COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 1, 2014

MEMORANDUM

TO: The Honorable Terence R. McAuliffe
Governor of Virginia

The Honorable Charles J. Colgan
Co-Chairman, Senate Finance Committee

The Honorable Walter A. Stosch
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

Daniel S. Timberlake
Director, Virginia Department of Planning and Budget

FROM: Cynthia B. Jones Cynthia Jones
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on Implementation Progress of the Financial Alignment Demonstration Waiver (Duals)

The 2013 Appropriations Act, Item 307 AAAA requires:

> *The department shall report by November 1 of each year to the Governor, the Chairmen of the House Appropriations and Senate Finance Committees, and the Director, Department of Planning and Budget detailing implementation progress of the financial alignment demonstration waiver. This report shall include, but is not limited to, costs of implementation, projected cost savings, number of individuals enrolled, and any other implementation issues that arise.*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Department of Medical Assistance Services
Annual Report to the General Assembly

Report on Implementation Progress of the Financial Alignment Demonstration Waiver (Duals)

November 2014

Report Mandate

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Background

Nationally, and in the Commonwealth of Virginia, dual eligible individuals have the most complex health care needs of any Medicaid or Medicare members, including multiple chronic health conditions, behavioral health needs, and disabling conditions. Medicaid-Medicare beneficiaries comprise 15 percent of the Medicaid population and 39 percent of the expenditures. In Virginia, individuals who are eligible for both programs are currently excluded from participating in Medicaid managed care programs and receive care driven by conflicting state and federal rules and separate funding streams, potentially resulting in fragmented and poorly coordinated care. Therefore, addressing quality and costs for these individuals has been a priority in the Commonwealth.

Legislative and Executive leadership have provided exemplary support as demonstrated from 2011 through 2014 in the *Acts of the Assembly*, which directed the Department of Medical Assistance Services (DMAS) to implement an integrated support model for individuals who are dually eligible for Medicare and Medicaid services. DMAS has made significant strides in implementing a coordinated, integrated model of care for dual eligible individuals via the Medicare – Medicaid Financial Alignment Demonstration (FAD). Virginia's FAD, termed Commonwealth Coordinated Care (CCC), is an opportunity authorized by the Patient Protection and Affordable Care Act to integrate covered Medicare and Medicaid benefits under one system of coordinated care using a full-risk capitated model or through a fee-for-service model operated jointly by the state and the Centers for Medicare and Medicaid Services (CMS).

In October 2011, DMAS submitted a letter of intent to CMS that indicated the Commonwealth's desire to pursue a capitated, managed care model of service delivery. After many months of negotiation, Virginia became the sixth state to sign a Memorandum of Understanding with CMS which signifies Virginia's formal acceptance into the FAD. The goals of CCC includes removing systematic barriers to providing seamless care across the full spectrum of services and removing financial disincentives that have discouraged states from providing care coordination services to dual eligible individuals.

Under this capitated model, Virginia, CMS, and three Medicare-Medicaid health plans (MMP's) have entered into three-way contracts through which the health plans will receive a blended capitated rate for the full continuum of benefits provided to full benefit dual eligible individuals enrolled in CCC.

CCC blends Medicare and Medicaid services and financing to provide high-quality, person-centered care to Virginians who are dually eligible for Medicare and Medicaid. Under the CCC Program the MMPs receive a blended capitated rate to provide and coordinate the full continuum of benefits currently provided under Medicare and Medicaid, including: primary care, acute care, behavioral health services, nursing facility care, long-term care services through the Elderly or Disabled with Consumer Direction (EDCD) Waiver, and the added benefit of care coordination services for all eligible beneficiaries. MMP's also have additional benefits such as dental, vision and podiatry.

Implementation Progress

Since last year DMAS has made significant strides in implementing the CCC program. On March 1, 2014 eligible individuals were able to start enrolling with services starting in the Tidewater region on April 1, 2014. In this effort, DMAS has continued to consult with the CCC Advisory Committee, other important stakeholders, CMS and members of the State Administration, to ensure proper design and operations. Some of the accomplishments achieved by DMAS under this initiative include:

1. Finalized the Request for Proposals (RFP) process to identify health plan providers,
2. Finalized three-way contracts between CMS, DMAS and three MMP's (Anthem HealthKeepers, Humana and Virginia Premier). The contract establishes each party's roll in providing all Medicare Part A, B and D benefits (Inpatient, Outpatients and Professional, and Prescription Drugs, respectively) and the majority of Medicaid benefits to CCC enrollees, including medical services, behavioral health services and both institutional and community-based long term care services and supports (including consumer direction),
3. Began enrolling beneficiaries on March 1, 2014 with coverage starting on April 1, 2014, and

4. With the beginning of beneficiary enrollment, began the operational duties of the program, which include but are not limited to:
    a. Bringing Division staffing up to operational requirements,
    b. Began contract compliance monitoring,
    c. Comprehensive beneficiary, provider, and advocate education and outreach initiatives,
    d. IT Systems coordination and monitoring,
    e. Initiated Quality Management and Oversight initiatives including developing advisory committees to address our quantitative and qualitative quality monitoring efforts, and
    f. Contracted with George Mason University (GMU) staff to gauge stakeholder (i.e., provider groups and enrollees) satisfaction and the overall success of the program through interviews with providers, MMP's and advocacy groups and through beneficiary surveys and focus groups.

To ensure a smooth roll-out of the program, DMAS has employed several outreach strategies to educate and engage CCC beneficiaries and stakeholders. These efforts include multiple Town Hall meetings in each of the five regions and development and distribution of fact sheets and educational materials. Additionally, DMAS hosts seven weekly Stakeholder Conference Calls. These calls are separated into provider calls (by type) and beneficiary calls. These calls feature CCC implementation updates and opportunities for stakeholders to ask questions of DMAS and MMP staff. Finally, each of the MMPs host web-based and in-person training modules for providers. Provider trainings cover topics such as: how to join the networks, service authorizations, claims, and care coordination.

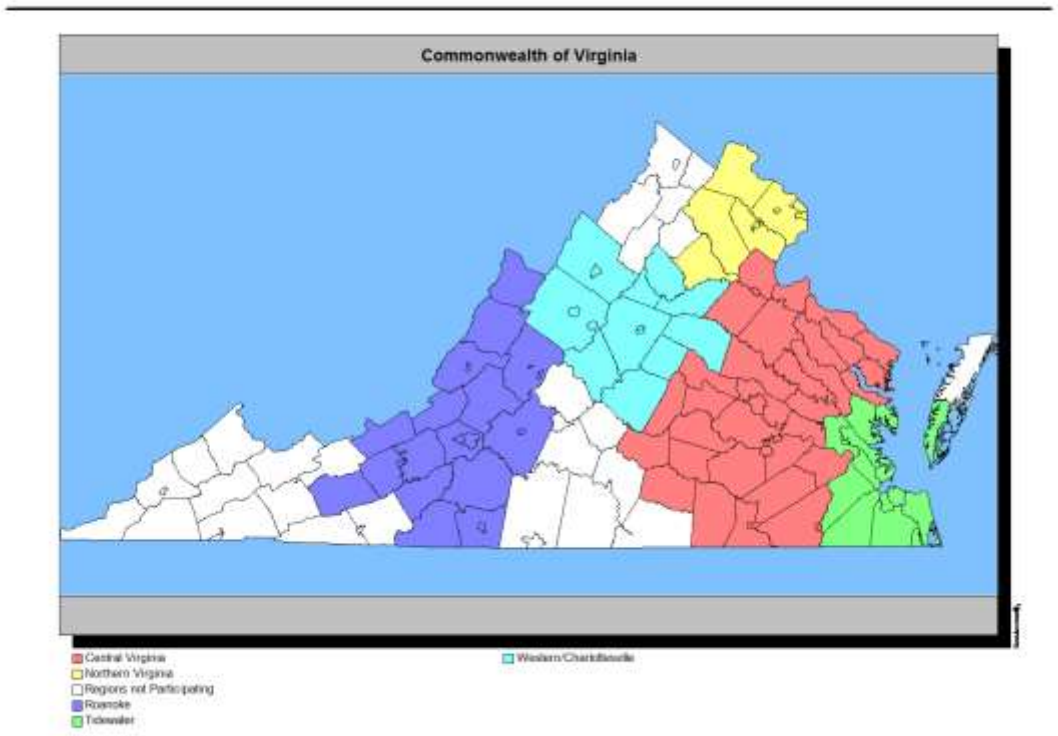
The CCC team also communicated information through several resources published in the community. A Medicaid Memo introducing CCC was released the same day the Governor's Press Release announced the launch of the program. DMAS also released a Broadcast to the Department of Social Services and other sister agencies regarding CCC launch. While in-person training and conference call communication continues, another method of learning information about CCC can be found on the DMAS website. The CCC webpage contains information for providers and beneficiaries about the program, upcoming events, program evaluation, and new information is added regularly. Finally, the CCC team continues to release monthly Stakeholder Update newsletters to an ever-growing stakeholder email distribution list, and posts updates to the CCC website.

CCC Enrollment Activities

CCC enrollment is offered to Virginians over age 21 who are eligible for both full Medicare and Medicaid benefits and live in one of the following five regions: Tidewater, Central Virginia, Northern Virginia, Roanoke and Charlottesville. A map of localities included in these regions is provided in Figure 1. CCC enrollment occurs in two phases: The first phase is called "voluntary enrollment" where an individual proactively enrolls in the program. The second phase is called "automatic enrollment" where the individual is

enrolled into the CCC if they do not choose to opt out. Enrollees may change MMP's each month if they choose. The specific timeline for enrollment by region is provided below:

Figure 1: CCC Program Regions



TIMELINE FOR CCC ENROLLMENT BY REGION:

Tidewater area

- March, 2014: Voluntary enrollment (phase 1)
- April 1, 2014: Coverage begins (phase 2)
- May, 2014: Automatic enrollment begins
- July 1, 2014: Coverage for those automatically enrolled begins
- August 1, 2014: Coverage for those reassigned due to Nursing Facility or Adult Day Health Center begins

Central Virginia/Richmond area

- March, 2014: Voluntary enrollment (phase 1)
- April 1, 2014: Coverage begins (phase 2)
- June 2014: Automatic enrollment begins
- September 1, 2014: Coverage for those automatically enrolled begins

Roanoke and Charlottesville areas

- May 2014: Voluntary enrollment (phase 1)
- June 1, 2014: Coverage begins (phase 2)
- August 1, 2014: Automatic enrollment begins
- October 1, 2014: Coverage for those automatically enrolled begins

Northern Virginia area

- June 1, 2014: Voluntary enrollment (phase 1)
- July 1, 2014: Coverage begins (phase 2)
- September 1, 2014: Automatic Enrollment begins
- November 1, 2014: Coverage for those automatically enrolled begins

Currently we estimate the total CCC eligible population to be roughly 70,000. On September 20, 2014, 31,363 beneficiaries have been enrolled in CCC while 20,273 have elected to remain in their current fee-for-service health benefit. Of those enrolled, 3,440 are voluntary enrollees and 27,923 have been automatically enrolled. Using these early enrollment figures, 26.9 percent of all 70,000 eligible beneficiaries are electing to opt-out of CCC. Based on anecdotal evidence provided by other states participating in the FAD, the average opt-out rate is roughly 25 percent. Detailed tables describing the enrollment and disenrollment figures, on September 20, 2014, are provided below.

Due to the voluntary nature of CCC, coupled with typical beneficiary eligibility status changes, we expect enrollment and eligibility data are expected to continually be in flux throughout the life of the program. Because enrollment is in phases as described above, and to the voluntary nature of the program, it is impossible to know exactly how many eligible beneficiaries will participate.

EARLY ENROLLMENT DATA:

Total Enrollment (As of September 20, 2014)

MMP	Voluntary	Auto-Enrollment	Total
Anthem HealthKeepers	**1,834**	**10,183**	**12,017**
Humana	**1,092**	**11,078**	**12,170**
VA Premier	**514**	**6,662**	**7,176**
Total	**3,440**	**27,923**	**31,363**

CCC Beneficiaries By Age (As of September 20, 2014)

AGE	Voluntary	Auto-Enrollment	% of Total	Opt-outs	% of Total
021-029	214	1,846	7%	495	2%
030-039	391	2,567	9%	979	5%
040-049	445	3,100	11%	1,829	9%
050-059	657	4,519	17%	3,291	16%
060-069	780	5,412	20%	4,157	21%
070-079	576	5,413	19%	4,549	22%
080-089	280	3,753	13%	3,503	17%
>90	97	1,313	4%	1,470	7%
Total Members	3,440	27,923	100%	20,273	100%

CCC Beneficiaries By Region (As of September 20, 2014)

Region	Voluntary	Auto-Enrollment	% of Total	Opt-outs	% of Total
Central Virginia	1,485	9,983	37%	7,506	37%
Northern Virginia	226	1,948	7%	962	5%
Roanoke	403	5,268	18%	2,859	14%
Tidewater	1,074	7,658	28%	7,405	37%
Western/Charlottesville	252	3,057	11%	1,526	8%
Total Members	3,440	27,923	100%	20,273	100%

Implementation Challenges

Challenges are inherent in the creation and operation of such a unique program. While none of the challenges discussed below is insurmountable, documenting them will ultimately help with broader implementation of similar projects in the future.

Enrollment Issues

CMS required CCC Program beneficiaries to have maximum flexibility in terms of their ability to opt-in and out of the program in its entirety as well as their ability to change MMPs as often as desired. (This differs from the other Medicaid managed care program, Medallion 3.0, which has a mandatory enrollment period of one year.) Enrollment changes take effect only on a monthly basis. Members are obligated to remain in their health plan through the end of the month but there is no limit on the number of times a beneficiary can opt-in or opt-out in a day, week or month. This causes significant difficulty with the programming of the Medicaid IT system, transition of care and the MMPs' ability to make a positive impact on members through care coordination.

Systems Issues

The coordination of the CMS and DMAS IT systems have proven to be particularly complex. Allowing members multiple avenues in which to disenroll or enroll such as

calling 1-800 Medicare and/or calling the Medicare Advantage Plans causes a hardship on the states like Virginia that have their own enrollment brokers. This causes confusion for the CCC-specific broker because the Medicare disenrollment information is not forwarded from Medicare. CMS is actively working with Virginia to provide this data in the near future to the MMPs.

Another issue was the inability to perform end-to-end testing of the enrollment data exchange systems among CMS, CCC and the MMPs before going live. Testing was completed with DMAS, MMP, and enrollment broker systems, but CMS did not participate with pre-implementation systems testing. This resulted in multiple, significant retro-system changes for DMAS, MMPs and the enrollment broker for all systems to be able to appropriately respond to the files. Additionally, the delay in obtaining the individual-specific Medicare claims history data from CMS resulted in not being able to consider the beneficiary's existing PCP during the beneficiary's assignment to a health plan. This has led to more changes and disenrollment when members find that their PCP is not in the network.

Finally, recent notices by CMS of mandated implementation changes to IT/systems modifications and policy changes have resulted in confusion and costly retro-system changes. Most recently, the State received notice in July of a significant system change that had to be implemented in October. Failure to implement the change would have resulted in a loss of over 20,000 members who would otherwise be eligible for the program. DMAS was successful in making the change and it is anticipated these changes will decrease as the program matures.

Provider Participation and its Influence on Member Participation

During the first few months of implementation, it became clear that providers have a significant influence with CCC eligible members. Given that this is not a mandatory program some providers and health system(s) have chosen not to contract with one or more MMPs. In exercising this choice and by notifying their members that they do not participate in CCC, this has led to numerous individuals choosing not to participate in CCC and reducing the overall number of participating individuals. The choice of health system(s) to not contract with the MMPs has also led to one or more CCC regions not being eligible for automatic beneficiary assignment. Even when members have chosen to remain in the program, some providers have refused to be in a MMP's network or even sign a single case agreement to serve as an out of network provider for the beneficiary's continuity of care period. This has caused some members to miss appointments and not to be able to get some services (including previously scheduled surgeries) until the MMP can help them find another provider.

It must also be recognized that the CCC implementation has been a significant change for providers. Providers who participate now have to work with one or more MMPs in addition to the Medicaid fee for service system. Providers have had to contract with the MMPs and learn their new service authorization requirements as well as billing processes, which DMAS, CMS and the MMPs continue to work on with stakeholders as complications arise. DMAS and the MMPs are committed to working with provider

associations to identify and address issues that appear to cause problems for providers and consequently lead to them not participating in CCC.

Programmatic Issues

Several modalities of care including the 1915(c) waiver, hospice, admittance to Institutes for Mental Disorders and Intermediate Care Facilities for Individuals with Intellectual Disabilities accept enrollments at any point during the month which causes service authorizations and payment issues when there is an overlap with CCC, because, due to the capitated nature of the program, the beneficiary cannot be disenrolled from the system prior to the end of the month. For example, someone who is on the EDCD Waiver and on the ID Waiver waiting list enrolls with CCC. During the month, the person gets an ID Waiver slot. The member must stay in CCC until the end of the month but also needs to start ID Waiver services as quickly as possible. The inability to remove the member from CCC in the middle of the month caused the state to have to build a mechanism to allow the ID Waiver services to overlap with CCC and be paid via FFS.

Communication with beneficiaries also represents a programmatic challenge. For example, the number, frequency and lack of clarity of the letters sent to enrollees has caused confusion, especially for the older adult population.

Cost of Implementation

The 2013 Appropriations Act provided administrative funding for State Fiscal Year's 2014 and 2015 to assist with the implementation costs of CCC. The approved amounts, reflected in table below, cover costs to:

- hire necessary personnel to implement and oversee the program (program analyst, quality analyst, and supervisor);
- support contract modifications for the Commonwealth's Medicaid External Quality Review Organization, as required by federal regulations for Medicaid managed care systems;
- cover implementation and initial operating costs for the enrollment broker; and
- cover actuary expenses to develop rates for the MMPs.

CCC APPROPRIATION		
FY 14		
GF	**NGF**	**Total**
$650,784	$1,850,891	$2,501,675
FY 15		
GF	**NGF**	**Total**
$1,208,568	$2,408,675	$3,617,243
Total to Date		
GF	**NGF**	**Total**
$1,859,352	$4,259,566	$6,118,918

Additional total funding of $1,115,564 ($557,564 GF and $557,564 NGF) was requested during the 2014 General Assembly Session. The request was approved and is reflected in the FY 2015 appropriation. The increase is provided to support contract modifications that cover:

- Increased costs for implementation and initial operating costs for the enrollment broker; and increased costs to cover actuary expenses to develop rates for the MMPs, and
- Support contract modifications to cover the addition of LTC/Acute and Expedited Enrollment for the enrollment broker contact.

Projected Cost Savings

As a requirement of CCC, Medicaid payments to MMPs are based on estimates of what would have been spent in absence of the CCC Program, less a savings adjustment of one (1), two (2), and four (4) percent in years one (1), two (2) and three (3), respectively.

Current projected savings estimates show a net savings of $5.9 million in FY 2015 and $18.2 million in FY 2016. These figures are based off the reduction in the capitated payment amounts as described above and the anticipated savings in reduced service needs of the enrollees due to a more robust care coordination model. The FY 15 projections are restricted because the provision of services had just begun for a limited segment of enrollees at the time this report was written and the total enrollees have been fewer than anticipated.

The table below shows the projected savings by SFY. The column labeled "Cost Without CCC" reflects the projected total Medicaid costs for dual eligible beneficiaries if CCC was not an option, while the column labeled "Cost With CCC" reflects the projected total Medicaid costs for dual eligible beneficiaries now that CCC is available and operating.

CCC ANTICIPATED SAVINGS

	COST WITHOUT CCC	COST WITH CCC	NET SAVINGS
FY 15	$363,360,910	$357,392,211	**($5,968,699)**
FY 16	$509,504,175	$491,305,647	**($18,198,528)**

Beneficiary Success Stories

It is important to close the summary of the past year of this program's implementation by focusing on the reason why this program was created – to streamline and improve the health outcomes and care coordination for individuals who must navigate the Medicare and Medicaid systems. The examples below of CCC beneficiaries are important reminders of why, despite the challenges associated with adjustment to the CCC

Program, the person-centered model of integrated service delivery can make a significant difference in a beneficiary's life.

Success Story One: One of the MMP's Care Managers met face to face with a Member to complete an assessment. During the visit, the Care Manager noted that the Member's prescription bottle for thyroid medication was empty and there were no refills available. The Member had recently undergone thyroid surgery and this medication is essential to her health. The Member had missed her office visit with her primary care physician after her surgery so she never received the needed prescription. The Care Manager called the Member's physician and made an urgent visit appointment so that the Member could follow up with her physician and get her prescription renewed.

The Member was also receiving personal care services three hours a day, three days a week. After completing the assessment, the Care Manager recognized the Member needed additional personal care services for completion of activities of daily living and safety needs. The Care Manager contacted the Member's agency and suggested an increase in personal care services due to the Member's recent falls, increased weakness and confusion. The agency did increase the Member's hours to better meet the Member's needs. In addition, the Care Manager arranged for the Member to receive a Personal Emergency Response System.

Success Story Two: Member is married and her spouse is deaf. Member lives in a rural area with minimal access to home care agencies. The Member's home is in disrepair, the flooring in the kitchen is falling through into the crawl space under the house, and she was unable to safely prepare meals for herself or her spouse. The flooring in the bathroom was falling through the floor, surrounding the commode. Member used a bedside commode and had difficulty emptying it because she couldn't get close enough to the existing commode due to the damage surrounding the toilet. The MMP's Service Coordinator performed an initial assessment and at that time, the Member had no help. Member had several conditions such as myocardial infarction, stroke, multiple back surgeries, hypertension and diabetes.

The Service Coordinator found a personal care company that would agree to go to the Member's home. A personal care worker is currently working 5 days a week, 3 hours a day for the Member. The Service Coordinator also located an in-network provider for a PERS (Personal Emergency Response System) for the Member. The local Area on Aging was contacted for help and they assisted with food delivery, offered grants to receive funds and assistance to repair their home. The Member now has healthy food in her freezer at all time and uses her microwave to prepare the food. The PERS (Personal Emergency Response System) was installed in the home and because her husband is deaf, the Service Coordinator made sure that the person who would be alerted, as well as the emergency response team, was her neighbor who lives close by.

The Member and the MMP team are currently awaiting a phone call back from the Area Agency on Aging regarding the plans to renovate. Per the Service Coordinator, "This is a success story because until we, the Anthem LTSS /MMP team, became involved, this Member was at risk daily for injuries and for her health. She was unable to clean and dress herself. She was trying to do tasks that also put her at risk for falls. She now has a personal care worker to help her. She doesn't eat meals daily that are harming her. She had joy in her voice the last time we spoke."

Summary

As noted in the opening of this report, dual eligible individuals have the most complex and costly health care needs of any Medicaid or Medicare members, including multiple chronic health conditions, behavioral health needs, and disabling conditions. In order to better serve these individuals and reduce costs the CCC program aims to: reduce fragmentation; provide high-quality and coordinated care; improve the health and lives of enrolled individuals; reduce the need for avoidable services, such as hospitalization and emergency room use; encourage individual participation in treatment decisions; and support the goal of providing treatment in the least restrictive, most integrated setting.

The success stories noted above demonstrate how CCC is working to achieve the goals for all the 31,363 enrollees. By aiding beneficiaries in attaining critical medication, additional services and utilizing existing community resources CCC will reduce the need for more intensive and avoidable services and be able to keep beneficiaries in their own homes longer and safer.

Despite those and the other successes challenges remain. This report summarized the implementation issues, including coordination of the Medicare and Medicaid IT systems; large systemic changes that have resulted in some providers opting not to participate; and the programmatic issues with disenrollment and enrollment aligning with other systems of care. In part these challenges have led to some of the 20,273 opt-outs. Those individuals who opted out are considered "missed opportunities" and the Department will be working diligently to ensure missed opportunities are minimized for our beneficiaries' health care services.

It is anticipated that as the CCC Program matures, comfort levels from both the provider and member communities will increase and the number of enrollees will increase. Further experience will provide the state and MMPs the knowledge to make appropriate changes to systems and processes to adapt to the complexities of the dual population.