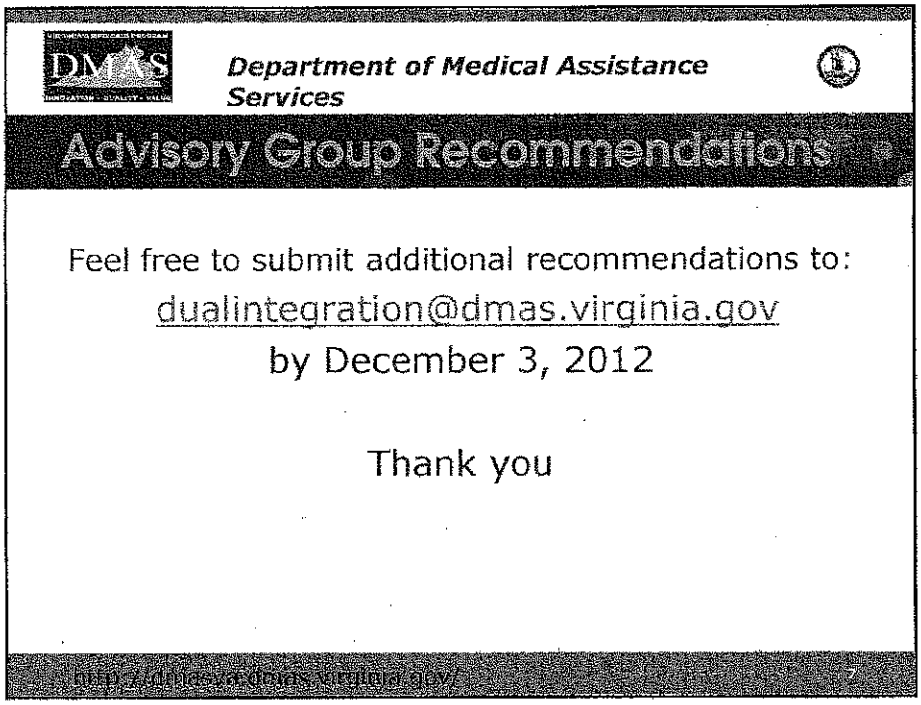
Tailoring Services to Meet the Needs of Medicare-Medicaid Enrollees

Population	Program Strategies and Benefits
Seniors	• Access to providers knowledgeable about geriatrics; • Involvement of and training for family or community caregiver as requested; and • Knowledge of social and community engagement opportunities.
Individuals with behavioral health needs	• Access to specialist and primary care providers knowledgeable about working with individuals with behavioral health needs; • Access to peer supports and non-traditional providers; • Access to community integration activities such as clubhouses, social and recreational activities, and supports for independent living.

Department of Medical Assistance Services

LTC and Behavioral Health Networks

- Travel time and distance to appointments
  - 30 minute maximum travel time?
  - Rural, Northern Virginia, Urban differential?
- Choice of providers
  - E.g., is choice of 2 providers *always* appropriate?
- Consumer Direction
- Other priorities for providers


DMAS
Department of Medical Assistance Services
Advisory Group Recommendations
Feel free to submit additional recommendations to:
dualintegration@dmas.virginia.gov
by December 3, 2012
Thank you
http://duals.dmas.virginia.gov/
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Department of Medical Assistance Services

Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

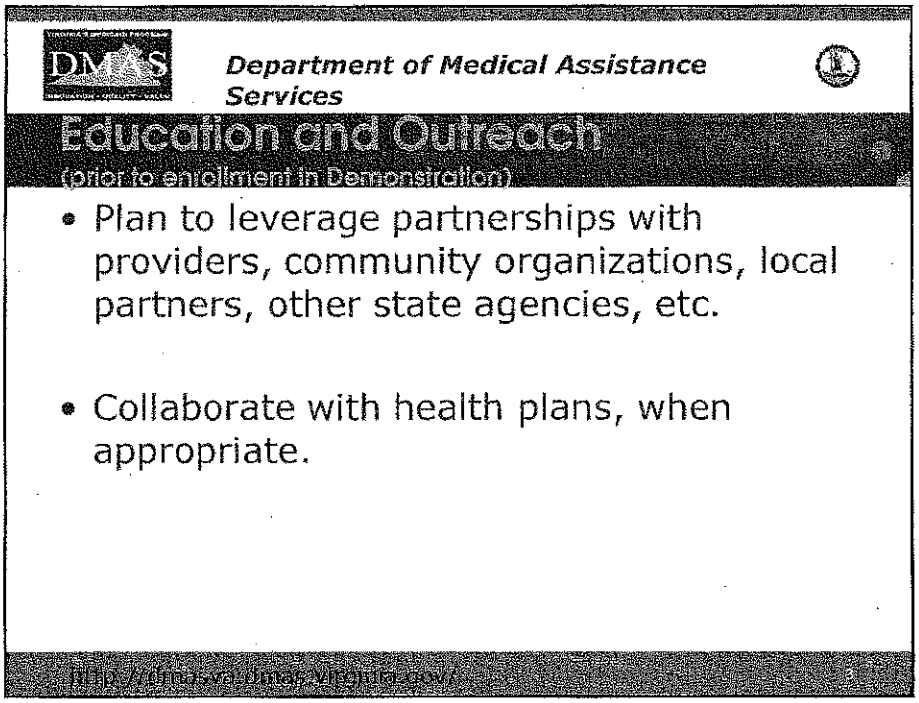
Stakeholder Education and Outreach

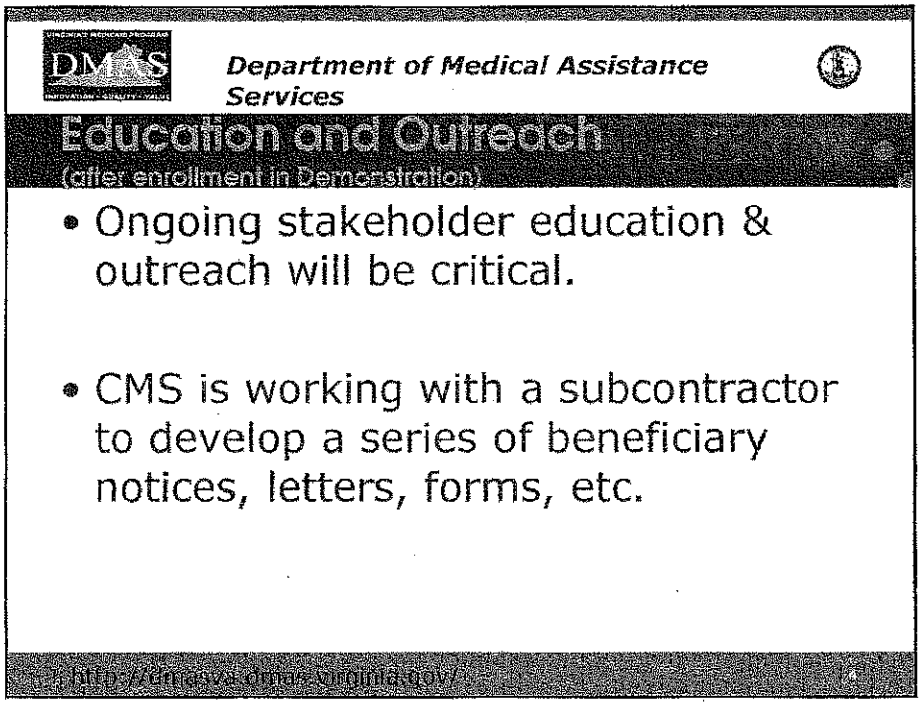
November 15, 2012

Department of Medical Assistance Services

Education and Outreach
(Prior to enrollment in Demonstration)

- Education and outreach activities will begin in 2013.
  - Demonstration will launch on January 1, 2014 (open enrollment will begin October 15, 2013).
- DMAS is in the process of developing an education and outreach plan.
  - Fact sheets, regional trainings, Medicaid Memos, telephone conferences, WebEx, website updates, recipient letters, etc.
  - Receiving technical assistance from national experts on how to effectively communicate messages.


Department of Medical Assistance Services
Education and Outreach
(prior to enrollment in Demonstration)
• Plan to leverage partnerships with providers, community organizations, local partners, other state agencies, etc.
• Collaborate with health plans, when appropriate.
http://dmas.virginia.gov/


Department of Medical Assistance Services
Education and Outreach
(after enrollment in Demonstration)
• Ongoing stakeholder education & outreach will be critical.
• CMS is working with a subcontractor to develop a series of beneficiary notices, letters, forms, etc.
http://dmasva.dmas.virginia.gov/

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Education and Outreach

(after enrollment in Demonstration)

- Enrollment broker and Ombudsman will play a role in beneficiary education.
- Search for possible grant opportunities to assist with education and outreach.

http://dmasva.hpes.vhcmtl.gov/

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Advisory Group Recommendations

- Best modes of communication to reach various stakeholder groups?
  - Beneficiaries (e.g., letters, health fairs)
  - Families/caregivers (e.g., health fairs, public forums)
  - Providers (e.g., Medicaid Memos, public forums, press releases, provider letters, webex)
  - Community organizations (e.g., e-mail, fact sheets, website, trainings)
  - Local partners (e.g., e-mail, website, trainings)
  - Other state agencies (e.g., e-mails, website, trainings)

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

Department of Medical Assistance Services

Advisory Group Recommendations

- Timing of outreach efforts?
  - Mornings
  - Evenings
  - Weekends
- Additional recommendations?

Department of Medical Assistance Services

Advisory Group Recommendations

Feel free to submit additional recommendations to:

dualintegration@dmas.virginia.gov

by December 3, 2012

Thank you

Department of Medical Assistance Services

Financial Alignment Demonstration to Integrate care for Individuals Eligible for Medicare and Medicaid

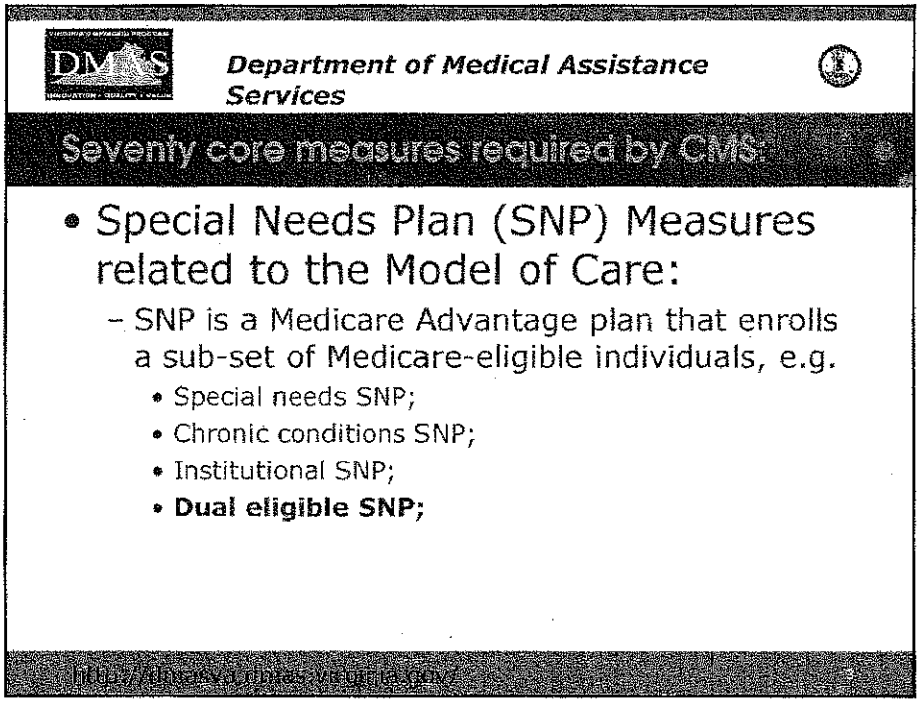
Quality Assurance

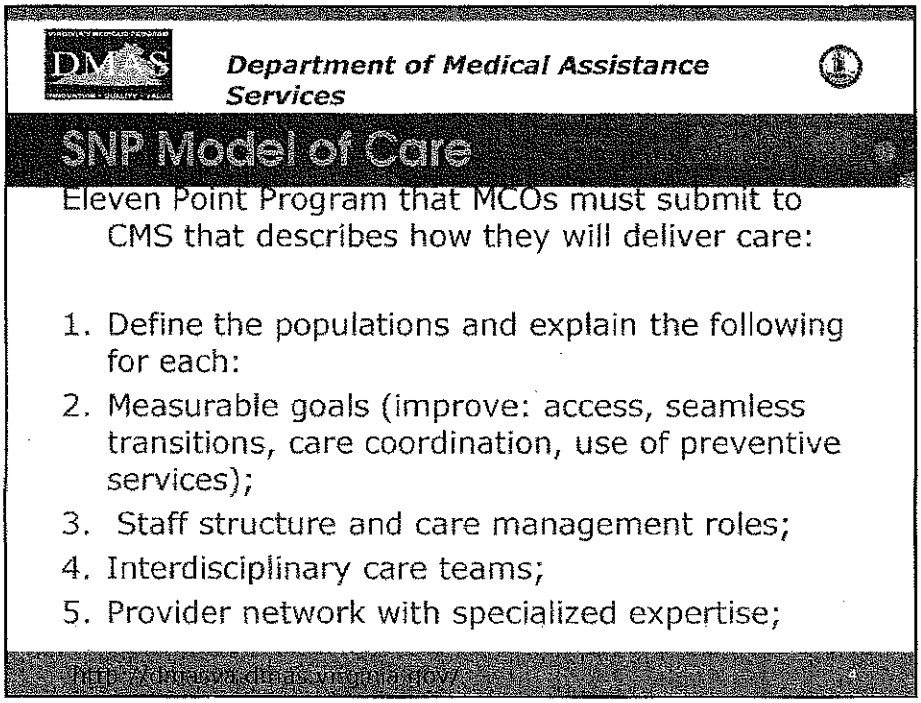
November 15, 2012

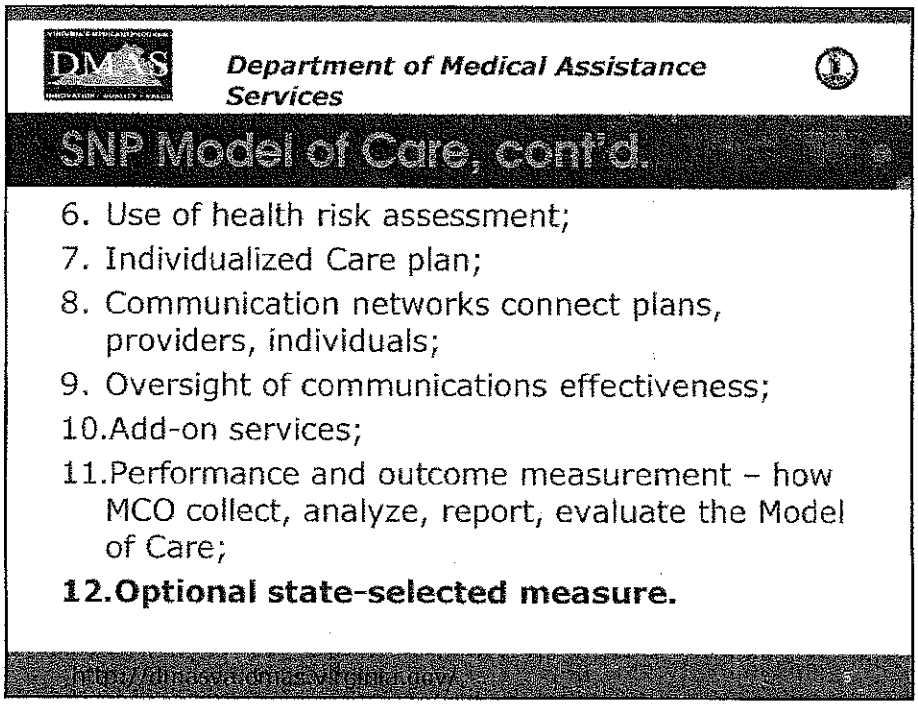
Department of Medical Assistance Services

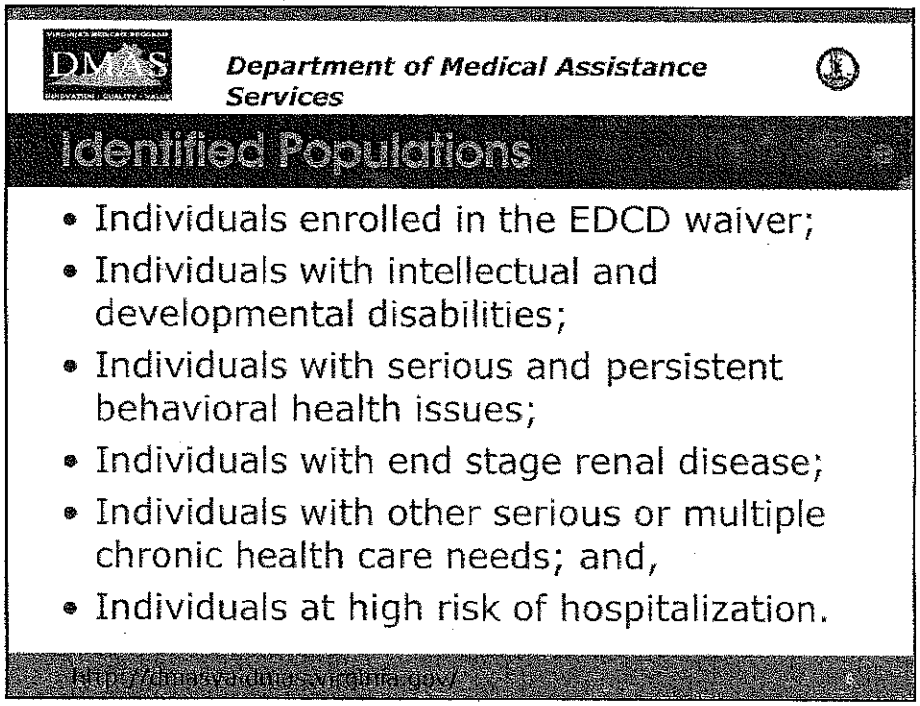
CMS Core Measures

- CMS is prescriptive on quality measures related to acute care and pharmacy services;
- states can submit measures related to Medicaid services (long term services and supports, behavioral health etc.).


Department of Medical Assistance Services
Seventy core measures required by CMS
• Special Needs Plan (SNP) Measures related to the Model of Care:
– SNP is a Medicare Advantage plan that enrolls a sub-set of Medicare-eligible individuals, e.g.
• Special needs SNP;
• Chronic conditions SNP;
• Institutional SNP;
• Dual eligible SNP;
http://dmasvcbnes.virginia.gov/


Department of Medical Assistance Services
SNP Model of Care
Eleven Point Program that MCOs must submit to CMS that describes how they will deliver care:
1. Define the populations and explain the following for each:
2. Measurable goals (improve: access, seamless transitions, care coordination, use of preventive services);
3. Staff structure and care management roles;
4. Interdisciplinary care teams;
5. Provider network with specialized expertise;
http://dmasvcbnes.virginia.gov/


DMAS
Department of Medical Assistance Services
SNP Model of Care, cont'd.
6. Use of health risk assessment;
7. Individualized Care plan;
8. Communication networks connect plans, providers, individuals;
9. Oversight of communications effectiveness;
10. Add-on services;
11. Performance and outcome measurement – how MCO collect, analyze, report, evaluate the Model of Care;
12. Optional state-selected measure.
http://dmasva.dmas.virginia.gov/


DMAS
Department of Medical Assistance Services
Identified Populations
• Individuals enrolled in the EDCD waiver;
• Individuals with intellectual and developmental disabilities;
• Individuals with serious and persistent behavioral health issues;
• Individuals with end stage renal disease;
• Individuals with other serious or multiple chronic health care needs; and,
• Individuals at high risk of hospitalization.
http://dmasva.dmas.virginia.gov/

Department of Medical Assistance Services

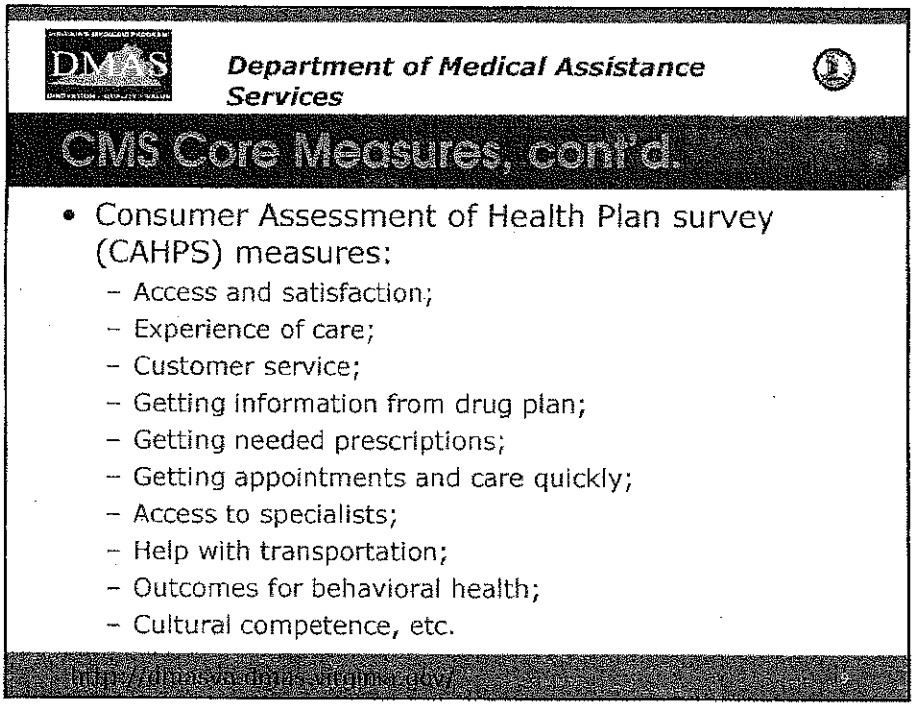
SNP Model Of Care quality measurement

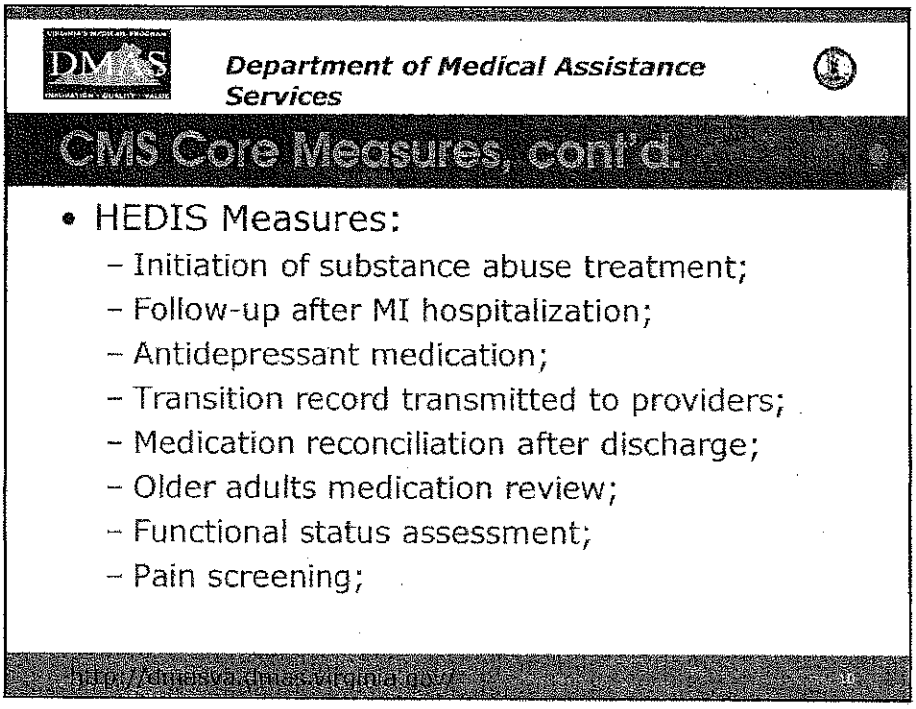
- CMS reviews MCO documentation to determine:
  - The MCO coordinates services for members with complex conditions and helps to access services;
  - Coordination of Medicare and Medicaid benefits;
  - IDs problems that could cause transitions, prevents unplanned transitions, etc.

Department of Medical Assistance Services

CMS Core Measures, cont'd.

- Medicare Part D Measures:
  - Pharmacy hold time;
  - Foreign language interpretation;
  - Appeals auto-forwarded (plan did not meet deadlines for timely decisions);
  - Appeals upheld;
  - Complaints about drug plan;
  - High risk medication when may be safer drug choices;
  - Diabetes, hypertension, cholesterol treatment.


DMAS
Department of Medical Assistance Services
CMS Core Measures, cont'd.
• Consumer Assessment of Health Plan survey (CAHPS) measures:
– Access and satisfaction;
– Experience of care;
– Customer service;
– Getting information from drug plan;
– Getting needed prescriptions;
– Getting appointments and care quickly;
– Access to specialists;
– Help with transportation;
– Outcomes for behavioral health;
– Cultural competence, etc.
http://dmasva.dmas.virginia.gov/


DMAS
Department of Medical Assistance Services
CMS Core Measures, cont'd.
• HEDIS Measures:
– Initiation of substance abuse treatment;
– Follow-up after MI hospitalization;
– Antidepressant medication;
– Transition record transmitted to providers;
– Medication reconciliation after discharge;
– Older adults medication review;
– Functional status assessment;
– Pain screening;
http://dmasva.dmas.virginia.gov/

Department of Medical Assistance Services

CMS Core Measures, cont'd.

- HEDIS Measures, cont'd:
  - Diabetes care (eye exams, kidney function test, blood sugar control);
  - Rheumatoid arthritis management;
  - Readmissions;
  - Reduce fall risk;
  - Control BP;
  - Preventive health screenings;
  - Flu, pneumonia vaccines;
  - Access to primary/specialist care.

Department of Medical Assistance Services

CMS Core Measures, cont'd.

- Nursing facility residents with pressure ulcers (National Quality Forum);
- Part D appeals times (Independent Review Entity);
- Comprehensive Medication Review (Pharmacy Quality Alliance);
- State defined measures:
  - Completed assessments;
  - Individualized Care Plans meet all needs;
  - Hospital admission notification;
  - Risk stratification using BH/LTSS indicators;
  - Time to follow up visit after discharge.

Department of Medical Assistance Services

DMAS Measures

- Long Term Services and Supports
  - May need to include some measures required by the Elderly and Disabled with Consumer Direction waiver:
    - Other process measures:
      - Validate that individuals meet Level of Care criteria;
      - Annual reassessments performed;
      - Service plans updated as required;
      - Individuals offered choice between institutional and home-based services;
      - Providers meet qualification requirements;
      - EDCD provider training conducted;
      - MCOs ID and address abuse, neglect, exploitation.

Department of Medical Assistance Services

CMS External Evaluation

- CMS contracted with an evaluator to conduct a study of the demonstration, both on a national scale and state-specific. Specific measures unknown, but they will include analysis of utilization data and costs.

Department of Medical Assistance Services

Advisory Group Recommendations

- Given the large number of CMS-required core measures, need to be judicious and select state measures that are most salient.
- Do core and LTSS measures seem sufficient?
- Should DMAS require a 12th optional Model of Care Measure? If yes, what should it be?
- What other state measures should be included, if any?

Department of Medical Assistance Services

Advisory Group Recommendations

Can also submit additional written recommendations to:

dualintegration@dmas.virginia.gov

Please provide additional written recommendations by December 3, 2012

Thank you

DUAL DEMONSTRATION CMS CORE MEASURES
AND DRAFT OPTIONAL MEASURES

Measure	Description	Data Source
1. Antidepressant Medication Management	Percentage of members diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment	NCQA/HEDIS
2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of members with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS
3. Follow-up After Hospitalization for Mental Illness	Percentage of discharges for members who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner	NCQA/HEDIS
4. Screening for Clinical Depression and Follow-up Care	Percentage of patients screened for clinical depression using a standardized tool and follow-up plan documented.	CMS
5. SNP1: Complex Case Management	The organization coordinates services for members with complex conditions and helps them access needed resources. Element A: Identifying Members for Case Management Element B: Access to Case Management Element C: Case Management Systems Element D: Frequency of Member Identification Element E: Providing Members with Information Element F: Case Management Assessment Process Element G: Individualized Care Plan Element H: Informing and Educating Practitioners Element I: Satisfaction with Case Management Element J: Analyzing Effectiveness/Identifying Opportunities Element K: Implementing Interventions and Follow-up Evaluation	NCQA/HEDIS

6. SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members. Element A: Coordination of Benefits for Dual Eligible Members Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) Element D: Service Coordination Element E: Network Adequacy Assessment	NCQA/HEDIS
7. Care Transition Record Transmitted to Health Care Professional	Percentage of patients discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	NCQA/HEDIS
8. Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS
9. SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions Element B: Supporting Members through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E; Analyzing Transitions Element F: Reducing Transitions	NCQA/HEDIS
10. CAHPS, various settings	-Health Plan plus supplemental items/questions, including: -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home	AHRQ/CAHPS
11. Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the drug plan's pharmacy help desk.	CMS Call Center data

12. Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number.	CMS Call Center data
13. Part D Appeals Auto–Forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.	IRE
14. Part D Appeals Upheld	How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100	IRE
15. Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 days.	Medicare Advantage Prescription Drug System (MARx)
16. Part D Complaints about the Drug Plan	How many complaints Medicare received about the drug plan. For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data
17. Part D Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Administrative data
18. Part D Members Choosing to Leave the Plan	The percent of drug plan members who chose to leave the plan in 2014.	CMS Medicare Beneficiary Database Suite of Systems

19. Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan
20. Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data
21. Part D Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data
22. Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data
23. Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data
24. Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data
25. Plan Makes Timely Decisions about Appeals	Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage	IRE
26. Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	IRE

27. Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.	CMS Call Center data
28. Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed
29. Consumer Governance Board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements.	CMS/State defined process measure
30. Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS
31. Assessments	Percent of members with initial assessments completed within required timeframes.	CMS/State defined process measure
32. Individualized Care Plans	Percent of members with care plans by specified timeframe.	CMS/State defined process measure
33. Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure
34. Risk Stratification Based on LTSS or Other Factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/State defined process measure
35. Discharge Follow-up	Percent of members with specified timeframe between hospital discharge to first follow-up visit.	CMS/State defined process measure
36. Self-direction	Percent of care coordinators that have undergone training for supporting self-direction under the Demonstration.	CMS/State defined process measure
37. Care for Older Adults – Medication Review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/ HEDIS

38. Care for Older Adults – Functional Status Assessment	Percent of plan members whose doctor has done a—functional status assessment to see how well they are doing —activities of daily living (such as dressing, eating, and bathing).	NCQA/HEDIS
39. Care for Older Adults – Pain Screening	Percent of plan members who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS
40. Diabetes Care – Eye Exam	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS
41. Diabetes Care – Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS
42. Diabetes Care – Blood Sugar Controlled	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS
43. Rheumatoid Arthritis Management	Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS
44. Reducing the Risk of Falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS
45. Plan All-Cause Readmissions	Percent of members discharged from a hospital who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS
46. Controlling Blood Pressure	Percentage of members aged 85 and under who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS
47. Comprehensive medication review	Percentage of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA)
48. Complaints about the Health Plan	How many complaints Medicare received about the health plan. Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract	CMS CTM data

	enrollment)] * 1,000 * 30 / (Number of Days in Period).	
49. Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Beneficiary database
50. Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2015.	CMS
51. Getting Information From Drug Plan	The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost. -In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? -In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? -In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? -In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?	AHRQ/CAHPS
52. Rating of Drug Plan	The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs. -Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	AHRQ/CAHPS

53. Getting Needed Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan. -In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? -In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	AHRQ/CAHPS
54. Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists. • In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS
55. Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care. • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	AHRQ/CAHPS
56. Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	AHRQ/CAHPS
57. Overall Rating of Plan	Percent of best possible score the plan earned from plan members who rated the overall plan. • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	AHRQ/CAHPS
58. Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS
59. Colorectal Cancer Screening Cardiovascular Care – Cholesterol Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer. Percent of plan members with heart disease who have had a test for —bad (LDL) cholesterol within the past year.	NCQA/HEDIS
60. Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for —bad (LDL) cholesterol within the past year.	NCQA/HEDIS

DUAL DEMONSTRATION CMS CORE MEASURES
AND DRAFT OPTIONAL MEASURES

61. Diabetes Care – Cholesterol Screening	Percent of plan members with diabetes who have had a test for —bad (LDL) cholesterol within the past year.	NCQA/HEDIS
62. Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data
63. Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	CMS HOS
64. Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS
65. Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS
66. Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS
67. Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS
68. Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS
69. Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS
70. Health Status/Function Status	Percent of members who report their health as excellent.	AHRQ/CAHPS

DUAL DEMONSTRATION CMS CORE MEASURES
AND DRAFT OPTIONAL MEASURES

Draft State Long Term Care Optional Measures (meet 1915c waiver requirements)

Performance Measure	MCO Requirement	Expected Performance Level
All new enrollees who have a level of care indicating a need for institutional/waiver services.	MCO will submit quarterly and annually a report on the number of new EDCD waiver enrollees	100%
The LOC of enrolled participants are reevaluated at least annually or as specified in the approved EDCD waiver.	MCOs will submit monthly to DMAS the number of EDCD waiver individuals who were due and received LOC re-evaluations within 365 of their initial LOC evaluation.	100%
The UAI was appropriately utilized to determine individual's level of care.	MCO's will assure all individuals will have a UAI screening to determine eligibility to EDCD waiver before providing long term care services. Submit a monthly report of the number of new enrollees.	100%
EDCD Waiver Services Plan of Care addresses all assessed needs and personal goals, either by EDCD waiver services or through other means.	MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%
EDCD Wavier Services Plan of Care is developed in accordance with DMAS policies and procedures	MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%
EDCD Waiver Services Plan of Cares are updated/revised at least annually or when warranted by changes in the waiver individual's needs	MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%
EDCD Wavier Services are delivered in accordance with the Plan of Care, including in the type, scope, amount, duration, and frequency specified in the Plan of Care	MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%

Individuals who meet criteria for long term services and supports are afforded choice: 1) Between waiver services and institutional care; 2) between/among waivers services and providers	MCO will have available the documentation for DMAS to conduct QMR review	100%
Licensed and non-licensed EDCD waiver service Providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services. *The only none EDCD licensed services are: PERS, Service Facilitation, and Transition Coordination.*	MCOs will document through their internal Quality Program that all of their providers meet or exceed the following credentialing standards. 1. Are DMAS enrolled providers. 2. Criminal record checks were run on all MCO & LTC provider employees and consumer directed providers. The MCO must separate their credentialing by Licensed and Unlicensed and provide a count in each category. MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%
EDCD waiver services provider training is conducted in accordance with waiver and state requirements.	MCOs will document through their internal Quality Program that all Providers meet or exceed the MCO's training standards. In the following areas: Agency & Consumer Directed providers receive training 12 hours annually in accordance with training requirements outlined in the DMAS EDCD Wavier Manual. MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%
The MCO, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	MCOs will document through their internal Quality Program that any allegation of Abuse Neglect or Exploitation is reported to the appropriate DSS. MCO will review the allegation and take necessary action to assure the health and safety of the individual. MCO will have available the documentation for DMAS to conduct QMR review	100%