Virginia Advisory Committee
Meeting 2
April 11, 2013

Welcome and Introductions, Suzanne Gore

Summary

A lot has happened since we met last in November 2012. There are a few staff updates since we last met. We created a Deputy Director for Complex Care and Services, this is Karen Kimsey. Emily Carr will be managing operations of the duals program. We are also in the process of bringing Kristin Burhop over from the Governor's office. The Medicare Medicaid Enrollee (MME) Demonstration is a priority of the Administration and the Department and we appreciate your continued interest and support.

National Updates, Sarah Barth

Summary

MMEs receive both Medicare and Medicaid coverage. The focus of CMS's demonstration is to provide integration to the "full duals". 58.8% of duals are aged 65 or older, while 41.2% are under the age of 65. Medicare and Medicaid programs were not designed to work together. There has been very little coordination or interaction among providers to put together a person-centered care plan for these beneficiaries. Five states have signed MOUs since 2012. States must also conduct a state-based procurement process and then a readiness review. Massachusetts is in the process of undergoing readiness reviews; California has posted their tool online. Common hurdles in MOU development include: Rates, joint development process; benefits – continuation of supplemental benefits; Outcome-based performance measures: combination of Medicare, demonstration "core" and state-specific measures.

- Committee Member: Inquired about enhancing the NWD and VICAP and the importance of these programs.
- Sarah Barth: There will be a grant opportunity upon signing of the MOU for AAAs.

- Committee Member: How do you issue an RFP without an MOU? Can you describe Massachusetts' program?
- Sarah Barth: Massachusetts is serving the dual population under 65. It is a capitated model and they are going forward with their readiness review.

- Committee Member: There are a number of services that are both Medicaid and Medicare, and there has been a lot of discussion about the appropriate rates for those services.
- Sarah Barth: You all will have your own discussion with CMS and through this group as well.

Virginia Updates, Paula Margolis

Summary

Here is a quick overview of who we are serving and what the benefits are: Full dual MMEs including, age 21 and over; living in the five demonstration regions; EDCD waiver participants and NF residents. There will also be a number of individuals excluded.

The program is voluntary with opt in and passive enrollment. It will be a capitated model with at least two MCOs in each region; with a regional phase-in. Last year we designed and submitted the design proposal to CMS. We have received and incorporated stakeholder feedback into that proposal. We have already held the initial Dual Eligible Advisory Workgroup meeting. We have distributed a Medicaid Memo to alert providers of the demonstration and have developed Virginia-specific components of the Model of Care.

We recently submitted 1932(a) State Plan Amendment to CMS, which allows for a voluntary managed care program. We have identified and submitted requests for MMIS systems changes. Interested health plans submitted Medicare applications through CMS' Health Plan Management System (HPMS) on February 21, 2013. Last Friday we published our RFP. We also created a new office for Care Coordination within DMAS to provide full attention to the Demonstration. We hope to be signing an MOU in the next few weeks. We are also in the process of reviewing rates with our actuary, which will then be reviewed and validated by CMS.

We are also amending our 1915(c) waiver. We are developing a comprehensive education and outreach plan that Kristin Burhop will be spearheading and we had our first committee meeting on communications, education, and outreach this morning.

- Committee Member: You said you will be excluding individuals that receive the low-income subsidy for Part D, is this correct?
- DMAS: We are not excluding them, but during the first year, individuals who elect to change their Part D plan during the fall 2013 Medicare open enrollment will not be included in the passive enrollment process during the first year. This is a beneficiary protection to prevent individuals from bouncing in and out of plans.

- Committee Member: Can you describe the community non-waiver population?
- DMAS: A significant number of them have behavioral health issues or other chronic conditions but they are not getting long-term services and supports.

- Committee Member: Can you describe some of the MMIS systems changes you have requested?
- DMAS: There are a lot, including, how to except encounter data and how to get reports that are coming out. For example, FFS pays directly through DMAS, and MMIS now needs to be able to accept encounter data. How assignment is ~~down~~

done? related to health plans. It will take at least eight months to get all the changes made.

- Committee Member: We need to consider what the MMIS changes impacts may or may not be on the provider community.
- Committee Member: Expressed concerns about confusion to beneficiaries and changes in insurance cards, etc.
- DMAS: One of the benefits of this program is that individuals will now only have one insurance program.

- Committee Member: The timeline on slides 9 and 10 did not talk about Medicare rate development.
- DMAS: CMS published their average county rates for Medicare this spring. CMS has published a paper for how that will work. DMAS is not intimately involved in the rate setting for Medicare services.

- Committee Member: Can you talk a bit more about what is involved in the readiness review process?
- DMAS: There will be a desk review and site visits. It is to ensure the plans are up and ready to accept the beneficiaries, that their networks are adequate, that their staff is adequate, that their communications systems are adequate, etc.

<u>Committee Member Focus Session 1: RFP and MOU, Karen Kimsey & Suzanne Gore</u>
Summary of RFP: Overview, Key Issues, and Timeline
We are in the procurement process so the questions we can answer on that document are rather limited. We released the RFP on Friday. There was a change made on April 10th from a Request for Applications to a Request for Proposals. We are looking to select two MCOs for each of the five regions. This is a very different procurement process than what Virginia typically undertakes. The universe of plans coming into Virginia was closed on February 21st. That information at this point is still confidential. The other states that are doing capitated models have also selected their plans before signing their MOU, so we have some precedent for doing this. We will select our plans in June. Since the demo is new, we are looking for some innovation.

Plans' past performance is critical, we will not consider a plan if it is under a Medicare enrollment and/or marketing sanction. We actually did something different this time and included five vignettes in the RFP that plans will have to respond to. We thank you all for help with those. We would love for it to be something that we could get stakeholder input on but since it is an RFP we unfortunately cannot make it public outside of DMAS. We have asked applicants to submit questions on the RFP by 5pm on April 19, 2013. Applications are due no later than 10am ET on May 15th. We expect to select plans early to mid June and have to stay on our timeline to make the program happen.

- Committee Member: I want to go back to transitions of care; I don't think we have had a discussion around components like advanced directives, end of life care, etc. At some point we need to have some real discussion about what our expectations are with MCOs in this area. That needs to be integrated into the plans.
- DMAS: That sounds like something we can do a workgroup on in June or July.

- Committee Member: DMAS did not talk about transition from the hospital to the home and not being readmitted.
- DMAS: We actually did include care transitions as the first state-specific additional element- it is element 12 in the model of care. We will also have to add that to the contracts. We will look at terminology in the definition. Thanks for pointing this out.
- DMAS: I believe it's an outcome measure as well.

- Committee Member: Want to talk about the MOC assessment and plan of care, who does the HRA?
- DMAS: That will be proposed by health plans. Each plan can have its own risk assessment model. The MOU has a chart to clarify the timelines we will require for assessments and for development of a plan of care.

<u>MOU between CMS and DMAS, Karen Kimsey</u>

Summary

A lot more detail to come in the three way contract. Unless you have a signed MOU, you are not formally accepted into the financial alignment demonstration. The MOU is a contract not unlike a SPA; outlines expectations and what the program will look like. MOU sections will cover eligible populations, enrollment and disenrollment process and timeframes: opt-in only period; passive enrollment; and two enrollment phases, based on regions. The phased in approach will assure we take this slowly and do this methodically. CMS is still finalizing the enrollment process, so this is still subject to change.

For example, I'm Karen and I just received a package on Jan. 5th, and I decide I want to participate. As long as I decide by the 25th of the month that I want to participate, I will be enrolled by the next month. Until May, it will be for only those individuals that proactively enroll.

- Committee Member: When you send the notice in Jan., are people given the choice then to say no thank you?
- DMAS: Yes, if someone says no then, they will not be passively enrolled.

The passive piece is a two month process. We are using an intelligent assignment process. Enrollment facilitators are third parties with no financial investment in the program. Phase 1 repeats in Phase 2 with the additional regions. We will be posting the timeline online. We are still working through this, but this is pretty much as close as we can get it to final. We have a chart after this that will share some more detail about the MOU sections. It can be difficult to keep up with expectations for the plans. This chart was created to keep track

of that. EDCD and nursing facility population must have assessments face to face. Periods of time for when assessments can be done varies across populations.

- Committee Member: When you say face to face, are you implying in home, or is video okay?
- DMAS: It depends, we were envisioning in home. I think we will see where some of the creativities are in the health plans. We will need to be clearer depending on what the plans propose.
- DMAS: The demo regions aren't particularly rural either.

- Committee Member: The difficult populations are those in the community, and determining who is well in the community and who is vulnerable.
- DMAS: Diagnosis codes and FFS data will be used in the algorithm for determining needs. They will have three years of claims data to help identify individuals. There also may be community partners to help identify additional people.

- Committee Member: How was the number of days selected based on enrollment for the HRAs?
- DMAS: A lot of our days were based on DMAS regulation. Probably should have shown a slide of how we defined "vulnerable populations" in the MOC.

- Committee Member: These can be aggressive, especially for some of these vulnerable populations. Can a plan use an AAA, etc. to make the contact?
- DMAS: Absolutely.

There are still some outstanding items that will need to be finalized. The savings adjustment is still being determined by CMS. The quality withholds are something we would like your advice on. We are seeking advisory committee recommendation on what you think would be the most important LTC issue to measure. The challenge may be finding the balance in what we want to measure vs. the feasibility of standardizing that measure. We have come up with a few that we can walk you through. The five domains of measures we would like your input on are: 1) Assessments; 2) Plans of Care; 3) Adjudicated Claims; 4) Hospital and Nursing Facility Transitions; and 5) Severe Mental Illness (SMI). We have some flexibility with some of them and want to know your feedback.

- Committee Member: Just off the top of my head, for #4, just having a work plan seems pretty low, wouldn't you want to see something more about if the plan actually works, not just that they have it? Maybe it doesn't work in year one, but we want to be getting real experiences and not stuff that just looks good on paper.

- Committee Member: Had a similar comment about the plan of care and making that a very high level expectation.

- Committee Member: The ideas you have for the SMI population are very good and are things we are already looking at. Might also look at the number of individuals with SMI receiving primary care in future years.

Committee Member Focus Session 2: Education and Outreach, Karen Kimsey & Kristin Burhop

Summary

Kristin Burhop's charge will be to make sure DMAS has an effective education and outreach plan for the demonstration. The meeting this morning included department of social services, behavioral health, department for aging, and a few others. We had a very active and interesting discussion. We are still working through who else we should include. Because we are under such an aggressive schedule, we are going to be meeting weekly. Our plan is to keep you in the loop. And another thing we are working on in a parallel track is a grant that will support our ADRCs/VICAP, which is due in the beginning of June.

These are some of the stakeholders we have identified. We are also going to be looking at the different modes and venues for getting the word out. Our approach will be on the marketing and PR side and then also making sure we are training folks appropriately.

- DMAS: There is a lady who is wonderful that works on logos and branding and we wanted to come up with a logo and brand. The beneficiary is the center of this program so the acronym we came up with is VIP. There is a lot of flexibility we have for the logo and tag lines and would love to get your input.

- Committee Member: I don't think the word integration is going to resonate with others the way it does for us. Note: a lot of other members agreed.
- Jill: I think there are also a lot of racial connotations associated with that word as well.

- Committee Member: I think the circle one carries a nice message of being surrounded, helped, and included.

- Committee Member: The middle imagine on the top row is very strong and creates a good visual, could move that into the circle.

- Committee Member: There should also be a little more diversity in the silhouettes.

- Committee Member: I think you have given us five of the same images. I'm not sure if this is my genius, but I wouldn't start with the quick and easy VIP and decide how to make sense of that. I'd love to see what fell on the floor.
- Karen: We can share those ideas.

- Committee Member: Both of the images on the right look like they are playing London bridge. Think they look more like a child playing a children's game.

- Committee Member: I don't believe the word blended is a word most people would appreciate. Just think you can keep it simple – remove the word Virginians from the tagline.

Wrap Up and Next Steps, Suzanne Gore

Kristin Burhop: If you are interested in joining our work group, let me know.
Suzanne Gore: Please email us if you have any ideas for logos or taglines.
Thank you!

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