

Memorandum of Understanding

Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees

July 1st, 2014



Our Mission:

Improving health care access
and outcomes for the **people**
we serve while demonstrating sound
stewardship of financial **resources**



Today's Topics

- Purpose of MOU
- Key Objectives
- Eligibility
- Enrollment
- Outreach and Education
- Protections
- Delivery System
- Financing and Payment
- Evaluation
- Written Protocols



Purpose of MOU

- Details the principles under which CMS and the State plan to implement and operate the Demonstration.
- Outlines the activities CMS and the State shall conduct in preparation for implementation of the Demonstration before the parties execute a Final Demonstration Agreement, which sets forth the terms and conditions of the Demonstration.



Objectives & Goals of the Program

- Key Objectives

- Alleviate fragmentation
- Improve coordination of services

- Key Goals

- Eliminate duplication of services for Medicare-Medicaid enrollees;
- Expand access to needed care and services;
- Improve the lives of beneficiaries, while lowering costs



Eligibility

Who is Eligible?

- Be enrolled in Medicare Parts A and B and eligible for Part D; and
- Receive full Medicaid benefits under FFS arrangements; and
- Have no other private or public health insurance; and
- Be a resident of the State.



Eligibility

Who is NOT Eligible?

- Individuals enrolled in a:
 - Medicare Advantage plan
 - The Program of All-inclusive Care for the Elderly (PACE)
 - the Denver Health Medicaid Choice Plan
 - Rocky Mountain Health Plan
- Individuals who are residents of an Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID)



Enrollment

September	7500	Those in community relatively well category whose primary care providers are already PCMPs in the ACC Program
October	7500	Remainder of those in the community relatively well category whose primary care providers are already PCMPs in the ACC Program; those in the community relatively well category whose Medicare-Medicaid primary care providers are not yet in the ACC Program
November	7500	Those in the community relatively well category and those receiving waiver services whose Medicare-Medicaid primary care providers are not yet in the ACC Program
December	7500	The remainder of those in the community relatively well category and those receiving waiver services whose Medicare-Medicaid primary care providers are not yet in the ACC Program
January	7500	The remainder of those receiving waiver services and those receiving high waiver services whose Medicare-Medicaid primary care providers are not yet in the ACC Program or whose Medicare primary care providers have no Medicaid billing identification number
February	7500	Those in skilled nursing facilities, including residents receiving nursing facility services for which Colorado Medicaid is the primary payer
March	remainder	



Outreach and Education

Info going to new eligible enrollees

1. Enrollment Letter



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Welcome to a new program to help with your Medicare and Medicaid services!

John Smith
12345 Anywhere St
City, ST ZIP

July 17, 2013

Your Medicaid number:
999999

Dear John,

On September 1, 2013, you are being enrolled in a new program for people who have both Medicare and Medicaid. This new program will help your Medicare and Medicaid work together better, making it easier for you to get the services you need.

In this new program, your local Regional Care Collaborative Organization, Colorado Access, will work with you. Colorado Access will help you, your doctors, and others to coordinate your care and services. Colorado Access can also help you find social and community services in your area.

Our information shows:

Your doctor is part of ABC Family Practice

Your new Regional Care Collaborative Organization is Colorado Access.

What do you have to do to be in the new program?

You don't have to do anything. You are automatically in the program. After September 1, 2013, Colorado Access will contact you to explain how the new program can help you.

Please read the other information in this packet to learn more about the program and better understand how it can help you.

For another language or larger print: 1-888-367-6557. The call is free.

For TTY: 1-888-876-8864

*The mission of the Department of Health Care Policy & Financing is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. colorado.gov/hcpf



Outreach and Education

Info going to new eligible enrollees

1. Enrollment Letter
2. FAQs



Full Benefit Medicare-Medicaid Enrollees

Integrating Care for Full Benefit Medicare-Medicaid Enrollees Frequently Asked Questions

What are the benefits of this program?

This new program will help your Medicare and Medicaid work together better, making it easier for you to get the services you need. In this new program, we will work with you to help you, your doctors, and others to coordinate your care and services. We can also help you find social and community services in your area.

Will my current benefits or services be disrupted if I participate in this program?

No, you will still have all the same Medicare-Medicaid benefits. All benefits and services will continue as normal including social and community supports or case management, pharmacy services, durable medical benefits, Home and Community based Services and Long-Term Supports and Services, and all other government benefits such as social security or food assistance.

Will I still be able to use my current providers for the services I receive?

Yes, you will still have your same providers.

Will I lose my Medicare and Medicaid benefits if I don't participate in this program?

No, if you choose not to participate in this program, you will still have the same Medicare and Medicaid benefits.

Will I need to get approval from anyone before I can see my doctor or access services?

No. Prior approval is not required to see your physician or receive services.

What about privacy, who will see my records and information?

All of your records and information will continue to be subject to existing privacy regulations, which restricts the sharing of your health information without your prior written consent.

Who do I call when I have questions about my services?

For questions regarding services, please contact Medicaid customer service at 800-221-3943.

Program Contact:
Van Wilson
303-866-6352

Media Contact:
Rachel Reiter
303-866-3921



Outreach and Education

Info going to new eligible enrollees

1. Enrollment Letter
2. FAQs
3. Member Handbook



Beneficiary Rights & Protections

- Beneficiary Rights and Protections Alliance
 - Commitment to providing “ombudsman services” through the alliance that fosters:
- Education and information about benefits options and enrollee rights;
- Seamless access to services provided by alliance members;
- Assistance to and advocacy on behalf of Medicare-Medicaid enrollees who have complaints or grievances.

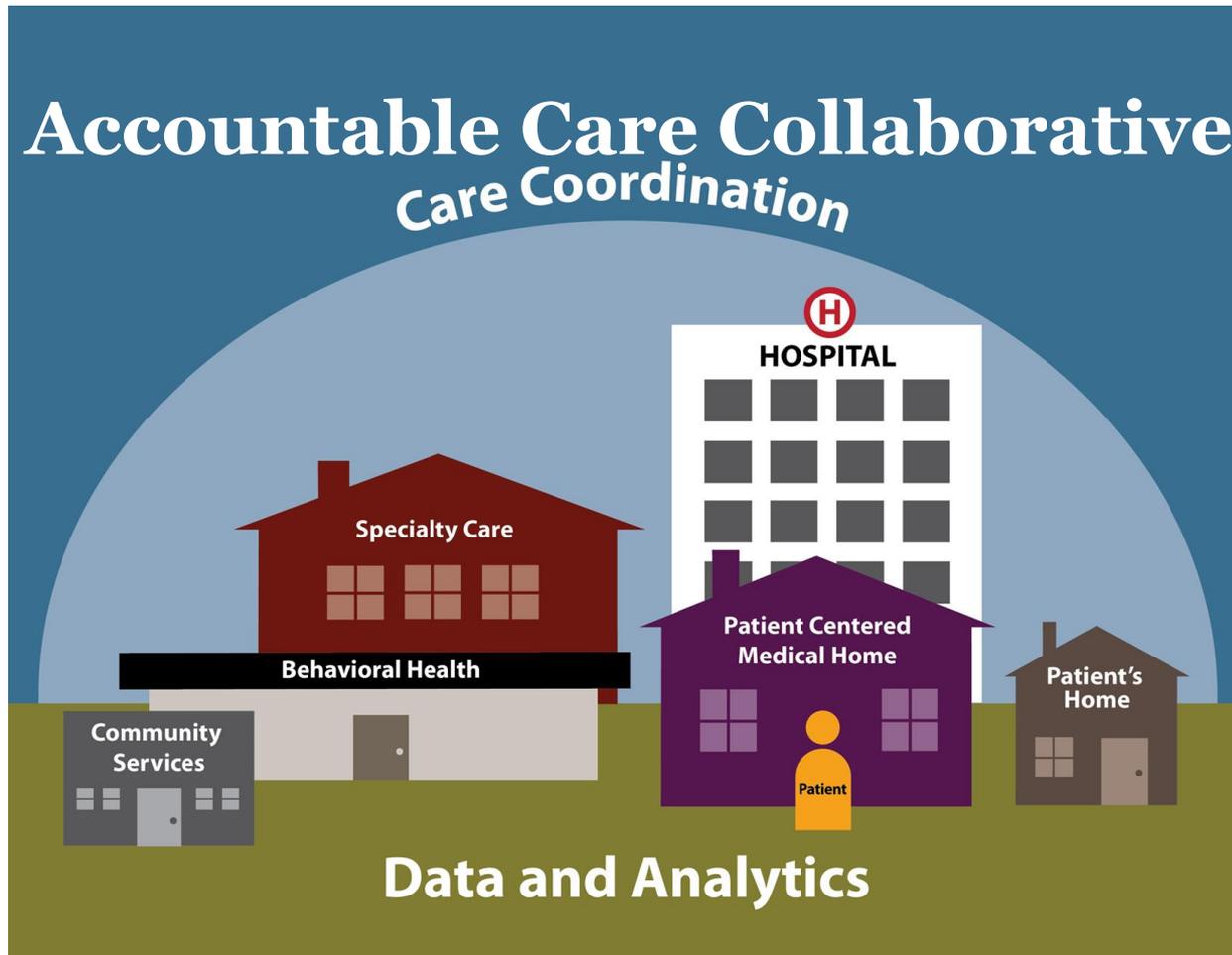


Beneficiary Rights & Protections

- MOU Guarantees the following Beneficiary Rights & Protections:
 - Choice of provider
 - Continuity of Care
 - Person-Centered, Appropriate Care
 - ADA
 - Beneficiary Participation on Governing and Advisory Boards
 - Customer Service Reps
 - Privacy and Security
 - Appeals and Grievances



Demonstration Delivery System



Service Coordination Plan (SCP)

- Tool to better coordinate care and identify gaps
- Provides a single, comprehensive view of all elements needed to coordinate physical, behavioral, and social health care, services, and supports
- Compliments existing care plans
- Workgroup ongoing



Financing & Payment

- *Medicare*: Providers continue to receive FFS payments
- *Medicaid*: Same methods as ACC payments



Financing & Payment

- Shared Savings
 - State is eligible to receive retrospective performance payment
 - Must meet requirements (appendix 7)
 - Contingent on achieving overall federal savings
 - Based on quality measures



Model Core Measures	Year 1	Year 2	Year 3
All Cause Hospital Readmission <i>(Plan All Cause Readmission NQF #1768)</i> Claim-based Measure	Reporting	Benchmark	Benchmark
Ambulatory Care-Sensitive Condition Hospital Admission <i>(PQI Composite #90)</i> Claim Based Measure	Reporting	Benchmark	Benchmark
ED Visits for Ambulatory Care-Sensitive Conditions <i>(Rosenthal)</i> Claim-Based Measure	Reporting	Benchmark	Benchmark
Follow-Up after Hospitalization for Mental Illness <i>(NQF #0576)</i> Claim-Based Measure	Reporting	Benchmark	Benchmark

Model Core Measures	Year 1	Year 2	Year 3
Depression screening and follow-up care <i>(#0418)</i> Partially Claim-Based Measure		Reporting	Benchmark
Care transition record transmitted to health care professional <i>(NQF #648)</i> Partially Claim-Based Measure		Reporting	Reporting
Screening for fall risk <i>(NQF #0101)</i> Partially Claim-Based Measure			Reporting
Initiation and engagement of alcohol and other drug dependent treatment (a) initiation, (b) engagement <i>(NQF #0004)</i> Partially Claim-Based Measure			Reporting

State-Specific Process Measures	Year 1	Year 2	Year 3
<p>Care Coordination/Service Coordination Plan: % of high-risk enrollees with a SCP within 90 days of connection with a Regional Care Coordination Organization (RCCO)</p> <ul style="list-style-type: none"> All non-high risk beneficiaries must have SCP within 120 days. 	Reporting	Benchmark	Benchmark
<p>Training on Disability, Cultural Competence, and Health Assessment: % of providers within a RCCO who have participated in training for disability, cultural competence, or health assessment</p>	Reporting	Benchmark	Benchmark
<p>Hospital Discharge and Follow Up: % of enrollees who received first follow-up visit within 30 days of hospital discharge</p>	Reporting	Benchmark	Benchmark

State-Specific Measures	Year 1	Year 2	Year 3
<p>Client/Caregiver Experience of care: % of enrollees reporting that their doctor or provider do the following:</p> <ol style="list-style-type: none"> 1. Listen to you carefully? 2. Show respect for what you had to say? 3. Involve you in decisions about your care? 	Reporting	Benchmark	Benchmark
<p>Care for Older Adults: % of enrollees 66+ who had each of the following during the measurement year:</p> <ol style="list-style-type: none"> 1. Advance care planning 2. Medication review 3. Functional status assessment 4. Pain screening 	Reporting	Benchmark	Benchmark

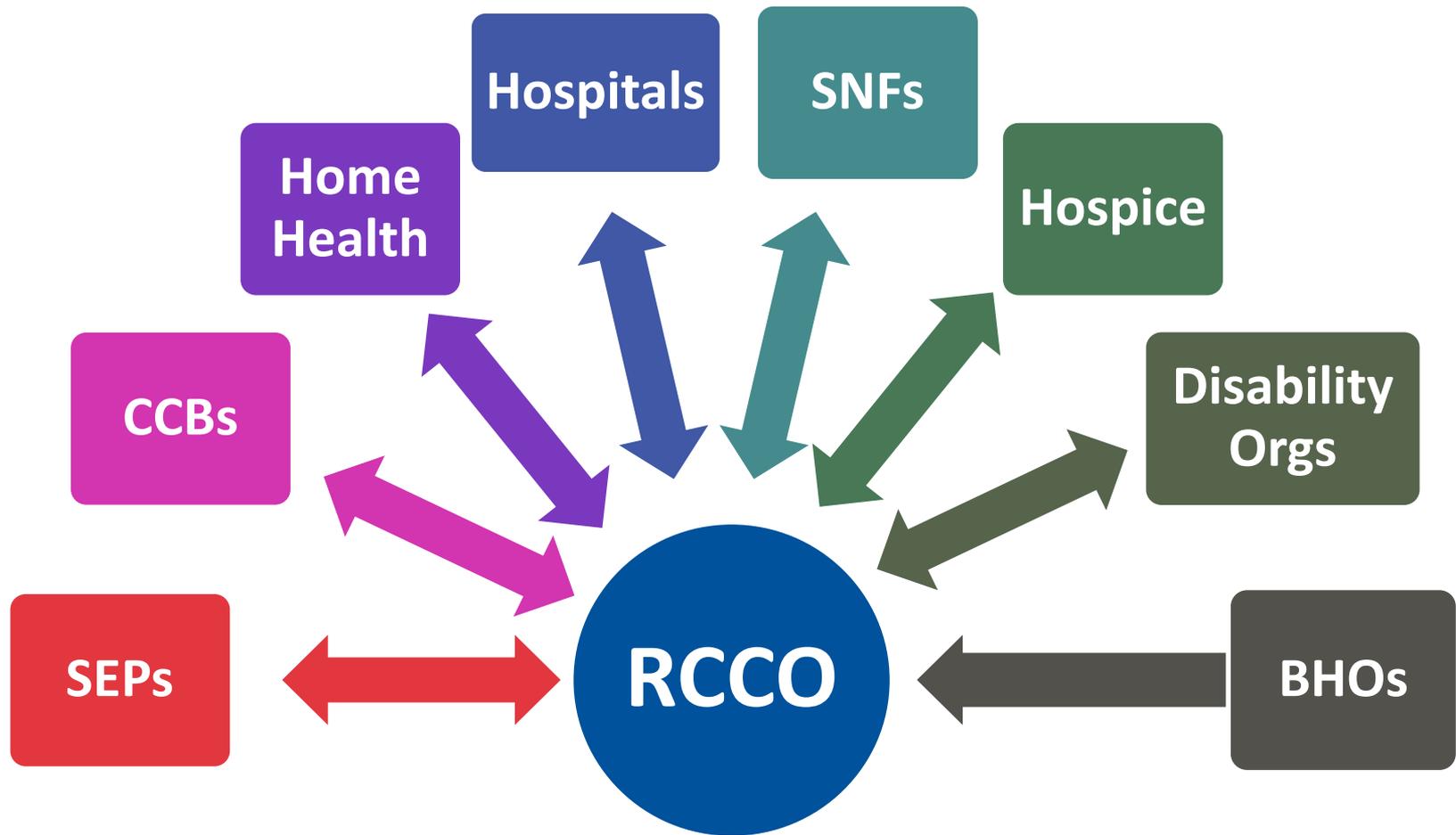
State-Specific Measures	Year 1	Year 2	Year 3
Control of Blood Pressure: % of enrollees who have a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) (NCQA/HEDIS)	Reporting	Benchmark	Benchmark
% of high-risk beneficiaries receiving community- based LTSS	Reporting	Benchmark	Benchmark
% of high-risk beneficiaries receiving LTSS services in SNF/ other non-HCBS setting	Reporting	Benchmark	Benchmark

Evaluation

- External evaluation funded by CMS
 - Measures impacts on:
 - On person-level health outcomes
 - Beneficiary experience of care
 - Changes in patterns of primary care, acute care, and LTSS utilization and expenditures;
 - Any shifting of services between medical and non-medical expenses



Communication Protocols



Protocol Requirements

1. Continuously improving
2. Bi-directional & collaborative
3. Identification & prioritization of shared clients
4. Understanding coordination activities
5. Regular contact & communication
6. Mutually agreed upon support function



Next Steps

- Training for RCCOs, PCMPs, providers & advocates
- Internal workgroup: operational work
- Medicare-Medicaid integrated dataset
- Weekly CMS meetings
- Continued work on Disability Accessibility
Competent Care



Questions?



Contact Information

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