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Virginia Department of Medical Assistance Services

NAMD
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http://dmas.virginia.gov
Overview

• Virginia Model Highlights
  – Regional implementation, enrollment metrics, flexible contract

• Planning and Operational Successes
  – Political support, strong collaboration with CMS infrastructure challenges/changes

• Stakeholder Engagement

• Evaluation Process

• Operational Challenges

• Success Stories

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

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

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

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

An advantage to Virginia of the Medicare/Medicaid Model is shared savings, which provides funding for care coordination and improves quality.
Regionally Phased Implementation

CCC enrollment occurred in phases from March 2014 – November 2014.
MOU

Competitive process for MMP selection

Summer-Fall 2013
Multiple-step readiness reviews
Ensure adequate provider networks

December 2013
Contracts signed
Extensive systems testing

March 2014-Present
- Phased in Enrollment
- Ongoing Outreach & Education
- Contract Monitoring
- Program Evaluation
<table>
<thead>
<tr>
<th>Region</th>
<th>Active Opt-ins</th>
<th>Passive Opt-ins</th>
<th>Opt-outs</th>
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<tr>
<td>Central Virginia</td>
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<tr>
<td>Northern Virginia</td>
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<tr>
<td>Western/Charlottesville</td>
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<td>2744</td>
<td>1823</td>
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<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
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
Planning and Operational Successes

• Received bipartisan support through legislature and Governor
• Reorganized internally (*next slide*)
• Received technical assistance from Center for Health Care Strategies
• Worked collaboratively with and received strong support from the Models and Demonstrations Group in the Medicare-Medicaid Coordination Office at CMS
Infrastructure Challenge . . .

- Staff with other responsibilities pulled to work on the demonstration
- Limited support between divisions
- Staff morale was abysmal
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 a dedicated Outreach Specialist
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
VICAP & Ombudsman

Partnership for outreach

DMAS

Sharing beneficiary concerns & trends

Ombudsman

VICAP

Problem Resolution
Evaluation Process

• 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
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
Operational Challenges

- Health systems not cooperating with Health Plans in some areas of the state
- Select providers not participating
- Winning over some of the advocates
- Lack of Medicare data to make intelligent assignments
- Medicare rules dominate
Operational Challenges (continued)

• Enrollment/Disenrollment functions coupled with member choice and opt-in rules can create systems and programming challenges

• Systems changes internally and with CMS

• Providers attempting mass opt-out
  – Memo on beneficiary choice
  – NF letter to share with beneficiary/legal rep
  – Targeted trainings
  – Partnership with State Health Insurance Program and ombudsman
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.
Recently, a 58 year old male member reported being so excited about the plan, that he read the member handbook from cover to cover. He had not had an eye exam in 10 years and needed glasses desperately. An appointment was attained with the assistance of his care coordinator and eye exam and glasses were obtained. The member has seen his PCP several times through encouragement of the Care Coordinator, and he has verbalized that the program has changed his life.
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