CHCS Center for Health Care Strategies, Inc.

Improving the quality and cost-effectiveness of publicly financed health care

# CCC Education Session

Richmond, VA

July 16, 2014

*Made possible by The SCAN Foundation & The Commonwealth Fund*

# Agenda

I. Welcome and Introductions

II. National Update on Duals Demonstrations

III. State Overview of CCC Program

IV. CCC Health Plan Presentations

V. Questions and Answer Session

VI. Break

VII. Beneficiary Rights

VIII. Care Coordination: Connecting Medical and LTSS Providers

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# National Update on Efforts to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid

July 16, 2014

# Agenda

I. Welcome and Introductions

II. Dual Eligibles – Who are they now?

III. Platforms for Service Delivery and Integration

IV. Overview of MLTSS Landscape

V. Movement to Integrated Care

# Welcome and Introductions

**Sarah Barth, JD**
Director, Long Term Services
Center for Health Care Strategies

CHCS
Center for Health Care Strategies, Inc.

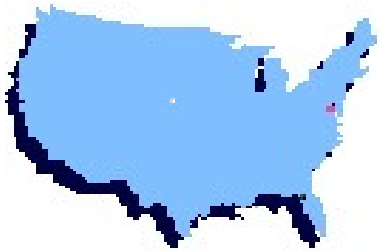
# A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care

- **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.

# Working With States

**Implementing New Systems of Integration for Dual Eligibles (INSIDE)**

- Supported by The SCAN Foundation and The Commonwealth Fund
- Brings together 16 states implementing programs of integrated care for group learning and innovation sharing, as well as opportunities to work with federal partners
- Arizona, Arkansas, California, Colorado, Idaho, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, and Washington



# Working With Community-Based Health Organizations

**Promoting Integrated Care for Dual Eligibles (PRIDE)**

- Supported by The Commonwealth Fund
- Brings together seven integrated health organizations to identify and test innovative strategies that enhance and integrate care for Medicare-Medicaid enrollees
- PRIDE consortium membership:

- CareSource (OH)
- Commonwealth Care Alliance (MA)
- Health Plan of San Mateo (CA)
- *i*Care (WI)
- Together 4 Health (IL)
- Ucare (MN)
- VNSNY Choice (NY)

# Working With Centers for Medicare and Medicaid Services

## Integrated Care Resource Center (ICRC)

- Established by CMS to help states advance integrated care delivery for dual eligibles
- Technical assistance and online resources provided by CHCS with Mathematica Policy Research
- Engage stakeholders at every level in design and implementation
- Build on existing relationships between state Medicaid agencies, providers, and beneficiaries
- Ensure beneficiary protections under Medicare
- Include quality standards and rigorous evaluations
- Establish payment strategies that encourage provider participation and create potential state and federal savings

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# Dual Eligibles - Who are they Now? The Numbers

- 10.2 million Americans are eligible for Medicare and Medicaid (known as Medicare-Medicaid enrollees or "dual eligibles")
- 7.4 million are "full duals"
- 17.7% increase, from 8.6 million to 10.2 million between 2006 and 2011 (One in five Medicare enrollees)
- In comparison, the number of Medicare-only beneficiaries grew by only 12.5%

Source: *Data Analysis Brief Medicare-Medicaid Dual Enrollment from 2006 through 2011,* Prepared by Medicare-Medicaid Coordination Office, February 2013.

# Dual Eligibles - Who are they Now? Trends

- The number of dual eligibles < age 65 increased by 15.6% since 2006 while those ≥ age 65 increased by only 5.2%
- Half qualified for Medicare because of disability (physical or mental) rather than age
- More likely to be younger, female, and of racial/ethnic minority status
- Nearly one-fifth have three or more chronic conditions
- Those over the age of 65 are much more likely to have been diagnosed with three or more chronic conditions
- Those under age 65 more likely than those 65 or over to have been diagnosed with a mental illness
- More than 40 percent use long-term services and supports

Sources: *Data Analysis Brief Medicare-Medicaid Dual Enrollment from 2006 through 2011,* Prepared by Medicare-Medicaid Coordination Office, February 2013; *Dual-Eligible Beneficiaries of Medicare and Medicaid:, Health Care Spending, and Evolving Policies*, Congressional Budget Office, June 2013.

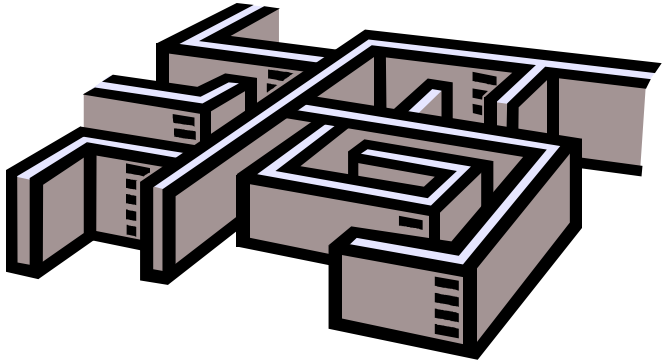
# Spending on Duals and Delivery System Trend

- In 2009, the federal and state governments spent more than $250 billion on dual eligibles' health care benefits
  - Dual eligibles are 13% of combined population of Medicare beneficiaries and aged, blind, or disabled Medicaid beneficiaries and account for 34% of combined Medicare and Medicaid total program spending
- The managed care enrollment rate for full benefit Medicare-Medicaid enrollees grew from 7.8% in 2006 to 15.2% in 2011

Source: *Data Analysis Brief Medicare-Medicaid Dual Enrollment from 2006 through 2011,* Prepared by Medicare-Medicaid Coordination Office, February 2013.

# What Does Care Look Like for Duals Without Coordination and Integration?

- Fragmented and uncoordinated
- Difficult to navigate
- Gaps in care
- Not focused on the individual
- Cost-shifting between states and the federal government
- Institutional bias, not communities



# At the Center: The Individual

- I decide where and with whom I live.
- I make decisions regarding my supports and services.
- I work or do other activities that are important to me.
- I have relationships with family and friends I care about.
- I decide how I spend my day.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect.

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V. Movement to Integrated Care

# Platforms for Service Delivery and Integration

| Approach | Examples |
| --- | --- |
| PACE | Most states |
| Medicaid FFS with enhanced care coordination | CO, NC |
| Medicaid Managed Long-Term Services and Supports | AZ, CA,DE, NJ, FL, KS, MI, MN, NM, NY, TX |
| Joint State & Federal Financial Alignment Initiatives | CA, CO, IL, MA, MN, NY, OH, SC, VA, TX, WA |
| Dual Eligible Special Needs Plan Platform | AZ, HI, NM, TN |
| Fully Integrated Dual Eligible Special Needs Plans | MA, MN, WI |

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# MLTSS - State Experience

- MLTSS programs doubled from 8 to 17 between 2004 – 2012 with 19 as of July 2014
- By end of 2014, 26 states are projected to have MLTSS programs
- Currently, 12 states have mandatory enrollment, 7 voluntary, and 1 has both
- Number of MCOs in the MLTSS market has expanded accordingly
- Most offer consumer-directed options *

* *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update,* Truven Health Analytics for Centers for Medicare and Medicaid Services, July, 2012.

# States with MLTSS Programs

- Arizona
- California
- Delaware
- Florida
- Hawaii
- Kansas
- Massachusetts
- Michigan
- Minnesota
- New Jersey
- New York
- New Mexico
- North Carolina
- Ohio
- Pennsylvania
- Tennessee
- Texas
- Washington
- Wisconsin

# Managed Care as a Purchasing Strategy for LTSS

- Managed care can be a tool to reduce fragmented acute and primary care, behavioral health, and LTSS.
- With strong oversight and incentives MLTSS programs can provide high-quality, person-centered and cost-effective care to eligible beneficiaries in the setting of their choice.

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# Movement to Integrated Care – Beyond MLTSS

- Financial Alignment Models – Capitated and MFFS
- Administrative Dual Demonstration Model (MN)
- Dual Eligible Special Needs Plan Platforms (AZ)
- Stepped Approach - Medicaid Managed Long-Term Services and Supports (NJ)

# Financial Alignment Demonstration Models*

## Capitated

CA, IL, MA, MI, NY, OH, RI, SC, TX, VA, WA

- Joint procurement of high-performing health plans
- Three-way contract: CMS, state, health plan
- Single set of rules for marketing, appeals, etc.
- Blended payment, built-in savings
- Voluntary, passive enrollment with opt-out provisions

## MFFS

CO, CT*, MO*, WA

- FFS providers, including Medicaid health homes or accountable care organizations
- Seamless access to necessary services
- Quality thresholds and savings targets

*As of June 2014 do not currently have signed Memorandums of Understanding with CMS

# Special Needs Plan (SNP) Basics

- SNPs are Medicare Advantage (MA) plans authorized to target enrollment to three specific vulnerable populations:
  - Beneficiaries who are dually eligible (D-SNPs)
  - Beneficiaries who live in long-term care institutions (or would otherwise require an institutional level of care) (I-SNPs)
  - Beneficiaries who have certain chronic conditions (C-SNPs)
- SNPs focus on care management of their targeted population
  - Health risk assessments (HRA)
  - Model of care (MOC)

Source: Medicare Advantage and D-SNPs: An Introduction to Medicare and Medicare Advantage, Centers for Medicare and Medicaid Services, Division of Medicare Advantage Operations State Resource Center, July 28, 2011.

# D-SNPs as a Platform for Integration

- Coordinating care is the main purpose of D-SNPs
  - D-SNP models of care must outline how Medicare and Medicaid covered benefits will be coordinated
  - Benefit integration under D-SNP contracts varies by state
- Some states were early leaders in contracting with D-SNPs to further integration (MA, MN, WI)

# State Contracting with D-SNPs

- As of January 2013, D-SNPs must have a contract with state Medicaid agency for coordination of Medicare and Medicaid benefits
  - D-SNP (at a minimum) agrees to provide or arrange for integrated and coordinated Medicare and Medicaid benefit package
  - State Medicaid Agency (at a minimum) agrees to allow the D-SNP to serve and coordinate care for its dual eligible population

Note: Section 164 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 as amended by the Affordable Care Act of 2010 mandates that D-SNPs have such a contract by CY 2013 and each subsequent year to continue to operate as a D-SNP.

# Visit CHCS.org to…

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services
- **Subscribe** to CHCS e-mail updates to learn about new programs and resources
- **Learn** about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries

**www.chcs.org**

# Thank you!

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Tammy Whitlock, Director
Division of Integrated Care & Behavioral Services

Virginia Department of Medical Assistance Services

Virginia Update for CHCS Provider Training
July 16, 2014

# Overview

- Background
- Intelligent Assignment
- Continuity of Care
- Contract Requirements
- Contract Oversight
- Beneficiary Choice

# CCC Highlights

1. High-quality, **person-centered** care for the Dual Eligible that is focused on their needs and preferences
2. All the **same benefits currently available** under Medicaid and Medicare
3. **Single program with built-in Care Coordination** for primary, preventive, acute, behavioral, and long-term services and supports
4. Promotes **improved transitions** between acute and long-term facilities

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# CCC Highlights

Three-way contract between CMS, DMAS, and health plans referred to as MMPs (Medicaid-Medicare Plans). 5

Same fiscal agent for consumer-directed services to ensure continuity of care 6

Reimbursement – Blended, risk adjusted rate based on Medicaid, Medicare, and Medicare Advantage data 7

The three MMPs for CCC 8

Healthkeepers
Humana
Virginia Premier

# Enrollment Regions and Phases

**Five Enrollment Regions**

1. Central VA/Richmond
2. Tidewater
3. Northern Virginia
4. Roanoke area
5. Western/ Charlottesville area

**Two Phases of Enrollment**

- Opt-in Phase
  - Eligible individuals elect to proactively enroll in the program
- Automatic Phase
  - Eligible individuals are automatically enrolled into the CCC program through an intelligent assignment algorithm based upon previous health plan enrollment, health plan network that includes the current adult day health provider or nursing facility (if applicable)

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# Supplemental Benefits and Supports

- Varies by MMP
- May include:
  - Dental
  - Vision, to include eyeglasses
  - Podiatry
  - Gym (wellness) memberships
  - Hearing exams, to include hearing aides

# Beneficiary Notification

Eligible individuals are identified by a join process in DMAS & CMS information systems

| Eligible Individuals Receive 4 Letters |
| --- |
| 1. A letter introducing CCC |
| 2. A 60 day letter informing the individual he/she will be signed up by a specific date unless he/she opts out |
| 3. A 30 day letter informing the individual he/she will be signed up by a specific date unless he/she opts out |
| 4. A welcome package from the health plan providing coverage for the individual |

Individuals are given the option to choose a Medicare-Medicaid Plan (MMP) or opt out of the program.

# Virginia Enrollment

| CCC Member Participation By Region - July 12,2014 | | | |
|---|---|---|---|
| **CCC Region** | **Active Opt-ins** | **Automatic Assignments** | **Opt-outs** |
| Central Virginia | 1189 | 13994 | 3105 |
| Northern Virginia | 170 | | 531 |
| Roanoke | 234 | | 615 |
| Tide Water | 908 | 9495 | 5639 |
| Western/Charlottesville | 156 | | 322 |
| **Total Members** | **2657** | **23489** | **10212** |

# Virginia Enrollment

| ACTIVE OPTINS BY WAIVER IND BY PLAN - July 12,2014 | | | | | |
|---|---|---|---|---|---|
| | WAIVER INDICATOR - MEMBERS | | | | |
| MMP Name | 1-ICF | 2-SNF | 9-EDCD | Community Well | Total |
| Va Premier | 10 | 1 | 63 | 306 | 380 |
| HealthKeepers | 59 | 10 | 122 | 1196 | 1387 |
| Humana | 35 | 4 | 106 | 745 | 890 |
| | 104 | 15 | 291 | 2247 | 2657 |

Numbers Change Daily!

| PASSIVE Enrollments by Waiver Ind by MMP- July 12, 2014 | | | | | |
|---|---|---|---|---|---|
| MMP | 1- ICF | 2- SNF | 9- EDCD | Other | Grand Total |
| Va Premier | 433 | 96 | 1027 | 4543 | 6099 |
| Healthkeepers | 1015 | 178 | 1128 | 5711 | 8032 |
| Humana | 1179 | 164 | 1513 | 6515 | 9371 |
| **Grand Total** | **2627** | **438** | **3668** | **16769** | **23502** |

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# Intelligent Assignment

- Algorithm assigns beneficiaries to MMP based on the following criteria:
  - Participation with one of the MMPs (ex: MA plan)
  - Nursing Home Resident
  - Adult Day participant
- In the absence of these criteria, assignment would be random

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# Continuity of Care

- Care should never stop because a beneficiary has joined the CCC program!
- Authorizations honored through the end of the authorization or up to 180 days, whichever comes first

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# What is Different with CCC?

1. Care Manager from the MMPs will complete the Health Risk Assessment
2. MMP Care Manager will coordinate with your staff to develop ICT
3. MMP Care Manager will work with your staff to coordinate appointments & services
4. Provider will bill MMP for services and work with MMP for future service authorizations

# Contract Requirements

- Claims payments within 14 days for Medicaid Services
- Care Coordination
  - Health Risk Assessments (HRA)
    - EDCD, NF Residents and other vulnerable subpopulations: HRAs will be completed within 60 days of CCC enrollment
    - Community Well: HRAs complete within 90 days
  - MMP Care Managers
  - MMP POC is not replacing the provider POC

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# Contract Oversight

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

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# Stakeholder Involvement

| Monday Provider Calls (LTSS) | | Friday Provider Calls | |
|---|---|---|---|
| Adult Day Services | 1:30-2p<br>Conference Line<br>866-842-5779<br>Conference code<br>7143869205 | Hospitals and Medical Practices | 11-11:30am<br>Conference Line<br>866-842-5779<br>Conference code<br>8047864114 |
| Personal Care, Home Health & Service Facilitators | 2-2:30p<br>Conference Line<br>866-842-5779<br>Conference code<br>8047864114 | Behavioral Health | 11:30am-12pm<br>Conference Line<br>866-842-5779<br>Conference code<br>8047864114 |
| Nursing Facilities | 2:30-3p<br>Conference Line<br>866-842-5779<br>Conference code<br>7143869205 | | |

**Plus Ongoing Association Meetings!**

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# Beneficiary Choice

- Opt-out decision rests with the beneficiary and their authorized designee (POA or family member)
- Opt-outs accepted by telephone through MAXIMUS (written opt-outs not accepted)
- As always, it is critical to honor beneficiary right to privacy. Think twice before sending PHI!
- Beneficiary Choice and flexibility is a hallmark of CCC and woven into the core of the program structure!

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# Additional Resources

**DMAS Website**

- http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx
- CCC Fact Sheet
- CCC Regions
- Initial Letter to beneficiaries
- FAQs

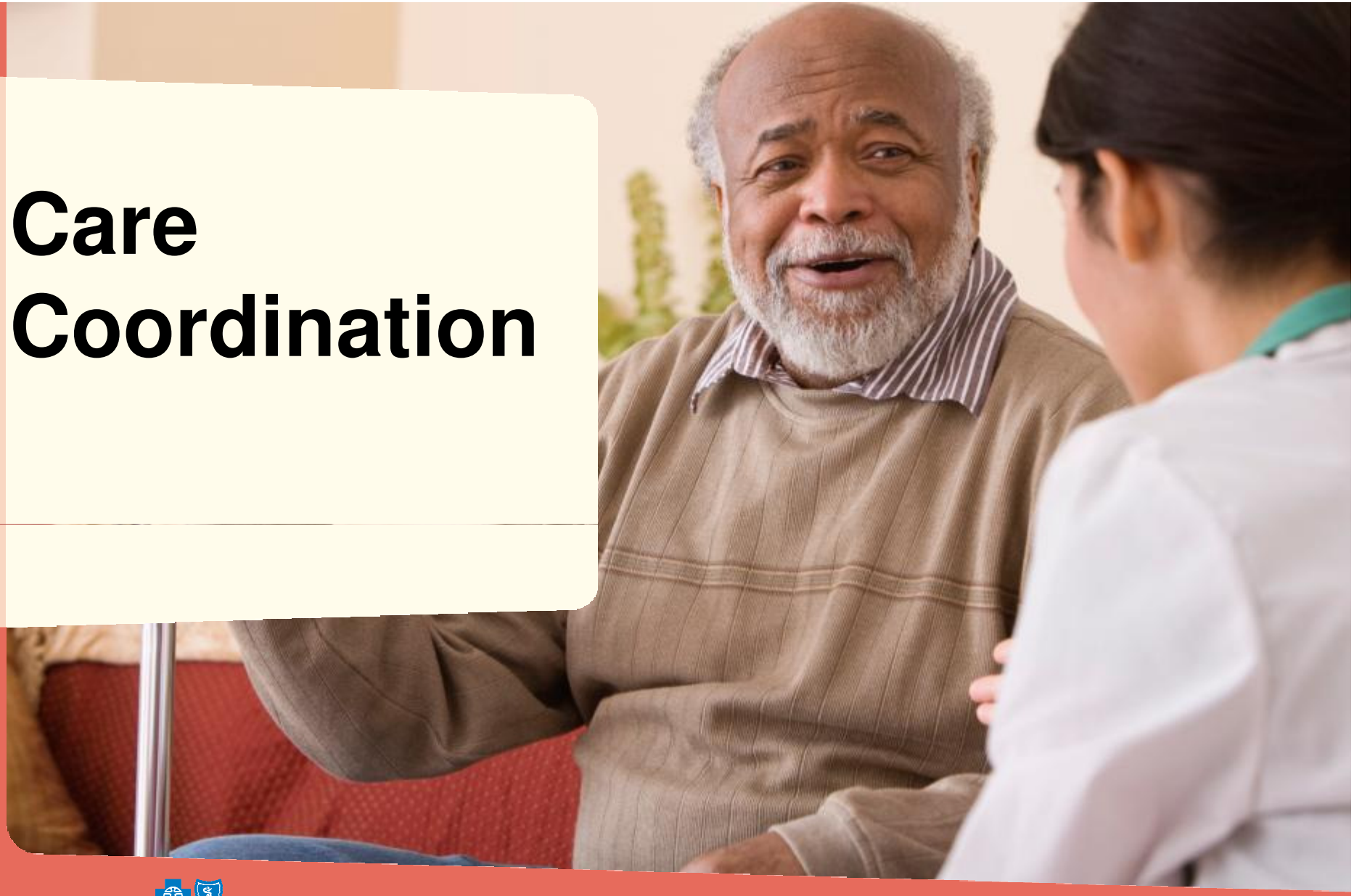
**MAXIMUS Website**

- http://www.virginiaccc.com/
- Comparison Charts
- MAXIMUS contact information

Townhall meetings and other community educational events are happening all across the Commonwealth

You can also email us at CCC@dmas.virginia.gov with questions or request to be added to the stakeholder email distribution list for future program updates!

# Care Coordination



Anthem HealthKeepers
Offered by HealthKeepers, Inc.

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# Care Coordination

- **Each member has a Care Manager who provides "*member-centered*" care management functions to all enrollees.**

- **Our goals focus to ensure members are educated on available services and community resources and assist in development of self-management skills to effectively access these services while *honoring member choice*.**



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# Functions of the Care Manager

- Monitors functional and health status and assists in seamless transfer of care across specialties and different level of care settings.
- Ensures that health care providers participate in decision making with respect to treatment options.
- Connects with services to promote community living in order to prevent premature or unnecessary NF placement.
- Coordinates with social service agencies including CSBs, social services, and local health departments



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# Care Coordination: Interdisciplinary Care Team (ICT)

- Our team of professionals collaborate, either in person or through other means, with members to develop and implement a plan of care that holistically supports their medical, behavioral, LTSS and social needs.

- ICTs may include physicians, physician's assistants, LTSS providers, nurses, specialists, pharmacists, behavioral health (BH) providers and/or social workers appropriate for the member's medical diagnosis and health condition, comorbidities and community support needs.

- ICTs employ both medical and social models of care.



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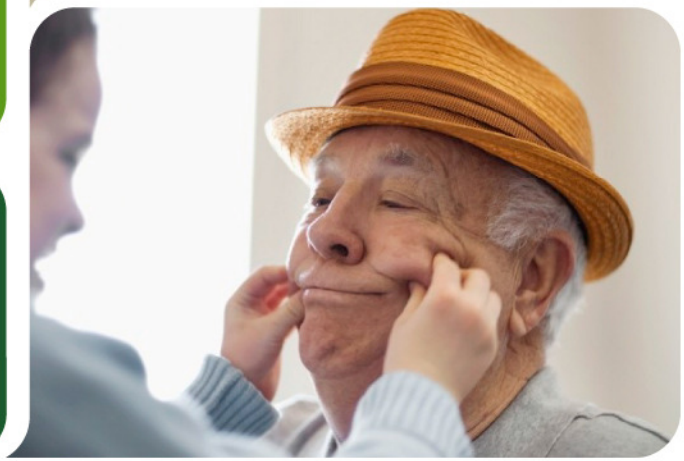
# CHCS CCC Education Session
# Nursing Facility and Personal Care

## Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan

July 16, 2014



Humana

760VA0614

# Who We Are - Humana

Humana companies and its various businesses **serve more than 12 million Members** across the country. Humana delivers primary care and occupational healthcare services through a network of **more than 300 wholly owned medical centers and clinics.**

*Helping people achieve lifelong well-being*

- **Founded in 1961**
- **Long term Commitment to Seniors & Chronically Ill**
- **5M Medicare Advantage and Part D Members**
- **550K Dually Eligible Medicare-Medicaid Members**
- **18 Years Medicaid Experience**

**Humana's Values**

- Thrive Together
- Cultivate Uniqueness
- Pioneer Simplicity
- Inspire Health
- Rethink Routine

# Humana for Virginia

Our 8 years of experience in Virginia prepare us well to meet the specific needs of our Members.

## Our Virginia Footprint:

- **120k Medicare Advantage and 98K Medicare Prescription Drug Plan Members**
- **The only Dual Eligible Special Needs Plan (D-SNP) within the Commonwealth's demonstration (CCC) area**
- **Unique partnerships aimed at promoting quality, delivering the highest standards of care, and providing access to coverage in historically underserved with various Virginia provider groups and clinic arrangements (i.e., Jencare, EVCTP)**
- **A highly-rated Medicare Advantage HMO plan across Virginia (achieving a CMS rating of 3.5 of 5 STARS)**

# Humana Highlights

Humana also offers the following member benefits:

- Assistive technology
- Vision – Exam plus $100 toward contacts, glasses and frames
- Dental – Two different types of fillings
- Hearing - $1000 toward hearing aide every three years
- $35 per month of over-the-counter health and wellness items
- Precooked frozen meal delivery after an overnight stay in a hospital or nursing facility, when approved
- Pest control treatments
- Transportation to and from medical appointments
- Basic fitness center membership (Silver Sneakers®) customized for older adults
- Smoking cessation services and resources

# Coordination of Care Model

## Enrollment and Care Coordination

Our tailored approach to care coordination enables our staff to build an **individualized, comprehensive plan of care** that can adapt based on a Member's developing needs and personal goals.

**Stratify** Members through Internal Systems

**Assess** Needs and Personal Goals

**Confirm** Stratification Level of Care

**Develop** Individualized Plan of Care

**Implement** new Plan with Member

**Monitor** and Reassess Plan of Care

A Member in any of the last 4 stages may return to the **Stratify** or **Assess** stages if their health circumstances or goals change.

# Interdisciplinary Care Team

## Coordination and Continuity of Care

The Interdisciplinary Care Team (ICT) is a Member-centered group that functions as a unit to **cultivate Member relationships and promote self care and management**.

At the center of the ICT model are the persons who serve at the core and most closely interact with one another: the Member and caregiver, the Care Manager and the service providers.

### The Interdisciplinary Care Team Model supports many facets of care, such as:

- Member **education** and connections to **community resources**
- Reinforcement of provider **treatment** and **medication** plan
- Provider practice **goals**
- **Preventive** screenings and wellness support
- **Care coordination** and care transitions
- Appropriate advanced illness and **end of life planning**

# The Care Management Team

- **Medical Director-** Provides consultative clinical oversight of clinical operations.
- **LTSS Transition Coordinators –** Conducts thorough face-to-face assessment of the Member and develops the Member-centric plan of care initially and with any change in condition.
- **LTSS Care Coordinators –** Responsible for ongoing care management of the Member. Reviews and updates the established Plan of Care, supporting the Member in meeting their goals. Leads the ICT , advocates for the Member. Collaborates with peers on Member's admissions, transition and discharge planning.
- **CW Care Managers–** Provide care management for the Community Well Members (i.e. non LTSS) telephonically. Conducts assessments, develops the Plan of Care. Leads the ICT , including referrals for a Field Care Manager home visit, when face-to face support is needed.
- **BH Care Managers** – Provide behavioral health care management, as either primary or in a care consultative role for both the LTSS and CW members.

# Information Needed by Care Manager

- We will be looking at the following information to incorporate into the POC:
  - Nursing Facility
    - Nursing facility POC.
    - Minimum Data Set (MDS) information.
    - Universal Assessment Instrument.
    - Medication list.
    - Recent hospital admissions.
    - Physical/Occupational Therapy notes.
  - Personal Care
    - DMAS forms (99, 96 and 97 A/B)
    - Universal Assessment Instrument

# Humana Network

- Network Phase I
  - Approved network in all counties with the following exceptions:
    - Mecklenburg
- Network Phase II
  - Approved network in all counties with the following exceptions:
    - Fauquier and Manassas Park City
    - Staunton City and Waynesboro
    - Henry and Martinsville City
- Network Build
  - Amending contracts with Humana participating providers
  - Contacting non-participating providers who are currently providing services to CCC members
  - Contracting with EDCD and Nursing Facility providers participating in the Medicaid program.
  - Requesting lists of ancillary providers from Nursing Facilities

# Closing

- **LTSS Provider relations:** 1-866-224-6947 (Monday through Friday, 8 a.m. to 5 p.m. EST)

Policy and procedure details may be found in the Provider Manual or Provider Handbook.

- Please refer to the Humana Provider Manual at https://www.humana.com/provider/support/publications

Thank you for your participation.

Questions?

Thank you!

Humana®

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

VA Premier
CompleteCare
a Commonwealth Coordinated Care Plan

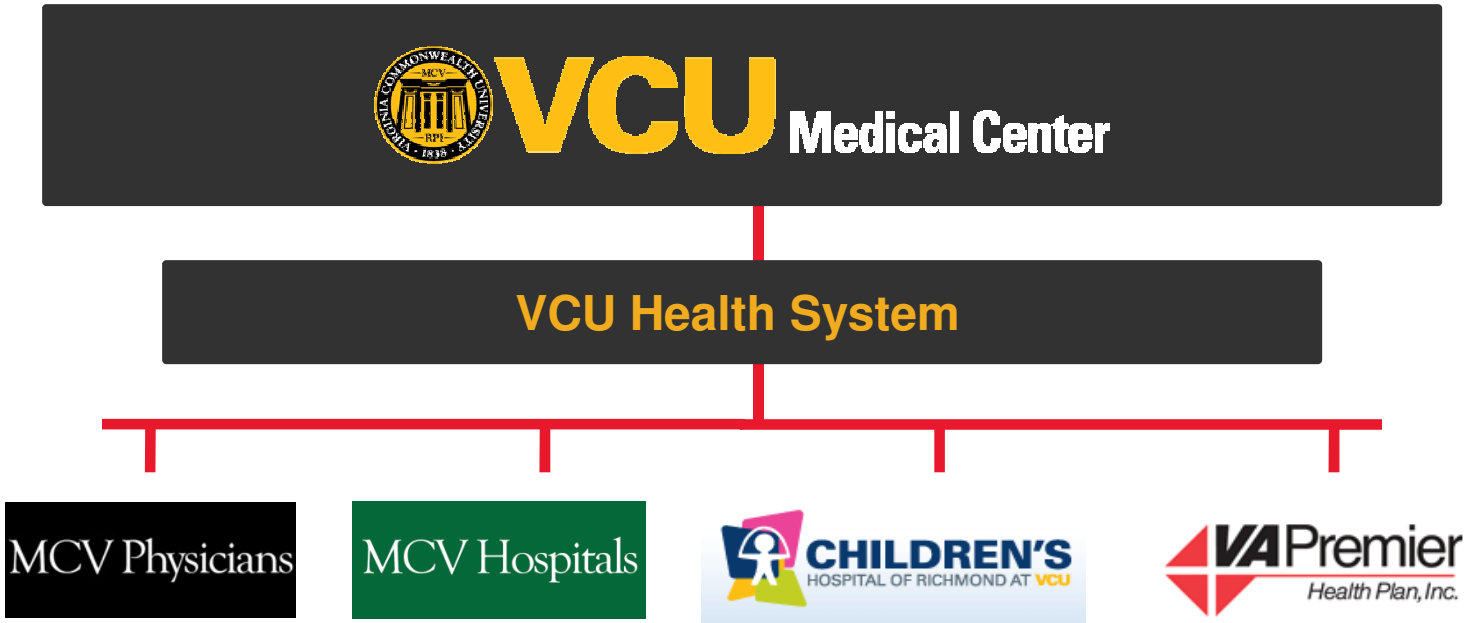
# Virginia Premier CompleteCare (Medicare-Medicaid Plan)

July 16,2014

Linda Hines, Vice President Health Services
Rick Gordon, Director Long Term Services & Support
Timothy Hart, Director Claims Operations
Patricia Suffern, Program Manager & CompleteCare Compliance Officer

# About Us

VA Premier CompleteCare



# What Sets Us Apart?

VA Premier CompleteCare

## The Basics

- We are the **#1 Medicaid Health Plan** in Virginia for six consecutive years, from **2008 - 2014**.*
- Ranked #38 in 2013 - 2014 by NCQA of Best Medicaid Health Plans in the United States.
- **Not-For-Profit** Health Plan
- Company owned transportation service
- The first and only **university-based** Managed Care Organization in Virginia

** NCQA's Medicaid Health Insurance Plan Rankings, 2013-2014*

# Care Management Success

VA Premier CompleteCare

# Care Management Structure

VA Premier CompleteCare

## Care Management Teams Per Region

(Tidewater, Central Virginia, Roanoke, Charlottesville)

## 3-5 Care Management Teams Per Region

(Determined by number of members, geography and composition of membership)

## Team Composition

Team Lead – Level III Care Managers

Level III, II & I Care Managers

Patient Care Coordinators, Medical Outreach, Social Workers & Health Educators

# Care Management Approach

VA Premier CompleteCare

**Community Well**

- HRA completed by Member Engagement Representative
- Level I Care Manager completes POC, ICT and on-going monitoring

**EDCD**

- Level III Care Manager performs face-face assessment
- Completes POC, ICT and monthly contact

**Nursing Facility**

- Level II & III Care Manager performs face-face assessment, interacts with Nursing facility staff
- Coordinates POC, ICT with Nursing Facility, quarterly contact

# Contact Information

VA Premier CompleteCare

## Our Call Centers

**Member Services**

- 1-855-338-6467

**Claims Customer Service**

- 1-855-338-6467

**Organizational Determinations**

- 1-888-251-3063

**Provider Services**

- 1-855-338-6467

**Case Management**

- 1-855-338-6467

# Provider Outreach

VA Premier CompleteCare

## Engagement & Interaction

- Provider Calls
- Mailings
- Site Visits and Recruitment
- Town Halls
- Association Meetings and Presentations
- Provider In-Services
- Provider Education Meetings
- Weekly Provider DMAS Calls
- MTR Follow Up

# CCC/ CompleteCare Training

VA Premier CompleteCare

- Provider Resource Guides
- Website
  - https://www.vapremier.com/providers/provider-resources
  - Provider Services: 1-855-338-6467
- FAQs
- CompleteCare Provider Point of Contact –
  - Rick Gordon, Director of Long Term Services & Support rgordon@vapremier.com OR 804-819-5151 Ext. 55075
- DMAS Link and Memos
- Training Sessions – Now a coordinated effort on the part of all 3 MMPs, Same Day, Same Location
- CCC Training- Learning Management System, Providers Login With NPI to Complete Required Training
- LTSS In-Services

# Non-Par Outreach

VA Premier CompleteCare

## How do We Reach Non-Par Providers?

- DMAS Medical Transition Report
  - Used To Identify Non Par Providers
  - Triggers Two Mechanisms For Outreach
    - Medical Management (Care Managers) – Provide Authorizations and Explain 180 Day Continuity of Care
    - Network Development – Reach out to discuss CCC, Requirements for Claims and Reimbursement, Provide contracts for review and consideration

- Non- Par Education and Outreach
  - Once identified, we utilize all means previously mentioned to communicate valuable information

# Claims

VA Premier CompleteCare

- **3 Ways To submit Claims**
  - **Provider Portal** – API/NPI Direct Data Entry
    - https://www.payertransactions.com/vpcc
  - **Clearinghouses**
    - Partnering with two of the largest clearinghouses in the industry **Availity and RelayHealth**
  - **Paper Claims** – Claims Created Electronically and Dropped to Paper
- **Claims Paid to Contracted (PAR) & Non-Contracted (Non Par)**
  - At a minimum we need a W-9 on file to pay Non-Par Claims
  - We use the MTR and the Authorizations Process to Identify Non-Par Providers and communicate requirements via letter

# Claims Operations

VA Premier CompleteCare

- Our Claims Department is committed to providing you with the highest level of service possible. Our goal is to pay claims appropriately and timely to ensure that your claims billing & payment experience is a success.

- Providers can submit claims using the following options:
  - Submission via the Provider portal.
  - Electronic Claims Submission (EDI) Submission
  - Paper claims submission

**So….How are we doing so far?**

# Claims Average Days To Payment

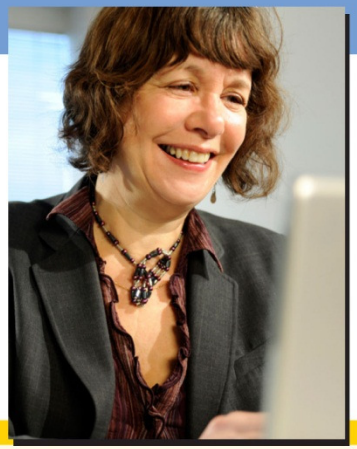
VA Premier CompleteCare

| Total Claims Paid: 551 | Average Turn Around Time (Days) |
|---|---|
| Behavioral Health Medicaid Claims | 3.80 |
| Long Term Care Claims | 6.69 |
| Nursing Facility Claims | 6.50 |
| Outpatient Facility Claims | 12.08 |
| Inpatient Facility Claims | 14.00 |
| Professional Claims | 7.02 |
| Year To Date | 7.22 |

## Provider Claims Support

Our Customer Service Team is available to assist you with any claims related issue you may be having.

**Please call us at (1) 855 338-6467**



# VICAP


**Anita Squire**
Coordinated Care Educator
DARS Division for the Aging


CCC Education Session
July 16, 2014

Johnston Willis Hospital

DARS
Virginia Department for Aging and Rehabilitative Services

# What is VICAP?

## *Virginia Insurance Counseling and Assistance Program*

- Information and Counseling on Medicare and other health insurance issues to seniors and adults with disabilities
- One of 54 State Health Insurance Programs (SHIPS)
- 100 % Federally funded
- Volunteer based

# VICAP Services to Beneficiaries

- Traditional Medicare (Medicare) A & B
- Medicare Advantage Plans (Part C)
- Medicare Prescription Drug Coverage (Part D)
- Medigap or Medicare Supplemental Insurance
- Long-Term Care Insurance
- Coordination of Benefits
- Appeals, Denials, etc.

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Virginia Department for Aging and Rehabilitative Services

# VICAP and Commonwealth Coordinated Care

***Coordinated Care Educator***

- Informs, Educates, Guides

OPTIONS

PLAN COMPARISON

BENEFICIARY RIGHTS

MAXIMUS

LOCAL VICAP OFFICE

DARS

VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

# VICAP and Commonwealth Coordinated Care

- Collaborates with DMAS

- Serves As Liaison

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION · QUALITY · VALUE

**AAA's**
(Area Agencies on Aging)

VICAP
Virginia Insurance Counseling and Assistance Program
HELPING YOU NAVIGATE MEDICARE

DARS
Virginia Department for Aging and Rehabilitative Services

**CONTACT**:


**Anita Squire, CC Educator**

Department for Aging & Rehabilitative Services

1610 Forest Avenue, Suite 100

Henrico, VA 23229

**anita.squire@dars.virginia.gov**

**(804)662-9329** or

Toll Free **1-800-552-3402**


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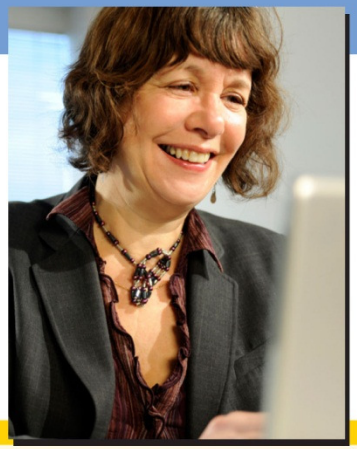

# Beneficiary Rights: The Role of the Virginia Long-Term Care Ombudsman Program

Commonwealth Coordinated Care Education Session
Johnston Willis Hospital
July 16, 2014

DARS
Virginia Department for Aging and Rehabilitative Services

# The Long-Term Care Ombudsman Program Overview

- The Virginia Office of the State-Long-Term Care Ombudsman Program (LTCOP) is operated through the Virginia Department for Aging & Rehabilitatative Services.
- Twenty-one local ombudsman, under the programmatic authority of the State Ombudsman, and housed in AAA's across the state, to provide direct assistance to long-term care recipients.
- DARS provides a statewide toll-free telephone number (1-800-552-3402) as a central point of access to local Ombudsman Program representatives.

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# Mission

- The mission of the LTCOP is to act as an **advocate** for older persons receiving long-term care, whether the care is provided in a nursing home or assisted-living facility, or through community-based services to assist persons age 60 and older still living at home.

  The Ombudsman serves as an **advocate** in order to protect and improve the quality of care and the quality of life of long-term care recipients.

  **The cornerstone of this mission is the concept of residents' rights.**

* The LTCOP mandate and authority are set forth in Title 7 Chapter 2 of the Older Americans Act and requirements set forth in the Code of Virginia Title 51.5

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# Ombudsman Activities

- Complaint investigation and resolution made by, or on behalf of residents;
- Providing services to assist residents in protecting their health, safety, welfare and rights;
- Representing the interests of residents before governmental agencies and seeking administrative, legal and other remedies to protect residents;
- Work with family, resident councils and citizen groups; and
- Community education and other systems advocacy initiatives.

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# Role of the CCC Ombudsman Project

- LTCOP will expand ombudsman program to ensure the beneficiaries of CCC have access to person-centered assistance in resolving problems related to the Demonstration.
- Long-Term Care Ombudsman Program will provide a new component of ombudsman services with regional Coordinated Care Advocates to address the needs of CCC enrollees of any age, who live in the community. (The LTCOP will continue to be delivered locally by AAAs, with oversight by the Office of the State LTC Ombudsman and regional Coordinated Care Advocates, staffed under the direction of DARS).
- Together, Ombudsmen and Coordinated Care Advocates will serve CCC Enrollees living in LTC facilities, nursing homes and assisted living facilities and dually eligible individuals enrolled in CCC living in the community.

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# Services Provided by Ombudsmen and CCC Advocate

- Provide one-on-one education about rights, benefits and/or quality of services
- Complaint investigation and resolution to include identification of issues
- Empower CCC Enrollees to resolve problems they have with their health care, behavioral health care, prescription drugs and long term services and supports
- Collect data on complaints and outcomes and assist in the recommendations for quality improvement

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# LTCOP Contact Information

Susan Johnson, CCC Advocate Manager
Office of the State Long-Term Care Ombudsman
Virginia Department for Aging & Rehabilitative Services
8004 Franklin Farms Drive
Henrico, Virginia 23229
804-662-7162
1-800-552-3402
Susan.Johnson@dars.virginia.gov

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# Questions