**Highlights of Virginia's Memorandum of Understanding with CMS**

For the Virginia Demonstration to Integrate Care for Dual Eligible Beneficiaries,
Commonwealth Coordinated Care

**Scope**

- Participants include dual eligibles ages 21 and older entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and receiving Medicaid benefits. Individuals enrolled in the Commonwealth's Elderly or Disabled with Consumer Director (EDCD) Waiver and those residing in nursing facilities are also included in the demonstration.
- Excluded individuals from the demonstration include, but are not limited to the following: persons who are required to "spend down" income to meet Medicaid eligibility requirements, individuals who are inpatients in Commonwealth mental hospitals, persons enrolled in a hospice program, individuals in the federal waiver programs for home and community based services except the EDCD waiver, and individuals in a Program for All-Inclusive Care for the Elderly (PACE), Money Follows the Person program, and CMS Independence at Home demonstration.
- The demonstration will be implemented in 5 regions of the Commonwealth and will run from February 1, 2014 to December 31, 2017.

**Contracting and Rates**

- CMS and the Commonwealth will enter into a joint rate-setting and procurement process as described in Appendix 7 of the MOU.
- CMS will develop baseline spending and payment rates for Medicare A and B services using estimates of what Medicare would have spent on behalf of beneficiaries without the demonstration using a blend of Medicare Advantage projected payment rates and Medicare FFS standardized county rates. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year.
- Medicaid actuarial soundness will apply to payments to health plans. The Commonwealth will develop baseline spending and payments rates for Medicaid based on historical Commonwealth data and trend rates with oversight from CMS.
- Rates for each demonstration year will incorporate projected savings as follows: Year 1, 1%; Year 2, 2%; and Year 3, 4%.
- CMS-HCC risk adjustment methodology will be applied to the Medicare A/B portion of the rate and Part D RxHCC will be applied to the Part D portion. The Medicaid portion of the blended rate paid to plans will include a rate cell structure risk adjustment.
- CMS will apply a certain Medicare Advantage coding intensity adjustment factor to risk scores in calendar year 2014 based on the proportion of the target population with prior MA experience on a county-specific basis. After 2014, CMS will apply the prevailing MA coding intensity adjustment.
- CMS will impose Minimum Medical Loss Ratio (MMLR) requirements on Participating Plans. If a plan has an MMLR between 85% and 90% of the joint Medicare-Medicaid payment to the plans, the Commonwealth and CMS may take corrective action or levy a fine on the plan. Plans must remit back to the Medicare and Medicaid programs any amounts by which the 85% threshold exceeds a plan's actual MMLR multiplied by the total applicable revenue of the contract.

**Enrollment**

- Passive enrollment is effective no sooner than 60 days after beneficiary notification of the right to select a Participating Plan. Eligible individuals will be phased-in and will have the opportunity to opt out until the last day of the month prior to the effective date of enrollment.
- Disenrollment from Participating Plans and transfers between Participating Plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month.

**Consumer Protections**

- CMS, the Commonwealth, and Participating Plans shall ensure that all medically necessary covered benefits are provided to Enrollees and are provided in a manner that is sensitive to the Enrollee's functional and cognitive needs, language and culture, allows for involvement of the Enrollee and caregivers, and are in a care setting appropriate to the Enrollees' needs, with a preference for the home and the community. Communication with Medicare-Medicaid enrollees must include accommodations for those deaf or hard of hearing, those with cognitive impairments, and those who do not speak English.
- Medicare-Medicaid enrollees will be provided independent enrollment assistance and options counseling.
- The Commonwealth intends to support an independent Ombudsman outside of the Commonwealth Medicaid agency.
- CMS and the Commonwealth will develop a unified set of requirements for participating plan grievances and internal appeals process that incorporate relevant Medicare Advantage and Medicaid managed care requirements, except Part D appeals and grievances will continue to be managed by CMS as proscribed under existing Part D rules.
- Quality withhold measures will be applied to the demonstration for Medicare Parts A and B and Medicaid. The percentage withhold will be 1%, 2%, and 3% in each of the three demonstration years, respectively.

**Care Model and Assessments**

- All Participating Plans will be required to implement an evidence-based model of care (MOC) having explicit components consistent with the Special Needs Plan Model of Care standards, as well as additional requirements established by the Commonwealth.
- Each enrollee will have a person-centered, individualized care plan led by an Interdisciplinary Care Team (ICT) that will ensure the integration of the Enrollee's medical, behavioral health, substance use, LTSS, and social needs. Participating Plans will implement a person-centered, culturally competent Plan of Care development process, incorporating Targeted Case Management as applicable to certain enrollees.
- If an Enrollee is receiving Medicaid State Plan Targeted Case Management services, the Participating Plans must develop a mechanism to include the targeted case manager as a member of the ICT.
- Initial comprehensive assessments must be completed within 90 days of enrollment and must be in person for individuals enrolled in the EDCD Waiver and those residing in nursing facilities.

**Continuity of Care**

- Participating Plans must allow Enrollees to maintain their current providers (including out of network providers) for 180 days from enrollment.
- Participating Plans will advise in writing beneficiaries and providers that they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, Participating Plans must also contact providers not already members of their network with information on becoming credentialed as in-network providers.
- Participating Plans are required to provide or arrange for all medically necessary services provided by the three-way contract, whether by sub-contract or by single-case agreement in order to meet the needs of an individual beneficiary.

**Evaluation**

- CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the demonstration on cost, quality, utilization, and beneficiary experience of care. The evaluator will design a Commonwealth-specific evaluation plan for the Virginia Demonstration, will use a comparison group for its impact analysis, and will also submit Virginia-specific annual reports that incorporate qualitative and quantitative findings to date and a final evaluation report at the end of the Demonstration. Virginia and Participating Plans must submit all required data for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements to be listed in the three-way contract.