June 2013

Summary of Virginia's Dual Eligible Demonstration Memorandum of Understanding

On May 21, 2013, the Centers for Medicare and Medicaid Services (CMS) released a Memorandum of Understanding (MOU) with the Commonwealth of Virginia for a capitated financial alignment demonstration for Medicare-Medicaid enrollees (also known as dual eligibles).

The demonstration, called Commonwealth Coordinated Care, will impact up to 78,000 of Virginia's 175,538[1] full benefit dual eligible individuals. Virginia is the sixth state to enter into a demonstration agreement with CMS.[2]

The Virginia demonstration is distinct from previous states as it is the first to extend to 2017. Another distinguishing feature is the level of detail provided in the discussion of the ombudsman program, the explanation of the rate review process, and the lack of specificity on supplemental services provided by the plans.

Basics:

Under the MOU, the state and CMS will contract with managed care plans to provide Medicare and Medicaid services to dual eligibles in five regions.[3] The demonstration will last for approximately four years, from February 2014 through December 31, 2017.[4] Some dual eligible subpopulations are carved out of the demonstration; carve-outs include individuals receiving hospice services, ESRD individuals, and some HCBS waiver participants.[5] The remaining full

[1] Kaiser Family Foundation, Number of Dual Eligibles in 2009, available at http://kff.org/medicare/state-indicator/dual-eligible-beneficiaries.
[2] Massachusetts, Ohio, Illinois, and California have also received approval to move forward with a capitated demonstration. Washington State received approval for a managed-fee-for-service demonstration.
[3] The five regions are: Central Virginia, Northern Virginia, Tidewater, Western Virginia/Charlottesville and Roanoke. MOU at 37.
[4] MOU at 41. Year 1 begins on February 1, 2014 and goes through December 31, 2015, Year 2: January 1, 2016 through December 31, 2016, and Year 3: January 1, 2017 through December 31, 2017.
[5] MOU at 8-9. The following individuals are not eligible: Medicaid spend-down, partial dual eligible individuals, individuals in State mental hospitals, ICF/MR residents, residents participating in HCBS wavier programs except the EDCD waiver, hospice enrollees, individuals receiving ESRD Medicare benefits, individuals with other comprehensive or individual health insurance, individuals receiving Medicaid for less than three months, retroactive Medicaid eligibles, individuals enrolled in: Virginia Birth-Related Neurological Injury Compensation Program, Money Follows the Person, PACE, and the Independence at Home demonstration.

benefit dual eligibles age 21 and older, including EDCD waiver participants and nursing facility residents, are eligible for the demonstration.

Authority and state structure:

The Medicare changes reflected in the MOU are authorized under §1115A of the Social Security Act, 42 U.S.C. 1315a. Changes to the Medicaid program are contingent upon CMS approving a 1932(a) State Plan Amendment and authorizing amendments to the state's 1915(c) program. The state has submitted its 1932(a) State Plan Amendment to CMS. The state will submit the necessary 1915(c) amendments as part of its next 1915(c) amendment or renewal process.[6]

The state has created a new Office of Coordinated Care in its Medicaid agency which will oversee the demonstration. The new office has a dedicated director and will coordinate with other state agencies and stakeholders.[7]

Enrollment:

Enrollment will be phased by region. Phase I will include Central Virginia and Tidewater. Beneficiaries will be allowed to voluntarily enroll in the demonstration beginning on January 1, 2014 with services beginning on February 1, 2014. Voluntary enrollment will continue through June. Eligible individuals who do not voluntarily enroll during this period will be passively enrolled effective July 1, 2014 with notices being provided 60 days in advance.

Phase II will cover Western Virginia/Charlottesville, Northern Virginia and Roanoke. Beneficiaries in these regions will be allowed to voluntarily enroll in the demonstration beginning May 1, 2014 with the enrollment taking effect June 1, 2014. Voluntary enrollment will continue in Phase II regions until the end of July. Eligible individuals who do not voluntarily enroll during this period will be passively enrolled effective August 1, 2014 with notices being provided 60 days in advance.[8]

As in other states, passive enrollment will be coordinated with CMS Annual Reassignment and daily auto facilitated enrollment for individuals with Medicare Part D Low Income Subsidy (LIS)[9] and will utilize an "intelligent assignment" process. The MOU includes more details about the assignment algorithm than has been found in other MOUs. The algorithm will consider previous managed care enrollment and historic utilization of certain provider types. An enrollee in a nursing facility will be assigned to a plan that includes the enrollee's nursing

[6] MOU at 40.
[7] MOU at 54.
[8] MOU at 56.
[9] MOU at 57.

facility in its network. Individuals in the EDCD waiver will be assigned to a plan that includes that individual's current adult day health provider in its network.[10]

Enrollees who transition out of nursing facilities will be disenrolled from the demonstration. Under the MOU, plans will need to ensure that individuals in nursing facilities who wish to move to the community will be referred to the preadmission screening teams or the Money Follows the Person (MFP) Program. If the individual enrolls in the MFP Program, he will be disenrolled from the demonstration.[11]

Ombudsman and oversight:

The state will support an ombudsman program, but the MOU does not indicate how the program will be funded. This MOU is the first to clarify that the ombudsman office will be independent of the state Medicaid agency.[12] According to the MOU, the ombudsman will advocate and investigate on behalf of nursing home recipients and demonstration enrollees receiving home and community-based care. CMS will support ombudsman training, and CMS and the state will provide technical assistance to the ombudsman. Consistent with other MOUs, the ombudsman will support individual advocacy and systemic oversight for plans, with a focus on compliance with principles of community integration, independent living, and person-centered care in the home and community-based care context. The ombudsman will be responsible for gathering and reporting data on ombudsman activities to the state and CMS.[13] As in other states, the MOU requires plans to establish an independent demonstration beneficiary advisory committee. The plan must also assure that the beneficiary advisory committee composition reflects the diversity of the demonstration population.[14]

Covered services:

The MOU requires participating plans to provide to enrollees all Medicare and all Medicaid services, including ECDC waiver services. The MOU gives plans the flexibility to offer additional services, "as appropriate to address the enrollee's need," but does not spell out what these services would include or require plans to provide them.[15] In limited cases, dental services will be provided under fee-for-service.[16] The MOU does not specify any enhanced supplemental services the plan must provide to the enrollee.

[10] MOU at 58.
[11] MOU at 62.
[12] Although not stated in the MOU, state stakeholders report that there is an assumption that the current state Long-Term Care Ombudsman office will assume the role of the demonstration ombudsman.
[13] MOU at 12-13.
[14] MOU at 14.
[15] MOU at 72.
[16] MOU at 73.

Spending reductions:

The Virginia MOU schedules a reduction in Medicare and Medicaid spending on dual eligibles for each of the three years of the demonstration. Plans will receive a payment from Medicare and a payment from Medicaid. Each rate will be determined based on a formula of historical costs and an acuity adjustment. The rates will then be reduced by 1%, 2%, and 4% in years 1, 2, and 3, respectively, to guarantee savings for both programs.[17] In addition to these spending reductions, a quality withhold will be applied to plan payments each year. Plans will have amounts withheld from their rates equal to 1%, 2% and 3% in years 1, 2 and 3 respectively.[18] Plans will be able to earn back these amounts by demonstrating satisfactory performance on a range of predetermined quality measures.

Risk adjustment and risk arrangements:

As in other demonstration states, the Medicare A/B county rate will be risk adjusted based on the risk profile of each beneficiary.[19] In this MOU, the Medicaid rate will be adjusted based on where the enrollee falls in one of four rate cells: Community Well, 21-64; Community Well 65+; Nursing Facility Level of Care (LOC) 21-64; and Nursing Facility LOC 65+. For Nursing Facility LOC, risk/cost differences of major subpopulations will be considered using a member enrollment mix adjustment.[20] This approach to adjusting the Medicaid rate mirrors the approach in Illinois.

Minimum Loss Ratio and rate review:

Each plan is required to meet a minimum medical loss ratio (MMLR). If a plan has an MMLR between 85% and 90% of the capitated payment, the state and CMS may require a corrective action plan or levy a fine on the plan. If the plan has an MMLR below 85%, the plan must remit a certain portion of the excessive amount to CMS and the state.[21]
In the event that one-third of plans experience losses in excess of 3% of revenue in the first year, the savings percentage in the third year of the demonstration will be reduced from 4% to 3%. If one-third of plans have an MMLR below 90%, CMS and the state will review the plan's financial reports and encounter data to assess the appropriateness of payments.[22]

[17] MOU at 42.
[18] MOU at 50.
[19] MOU at 46.
[20] MOU at 47.
[21] MOU at 52.
[22] MOU at 53.

Needs assessment and care management:

Plans must provide a needs assessment for all members within 90 days of enrollment. If an enrollee is considered to be part of a "vulnerable subpopulation,"[23] the care management team must complete the assessment within 60 days. Needs assessments are performed by the plan. The plan must receive state approval of their assessment tool. Nursing facility residents and EDCD waiver enrollees must receive a face-to-face assessment.[24] In the second year of the demonstration, the required timeframes for assessments are shortened to 30 days for EDCD waiver enrollees and 60 days for all others.[25]

State contracted hospitals and screening teams will continue to conduct initial LOC determinations for nursing facility services and EDCD waivers.[26] After the initial LOC determination, however, annual LOC reassessments will be conducted by the plans.
Plans will be required to provide care management services to enrollees. The MOU establishes twelve care management features that the plan must offer enrollees, depending on the needs and preferences of the enrollee, with six of those elements required to be part of care management for the "vulnerable sub-populations."[27]

Network adequacy:

This MOU builds off the current Medicare and Medicaid network adequacy requirements. Plans must maintain a network of providers sufficient in number, mix and geographic

[23] Vulnerable subpopulations include: 1) individuals enrolled in the EDCD waiver; 2) Individuals with intellectual/developmental disabilities; 3) Individuals with cognitive or memory problems; 4) Individuals with physical or sensory disabilities; 5) Individuals residing in nursing facilities; 6) Individuals with serious and persistent mental illness; 7) Individuals with end stage renal disease; and 8) Individuals with complex or multiple chronic conditions. MOU at 59.
[24] MOU at 60.
[25] MOU at 60.
[26] MOU at 60.
[27] MOU at 65. Under the MOU, care management must include: a single, toll-free point of contact for all questions; 2) ability to develop, maintain and monitor the plan of care; 3) assurance that referrals result in timely appointments; 4) communication and education regarding available services and community resources; 5) assistance developing self-management skills to effectively assess and use services; 6) ensure that individuals receive needed medical and behavioral health services, preventive services, medications, LTSS, social services and enhanced benefits; this includes setting up appointments; in-person contacts as appropriate, strong working relationships between care managers and physicians; evidence-based Enrollee education programs, and arranging transportation as needed; 7) monitor functional and health status; 8) ensure seamless transitions of care across specialties and settings; 9) ensure that individuals with disabilities have effective communication with health care providers and participate in making decisions with respect to treatment options; 10) connect individuals to services that promote community living and help avoid premature unnecessary nursing facility placements; 11) coordinate with social service agencies; 12) work with nursing facilities to promote adoption of evidence-based interventions to reduce avoidable hospitalizations, and include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the NF benefit. Items 6 through 12 must be part of the care plan for vulnerable populations.

distribution to meet the complex and diverse needs of the anticipated number of enrollee in the service area. For Medicare services, sufficiency is measured by current Medicare standards, unless Medicaid is more stringent. For long-term services and supports (LTSS), Medicaid standards apply. The MOU does not explain these standards in detail. Home health and DME, as well as other overlap services, are subject to the more stringent standard of either program.[28] Plans will be required to contract with any nursing facility that is eligible to participate in Medicare and Medicaid and is willing to accept the plan payment rates and contract requirements.[29] This requirement appears to extend through the duration of the demonstration.

Care continuity:

Under the Virginia MOU, plans are required to honor all existing care plans and prior authorization until the authorization ends or 180 days pass after enrollment, whichever is sooner.[30] Current residents of a nursing home are permitted to stay in the facility even if the facility is not part of the plan's network.[31]

One potential problem with the approach taken in the MOU is the use of the term "preauthorized services." This formulation may exclude scheduled services covered by Medicare that were not subject to prior authorization.

Virginia's 180 day care continuity period is similar to that in the Illinois MOU; however, the details of care continuity requirements across state MOUs show little consistency.[32]

Grievances and appeals:

The MOU creates a partially integrated appeals process. Enrollees are required to begin the appeal process by filing an internal plan appeal in writing within 60 days. Enrollees have to exhaust this internal plan appeal process before requesting a State Fair Hearing (SFH), a loss in rights and protections in Virginia where Medicaid managed care enrollees are currently permitted to straight to a SFH.

If the internal plan appeal upholds the plan's initial decision and pertains to a service covered by Medicare, a second level appeal will be auto forwarded to a Medicare Independent Review Entity (IRE). If the appeal pertains to a Medicaid service, the beneficiary can request a SFH. If

[28] MOU at 67.
[29] MOU at 68.
[30] MOU at 61.
[31] MOU at 74.
[32] National Senior Citizens Law Center, Continuity of Care in the Dual Eligible Demonstrations: A Tool for Advocates, (May 2013).

both the IRE and SFH issue a decision, the plan is bound by the decision most favorable to the beneficiary.

A separate system will be developed, in the plan contracts, for overlapping services.

For Medicaid services, enrollees will retain the right to receive aid paid pending an appeal as long as they meet applicable deadlines for filing appeals. At the internal plan level appeal, enrollees will also have a right to receive aid paid pending for Medicare services.[33]

Quality Measures

The MOU contains a long list of quality measures that are generally Medicare-related and consistent across all demonstration states. It also includes a few quality measures unique to the state. A subset of measures will used for the quality withhold described above. The quality withhold measures include state specific measures related to the provision of long term services and supports, such as:[34]

Percent of enrollees with documented plans of care developed within specified time frames.
Percent of enrollee plans of care that include documented discussions of care goals.
Participating plan has established work plan and systems in place for ensuring smooth transitions to and from hospitals, nursing facilities and the community.

In addition to these quality withhold measures, the MOU includes about40 more LTSS measures, most derived from Virginia's 1915(c) waiver program:[35]

This memo is a just a summary of the MOU. The MOU contains much more information about the demonstration and how it will impact the lives of dual eligibles living in Virginia. However, even with the information provided in the MOU, several important policy and operational questions are still outstanding and will need to be further developed in plan contracts and elsewhere.

For more information on the dual eligible demonstrations and their impact on beneficiaries, visit www.dualsdemoadvocacy.org, or subscribe to the National Senior Citizens Law Center's health policy alerts at www.nsclc.org/index.php/store/subscriptions.

[33] MOU at 77-79.
[34] MOU at 50.
[35] MOU at 95-98.