COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

January 10, 2014

MEMORANDUM

TO: The Honorable Robert F. McDonnell
Governor of Virginia

The Honorable Walter A. Stosch
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

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

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

SUBJECT: Report on the Financial Demonstration Waiver

The 2013 Appropriation Act, Item 307 AAAA requires:

> *2. 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.*

This report summarizes the implementation progress of the Financial Alignment Demonstration.

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 (DMAS)
Report to the General Assembly

Development of the Commonwealth Coordinated Care Program

November 2013

Report Mandate

The 2013 Appropriation Act, Item 307 AAAA requires:

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This report summarizes the implementation progress of the Financial Alignment Demonstration.

Background

Nationally, and in the Commonwealth of Virginia, dual eligible individuals have among the most complex health care needs of any Medicaid or Medicare members, including multiple chronic health conditions, behavioral health needs, and disabling conditions. 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 2013 in the *Acts of the Assembly*, which directs 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). The FAD 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).

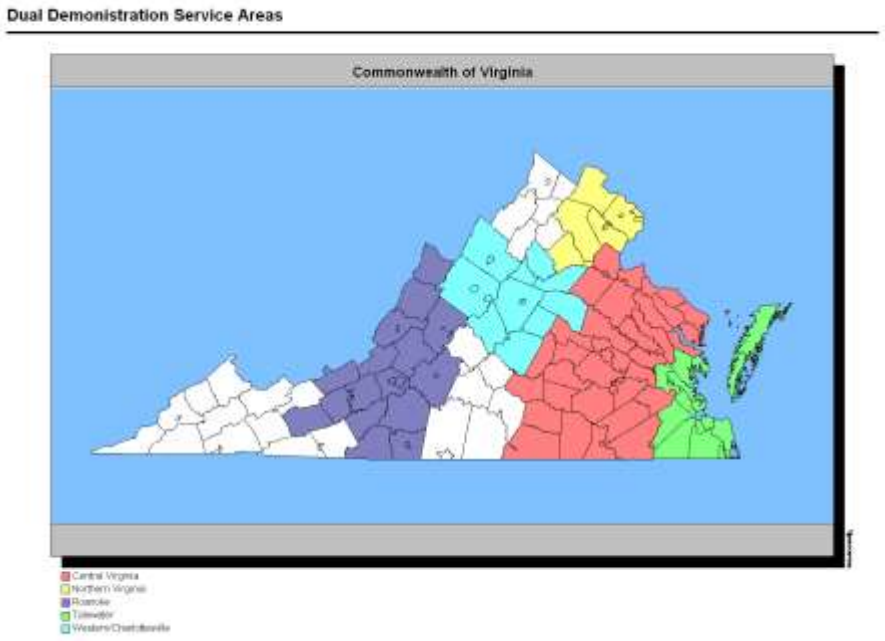
In October 2011, DMAS submitted a letter of intent to CMS that indicated the Commonwealth's desire to pursue a capitated, managed care model of service delivery to include all Medicare (A, B and D) and the majority of Medicaid services provided by Medicare-Medicaid health plans (MMPs). Under the capitated model, Virginia, CMS, and health plans will enter 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 the FAD MMPs.

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 Virginia's FAD, called the Commonwealth Coordinated Care (CCC) Program, 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.

In Virginia, the CCC Program will operate from January 1, 2014 through December 31, 2017. A summary of the CCC Program is provided below.

- Regions: Five Demonstration regions (Figure 1) include Central Virginia, Northern Virginia, Tidewater, Western/Charlottesville and Roanoke starting in 2014.

Figure 1: CCC Program Regions



- Eligible Population: Adult (21 years of age and older) individuals who are eligible for full benefits from Medicare and Medicaid Programs will be eligible, including those enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver, and those residing in nursing facilities. Individuals who have other forms of comprehensive insurance will not be eligible to participate. Figure 2 provides a

breakdown of the 78,600 full dual eligible individuals who would have been eligible for enrollment in the CCC Program had it been in effect during Calendar Year 2011. Due to the expected growth in Medicaid overall, it is anticipated that these numbers will increase by January 2014.

Figure 2: Eligible Medicare-Medicaid Enrollees, Calendar Year 2011

Medicare-Medicaid Enrollees in Virginia eligible for Commonwealth Coordinated Care

- Approximately 78,600 Medicare-Medicaid Enrollees

Region	Nursing Facility	EDCD Wavier	Community Non-waiver (not using LTC)	Total
Central VA	4,430	3,762	16,135	24,327
Northern VA	1,935	1,766	12,952	16,653
Tidewater	3,031	2,492	12,575	18,098
Charlottesville	1,477	842	4,427	6,747
Roanoke	2,833	1,355	8,583	12,771
Total	**13,706**	**10,217**	**54,672**	**78,596**

- Services provided in the CCC Program will include:
  - Full array of Medicare benefits (A, B, and D);
  - Majority of state plan services including community behavioral health, EDCD Waiver services, and nursing facility coverage;
  - Person-centered care coordination that integrates medical and social care coordination models; and
  - Supplemental/enhanced services (e.g., vision, hearing) that will be at the health plans' option.

- Enrollment will coincide with Medicare Advantage open enrollment (October 15-December 7). However, during the first year of implementation, a phased in, mixed approach will be used which will begin with an initial voluntary enrollment period followed by a passive enrollment approach. DMAS will contract with an enrollment broker to assist individuals with making enrollment/disenrollment decisions and to help individuals with knowing which providers are in which Health Plan, in order to facilitate continuity of care.

The CCC Program will be phased in on a regional basis over the first twelve months of the Demonstration, starting with the Central Virginia and Tidewater regions. Eligible individuals will be notified of the opportunity to sign up during February 2014 in these two regions, with actual enrollment targeted to begin on March 1, 2014. The remaining three regions will be phased in later in the 2014, with the first enrollment opportunity targeted for August 2014. Individuals will have the opportunity to voluntarily enroll. The voluntary enrollment period will be followed by a passive enrollment period, where individuals who are eligible for the CCC Program who did not opt in or those who did not choose to be excluded from the CCC Program will be automatically enrolled by DMAS (or its vendor) into a MMP. However, individuals who enroll voluntarily or who are passively enrolled can choose to opt out of the Demonstration at any time.

The CCC Program will operate through December 2017, in order to allow for three years of operation after full implementation.

Central Virginia/Richmond and Tidewater areas

- February 2014: Voluntary enrollment begins
- March 2014: Coverage for those who voluntarily enroll begins
- May 2014: Passive enrollment begins
- July 2014: Coverage for those passively enrolled begins

Northern Virginia, Roanoke, Charlottesville areas

- May 2014: Voluntary enrollment begins
- June 2014: Coverage for those who voluntarily enroll begins
- August 2014: Passive enrollment begins
- October 2014: Coverage for those passively enrolled begins

- Reimbursement: Medicare-Medicaid Plans will be paid a blended, risk adjusted rate that will be based on Medicaid fee-for-service data, Medicare fee-for-service and Medicare Advantage data for the eligible population. A percentage of the rates will be withheld each year, and the MMPs will be required to meet established quality thresholds in order to receive the withheld amounts. DMAS plans to contract with at least two health plans in each region. DMAS is currently in the procurement process, and is in negotiations with three health plans.

Implementation Progress

Over the past year, DMAS has made significant strides in the development of the CCC Program. One key area that informed all aspects of program development involved stakeholder input, which has been critical to this process. Over the past twelve months, DMAS held three quarterly meetings with the Medicare-Medicaid Advisory Committee

(appointed by the Secretary of Health and Human Services), and other important stakeholders, and finalized the design and name of the Demonstration. The next meeting is scheduled for November 7, 2013.

In addition to meeting with the Advisory Committee over the past year, DMAS worked closely with CMS and other stakeholders to discuss and finalize the terms and conditions under which the CCC Program will operate, including:

- who will be eligible to enroll;
- covered Medicaid benefits;
- the method of enrollment and the enrollment timeline;
- requirements and timeframes for participating plans to perform important functions, such as:
    - identifying vulnerable enrollees, gathering health risk assessments, forming Integrated Care Teams, and developing individual care plans;
    - establishing beneficiary protections, including an ombudsman program and requirements for ensuring the continuity of care;
    - identifying quality and performance outcome measures and other monitoring infrastructure;
    - establishing savings expectations;
    - designing partially integrated Medicare and Medicaid appeals processes; and
    - addressing other necessary operational details.

In April 2013, DMAS released a Request For Proposal (2013-5) to solicit proposals from managed care organizations to operate in the CCC Program. Proposals were received by DMAS on May 15, 2013, and DMAS has entered into negotiations with three of the Offerors, which continue.

In addition to the above accomplishments, over the past year DMAS created a new structure within the Agency that reflects the priority of improving the coordination of long-term care and behavioral health services. A new position to oversee all long-term and behavioral health services (the Deputy Director of Complex Care and Services) was created and filled. In addition, the Division of Integrated Care and Behavioral Services was created to oversee both the implementation of the CCC Program and the new behavioral health administrator contract. Recently, the Director of the Integrated Care and Behavioral Services Division and the Director of the Office of Coordinated Care within the Division were hired, and DMAS anticipates filling several staff positions in the near future for contract management, quality and enrollment monitoring, data analysis, and other key functions required for operation of the CCC Program.

Other CCC Program accomplishments this past year include:

- Developed requirements for Medicaid Management Information Systems (MMIS) changes required to operate the CCC Program, in conjunction with the DMAS contracted Fiscal Agent;
- Developed base expenditure data and risk-adjusted capitation payment rates with CMS, and its contracted consultant, in conjunction with the DMAS contracted

actuary. A combined Medicaid and Medicare rate report was developed by DMAS and CMS outlining the rate methodology for the two components of the rates in October 2013. It is anticipated that the 2014 rates will be finalized in October 2013;

- Created an independent evaluation process of the CCC Program in conjunction with staff from George Mason University;
- Submitted and received CMS approval of a Medicaid State plan amendment required to enroll dual eligible individuals into managed care;
- Hired an Outreach and Education Coordinator and convened an Outreach and Education Committee comprised of key stakeholders who met weekly over several months to develop communication materials and an outreach and education plan. Examples of materials include:
    - A logo and tag line;
    - A revised website that provides information to stakeholders;
    - A one page document that describes the Demonstration; and
    - A universal presentation that addresses issues important to all stakeholders.
- Worked with the Department of Aging and Rehabilitative Services, which applied for a Counseling Options Grant for FAD states and received grant funding to provide support to Virginia Insurance and Counseling Assistance Program counselors who assist individuals with making decisions regarding Medicare services;
- Worked with the Department of Aging and Rehabilitative Services, who applied for another federal grant to received funding to support the use of the Virginia Long-term Care Ombudsman system to serve as the Ombudsman for the CCC Program. (While Virginia may be awarded a grant, cuts resulting from sequestration will extremely limit the award amount);
- Developed the template for the Health Plan readiness reviews designed to evaluate the readiness of the MMP systems to begin services at program implementation. Readiness reviews began after DMAS entered negotiations with selected RFP Offerors;
- Acceptance by the Centers for Health Care Strategies to participate in the *INSIDE (Implementing New Systems of Integration for Dual Eligibles)* Initiative, which enables Virginia to remain at the forefront of innovative reforms for vulnerable populations; and
- Initiated development of the three-way contract between DMAS, CMS and the Health Plans.

In summary, over the past year DMAS met all CMS requirements for participation in the Demonstration and is scheduled to implement the CCC Program in 2014.

Costs of Implementation

The 2013 Appropriations Act provided administrative funding for State Fiscal Year 2014 to assist with the implementation costs of this Demonstration. The approved amounts are reflected 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.

GF	NGF	Total Funds
$650,784	$1,850,891	$2,501,675

Additional funding may be requested during the 2014 General Assembly Session to cover the administrative expenses associated with Ombudsman coverage for the Demonstration as well as increased costs for the Enrollment Broker that resulted from increased requirements by CMS for enrollment broker functions.

Projected Cost Savings

As a requirement of the FAD, Medicaid payments to MMPs are based on estimates of what would have been spent in absence of the FAD, less a savings adjustment of one (1), two (2) , and four (4) percent in years one (1), two (2) and three (3), respectively. Projected savings estimates were not available at the time this report was written as rates for the CCC Program were not yet finalized.